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# Refugees, HIV/AIDS and Access to Medical Care: A Case Study of Cairo, Egypt

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Refugees, HIV/AIDS and Access to Medical Care:  
A Case Study of Cairo, Egypt

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**Abstract**

Urban refugees in Egypt are at high risk for HIV/AIDS because of the lack of adequate health resources, social stability and the intense stigma and discrimination surrounding HIV/AIDS. Based on a literature review and semi-structured interviews conducted in Cairo, Egypt, this paper uses a vulnerability perspective to examine the challenges facing HIV-positive refugees in accessing necessary medical care. The combination of policy, structural forces and social relations results in a chain of causation that marginalizes refugees in Egyptian society. These social processes results in unequal access to health resources for refugees, thereby increasing their potential exposure to HIV transmission. This contextualized analysis of vulnerability and access to medical care highlights the potential to not only address the issue of HIV/AIDS services for refugees, but also to improve the economic, social and cultural standards of living for refugees in Cairo. Therefore a multi-faceted approach is necessary in order to find comprehensive solutions to address these underlying factors.

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**List of Acronyms**

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
IDU	Injection drug user
MOHP	Ministry of Health and Population
MSM	Men who have sex with men
NAP	National AIDS Program
PLHIV	People living with HIV
STI	Sexually transmitted infection
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing
WHO	World Health Organization

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## **Chapter I: Introduction**

The scope of the HIV/AIDS pandemic has created significant public health challenges around the world and in response, prevention efforts have focused on high-risk groups through country-specific programs. However, the increasing mobility of populations has impacted the diffusion of HIV and failing to acknowledge this relationship could undermine prevention efforts worldwide. Refugees, in particular, are a mobile population who face a variety of challenges that can inevitably increase their risk of HIV transmission (UNAIDS et al, 2005).

The relationship between HIV/AIDS and refugees is very complex as a variety of factors can influence the risk of refugees to HIV (Spiegel, 2004). Increased vulnerability results from the disruption of resources including treatment, prevention efforts and coping mechanisms. On the other hand vulnerability can also be reduced by limiting mobility and consequently decreasing exposure to the virus as well as increasing access to humanitarian services. Finally, vulnerability is influenced by prevalence gaps between populations and whether or not refugees enter into areas of higher or lower prevalence (Spiegel, 2004). Understanding this complex relationship between HIV/AIDS and refugees is imperative in order to help find ways to provide necessary health care and prevent increased transmission of HIV (Spiegel, 2004). This is particularly true in Africa, where not only the majority of HIV/AIDS cases are found, but increasing conflicts in the continent have displaced millions (UNAIDS et al., 2005).

Providing HIV/AIDS services to refugees is a daunting task due to the difficulty of establishing services in complex emergencies as well as the multitude of factors that both increase and decrease refugees' vulnerability (Spiegel, 2004). Under international



human rights law, countries of asylum are responsible for providing equal and non-discriminatory access to existing health services (UNAIDS et al., 2005). Yet, with many countries of asylum already overburdened by the HIV/AIDS epidemic, refugees are seldom included in National AIDS programs, leaving them with limited options for HIV/AIDS services. The HIV-related needs of refugees therefore are normally addressed by humanitarian organizations within the host country.

Cairo, Egypt has experienced an influx of refugees from Africa and the Middle East and provides a unique case study in understanding the relationship between HIV/AIDS and refugees. Due to reservations held by the Egyptian government on the 1951 Convention Relating to the Status of Refugees, refugees in Egypt receive little assistance from the Egyptian government and therefore must depend on the limited resources of international organizations (Zohry et al, 2003). Refugees in Egypt reside in the urban areas of Cairo, which complicates their access to services as they are dispersed throughout the city and essentially become invisible among the urban poor (Grabska, 2005). This leaves refugees in Egypt at high risk for HIV/AIDS as they are inherently more vulnerable to the virus without adequate health resources and social stability.

Apart from the limited availability of services, refugees also face several barriers in accessing HIV/AIDS services including constrained socio-economic rights, urban isolation as well as high stigma and discrimination. Using a vulnerability perspective, this paper looks at the challenges that result from economic, social and cultural forces and how they limit access to services and consequently increase refugees risk to HIV. Using a combination of a literature review and semi-structured interviews conducted with health agencies in Cairo, this paper incorporates the vulnerability perspective to provide

important insight into understanding how structural factors increase the vulnerability of refugees in Egypt to HIV/AIDS. Using this analysis will provide an avenue to investigate possible solutions to increase access to HIV/AIDS services by addressing the underlying vulnerabilities of refugees in Cairo through a more multi-faceted approach.

With the limited literature available on HIV/AIDS and refugees, this case study seeks to further the understanding of the relationship between HIV/AIDS and refugees. Current research primarily focuses on strategic plans and approaches to incorporate when addressing the HIV-related needs of refugees (UNAIDS et al., 2005). While the factors that influence HIV risk are discussed, there remains a gap in the literature about the application of these initiatives and other case specific examples of programs. As a result, this research provides a case study as an example of understanding access to HIV/AIDS services as well as offering insight into the unique situation of urban refugees and the challenges they face in accessing HIV/AIDS services. Finally, on a larger scale, by incorporating the vulnerability perspective, this research seeks to extend the analyses of refugees and HIV/AIDS to include questions of access and how structural factors influence the vulnerability of refugees.

## **Chapter II: Literature Review**

### *Epidemiology of HIV/AIDS*

Since the discovery of the HIV virus in the early 1980s, the HIV/AIDS pandemic has taken forefront in the global public health agenda. Globally there are estimated to be 33 million people living with HIV, and in 2007 there were 2.7 million new cases reported (WHO, 2008). Overall, AIDS has resulted in 27 million deaths worldwide with two million deaths reported in 2007. The prevalence of HIV/AIDS varies between the developed and developing world, with 95% of HIV cases reported in developing countries (Mayer, 2005). Sub-Saharan Africa has been severely affected by the pandemic as 67% of people living with HIV live in this region. This devastating rate of infection has led to significant demographic changes within the populations of countries throughout sub-Saharan Africa (WHO, 2008).

HIV is a retrovirus that attacks the T-helper cells in the human immune system. This leads to the weakening of the human immune system causing individuals to become more susceptible to disease and eventually unable to fight off infection (CDC, 2008). HIV is transmitted through the exchange of bodily fluids that contain the retrovirus, including blood, semen, vaginal fluids and breast milk. The virus enters the body either directly through the bloodstream or by passing through delicate mucous membranes. Once HIV enters the human blood stream, the retrovirus begins to proliferate through the body and in response the immune system creates antibodies to the virus. The main methods of transmission are unprotected sexual intercourse with an infected partner, infected blood transfusion, the sharing of infected needles and transmission from mother to child either through labor or breast-feeding (WHO, 2008).

Currently the only HIV testing routinely available looks for the presence of HIV antibodies in the blood stream (CDC, 2008). However, it can take anywhere from six weeks to twelve months for HIV antibody levels to reach a threshold that can be detected within this blood test. This “latency period” of the immune response creates a huge challenge for the prevention of HIV since HIV infected individuals can be tested for HIV but not test positive for an extended period of time. This leaves many unaware of their status, preventing them from taking appropriate precautionary measures to protect themselves and others (CDC, 2008).

When a person is HIV positive, HIV antibodies are present in their bloodstream, and as the virus continues to replicate in the body, the number of T-helper cells decreases thus weakening the immune system (CDC, 2008). Once the level of T-helper cells in the bloodstream reaches 200 hundred/ $\mu$ L or 400 hundred/ $\mu$ L with the presence of an opportunistic infection, a patient is diagnosed with Acquired immunodeficiency syndrome (AIDS). With a compromised immune system, they are unable to fight off common diseases and therefore become more prone to opportunistic infections like tuberculosis (TB) or pneumonia. While there is currently no cure for HIV infection or AIDS, individuals can prevent the onset of AIDS through antiretroviral drug therapy (ARVs). ARVs are drugs that specifically target the proliferation of the virus through the blood stream by preventing the retrovirus from replicating. The main types of ARV treatment include ARV prophylaxis and long-term treatment (UNAIDS, 2005). ARV prophylaxis is a shorter medicine regime that is prescribed in situations to prevent transmission after limited exposure. For example, ARV prophylaxis is generally given to rape victims or to mothers and infants before and after labor to prevent mother-to-child

transmission. Long-term ARVs on the other hand are given to patients infected with HIV to prevent the onset of AIDS by keeping the levels of the virus and t-cells controlled (UNAIDS, 2005).

There are two strains of HIV: HIV-1 and HIV-2, with HIV-1 being responsible for the majority of HIV cases worldwide (Mayer, 2005). The difference between these two strains can be mainly attributed to the biological structure of the retrovirus, with HIV-2 being a less virulent strain that is harder to transmit and slower acting. While HIV was globally recognized in 1981, HIV-1 was not isolated until 1983. Two years later in 1985, HIV-2 was first identified (Kalipeni, 2004). Both of these strains have been biologically characterized and traced to have originated in Central Africa (Mayer, 2005). HIV-1 in particular is structurally similar to simian deficiency virus (SIV) a similar immunodeficiency virus in chimpanzees whereas HIV-2 is similar to SIV in sooty magabeys (Mayer, 2005). Despite the biological similarities, how the virus mutated and transferred from the primate to human population remains unknown.

### *Vulnerability Perspective*

The vulnerability perspective is an important conceptual framework that seeks to understand what factors increase the vulnerability of populations to hazardous events. A common tool in critical hazards geography, Gilbert F. White introduced the importance of incorporating social approaches to hazard studies as an alternative to the “environment as hazard” approach, which was prevalent in geography (1942). Since then many authors including Kenneth Hewitt, Ben Wister and Terry Cannon, have continued to use the vulnerability approach in the analysis of environmental and natural hazards. By analyzing

the societal conditions that influence the vulnerability of individuals to hazards, the vulnerability perspective exposes underlying inequalities by looking at individual susceptibility, exposure and structural factors (Hewitt, 1997). Through this approach, risk is assessed as the combination of population vulnerability and potential hazard, leading to proposed societal solutions to address structural factors and thus decrease vulnerability (Rhodes et al., 2004).

There are a number of models which geographers who study environmental risk and hazards use to analyze how various scales and structures impact vulnerability. Two hazards approach models, proposed by Wisner et al., (2004) discuss how structural forces influence vulnerability and risk to natural hazards. For these models, structural factors are considered the combination of economic and social pressures from power structures, economic resources and social relations that cause unsafe conditions due to a differential access to resources (Wisner et al., 2004). For example, vulnerability to hazards can be magnified because of a lack of mitigation strategies available through public institutions, or because poverty limits the economic capacity of populations to protect themselves.

The Pressure and Release Model highlights the interaction between root causes, dynamic pressures and unsafe conditions, and how larger structural forces of political and economic systems can adversely affect the vulnerability of populations to hazards (Wisner et al., 2004). Expanding on this interaction between hazard and vulnerability, Wisner et al., also introduces the Access Model that focuses on the structural conditions within society that influence access to resources. Within this framework, social relations and structures of domination are analyzed in an attempt to understand the social causation of disasters. From this, scholars can analyze the progression of vulnerability of

populations and how hazards are intertwined with human systems in affecting assets and livelihoods (Wisner et al., 2004).

Another important concept within the vulnerability perspective is the risk environment and how particular social, cultural, economic and political conditions increase risk (Rhodes et al., 2005). At both the micro- and macro-level, the risk environment accounts for physical location, social and cultural norms, economic influences and applicable policy that combine to increase vulnerability to hazards. Through the combination of personal decisions and structural factors, this emphasis produces a more comprehensive analysis of risk (Rhodes et al., 2005). As a result the risk environment is an important concept that shifts the focus of intervention from individuals to the social situations that place populations in vulnerable situations.

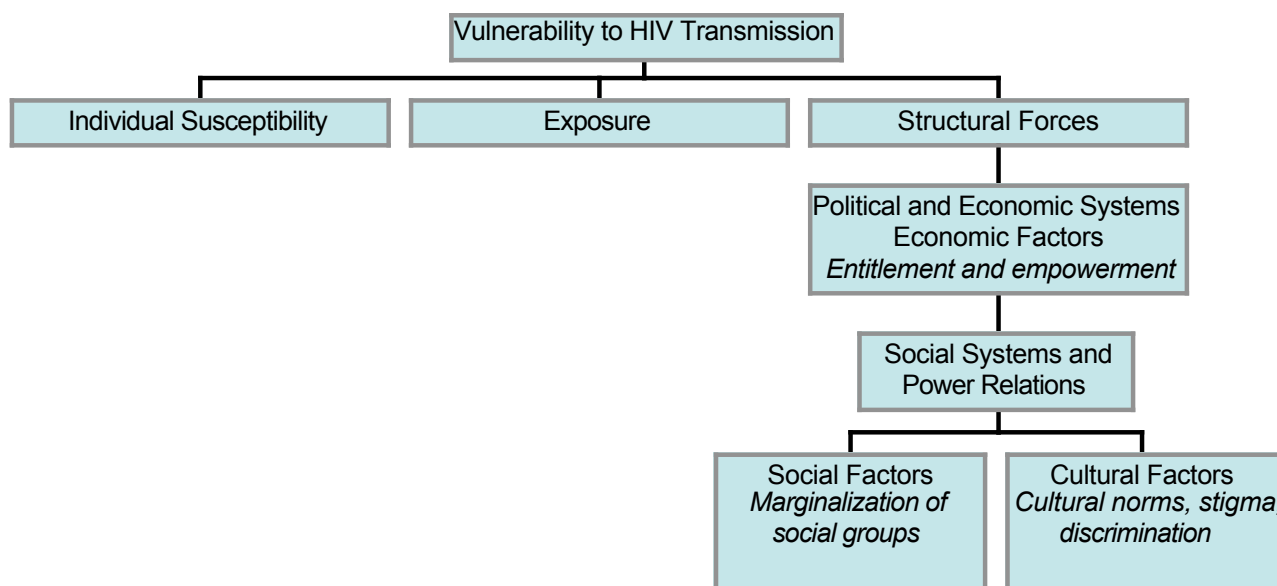
Apart from being an important tool in the study of natural hazards within geography, the vulnerability perspective has recently been adapted within the field of medical geography to become a powerful tool in explaining disease patterns. When applying the vulnerability perspective to understanding disease as an environmental hazard, the same criteria are adopted but altered to fit the mechanisms of disease and epidemic patterns. First of all, exposure relates to the exposure of an individual to the virus through direct or secondary contact. Following this, vulnerability can be influenced by individual susceptibility, which is determined by pre-existing immunological or biological conditions that increase the risk of an individual for acquiring the disease. Finally vulnerability is also assessed by looking at structural factors and specifically what societal factors influence access to health care, the ability to lead a healthy lifestyle,

forces that place individuals in hazardous conditions as well as the resources they have access to.

Within the study of HIV/AIDS and medical geography, the vulnerability perspective has been adopted to analyze the spatial distribution of HIV prevalence. While scholars have acknowledged that populations have similar individual susceptibility to HIV, structural factors play a large part in determining exposure to the virus. Thus, as shown in Figure 1, looking at economic, social and cultural factors contributes to differential access to resources, which in turn creates different levels of vulnerability to HIV transmission depending on an individual or groups' access to these resources. With this approach, risk is no longer based on purely biological characteristics but rather, is expanded to include the influences of social, cultural and economic factors (Mayer, 2005). Therefore the vulnerability perspective emphasizes how HIV diffusion patterns commonly reflect the spatial distribution of vulnerable groups by isolating them both geographically and socially (Oppong, 1998). Understanding the myriad factors that make vulnerable groups more susceptible to HIV can help strengthen public health initiatives by tackling the underlying causes of vulnerability and incorporating targeted initiatives to address the enablement and empowerment of vulnerable people (Oppong, 1998).



Figure 1: Vulnerability Perspective and HIV/AIDS



Source: Diagram based on the works of Oppong, 1998; Wisner et al., 2004

Economic vulnerability is related to a person's entitlement and empowerment, which when compromised, limits the availability of resources. As explained by Watts and Bohle, adverse circumstances like disease do not affect groups uniformly and this can be tied to economic factors (1993). On a large scale, economic vulnerability can be influenced by the outside forces of structural adjustment. As Mayer notes, the increased structural adjustment policies in sub-Saharan Africa aimed at increasing the economic growth of countries in reality has led to the weakening of their health infrastructure as resources have been reallocated to larger economic projects (2005). Through this, economic growth in other sectors has indirectly increased the vulnerability of populations by preventing them from accessing the necessary medical services to prevent the onset of the HIV epidemic.

Similarly, socioeconomic status within society can determine the degree of access populations have to resources. For example, poverty is one of the largest economic determinants, and as poverty limits the number of resources available, it can have severe

impacts on the ability for populations to protect themselves from disease. As a result, economic circumstances that determine an individual's entitlement to resources can make individuals more biologically susceptible (Kalipeni et al, 1998).

Through these structural forces that perpetuate economic vulnerability, individuals are forced to partake in risky behavior in order to gain access to necessary resources (Oppong, 1998). As shown in J.R. Oppong's case study of HIV prevalence in Ghana, poor economic conditions in Ghana have caused women in Ghana to become actively involved in the commercial sex industry with neighboring Cote d'Ivoire. Their actions consequently increase their risk to HIV, yet without alternative means to acquire resources, their economic circumstances influence their vulnerability to HIV.

In addition to economic vulnerability, the vulnerability perspective looks at how social systems and power relations impact risk through social and cultural factors. One important aspect is the marginalization of social groups and how through social vulnerability, populations become more prone to contracting the disease (Oppong, 1998). One of the most prominent examples is the relationship between HIV and gender as shown in the disproportional impact of HIV/AIDS on women in sub-Saharan African. For example, in Ghana, the sex ratio of HIV/AIDS cases is a staggering 5 female:1 male, which is extremely unusual (Oppong, 1998, 441). This ratio can be attributed to the lower status of women within society, which decreases their autonomy and negatively impacts their access to resources. This pattern can be seen across other countries as well, where women lack the independence to practice safe sex behavior or access to medical services due to their low status in society. This power differential consequently increases their vulnerability to HIV by limiting the efforts they can take to protect themselves.

Similarly, cultural factors can be the most influential in increasing vulnerability by impacting the cultural framing of disease (Craddock, 2000). Within the cultural framing of disease, knowledge is constructed that creates lasting impact on the way a society reacts to and engages with health and disease. As Craddock argues, powerful cultural factors cause disease to be “culturally constructed and socially deployed” (2000, 164). Through cultural narratives and norms, ideals surrounding behavior (and in the specific case of HIV/AIDS, expressions of sexuality and promiscuity) inevitably determine the way HIV/AIDS is perceived within a society. These cultural constructions can selectively impact which social groups become more vulnerable, as well as the way that society deals with a disease, by providing barriers to communication and ultimately prevention. Acknowledging how these cultural barriers are constructed through the interplay of local, state and global economies of power is essential in order to provide effective ways to deal with the epidemic.

Cultural narratives and norms also inevitably result in stigma and discrimination surrounding this virus and those affected with it (Craddock, 2000). As a result, one of the biggest challenges in addressing the HIV/AIDS pandemic is attempting to deconstruct the misconceptions surrounding the virus. Because HIV is most commonly transmitted by sexual acts, the disease is often a taboo topic. This frequently stifles discussion around HIV/AIDS or even silences it, which ultimately hinders prevention efforts by isolating vulnerable individuals and preventing them from seeking necessary education and treatment (UNAIDS, 2003). This stigmatization of the disease has led to increased discrimination against infected individuals, creating a vicious cycle that prevents HIV

positive individuals from receiving the care they need and therefore increasing their vulnerability and the vulnerability of those in their communities.

Looking specifically at differential access to resources resulting from social, economic and political factors, the vulnerability perspective provides important insight into understanding how the spread of HIV/AIDS is influenced by non-biological factors. Shifting emphasis from individual behavior to social structures that cause individuals to participate in risky behavior helps to identify risk environments. Recognizing these risk environments allows for the realization of how social processes place populations in risky circumstances (Rhodes et al., 2005). This acknowledgement that risk is no longer a purely biological entity is extremely important to acknowledge especially in public health initiatives, in order to ensure that solutions are proposed to remove the economic, social and cultural obstacles through appropriate structural changes (Oppong, 1998). Ensuring that the underlying causes of vulnerability are addressed will help the success of information-based programs by providing parallel initiatives to address the enablement and empowerment of vulnerable populations (Oppong, 1998).

### *Forced Migration*

With the increasing number of conflicts around the world, the number of refugees and displaced persons are of growing concern. In 2007, worldwide there were 25.1 million refugees and internally displaced persons, with 2.5 million new refugees in 2007 alone. This is a staggering increase from 19.2 million persons in 2005, highlighting the growing need for durable solutions to address conflicts that are continuing to increase the number of refugees (UNHCR, 2008). Further complicating the issue is the growing

number of refugees in the developing world. With the majority of refugees located in areas with limited resources, this further complicates access to necessary resources and the distribution of humanitarian aid.

The rights and status of refugees are defined by a number of international treaties and conventions (UN, 1967). States that ratify these instruments have the responsibility to provide the appropriate protection and rights defined within the convention such as determining refugee status, providing identity documents and ensuring human rights (Bailey, 2004). The first United Nations Convention Relating to the Status of Refugees took place in 1951 with the Protocol Relating to the Status of Refugees coming into effect in 1967. From these two legal conventions the term “refugee” was defined as any person who:

Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular group or political opinion, is outside the country of his nationality and is unable or owing to such a fear, unwilling to avail himself of the protection of that country (Art 1 (2)). (UN, 1967)

This definition, focusing on individual persecution was modified in 1969 by the

Organization of African Unity to include people who

owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part of the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside of his country of origin or nationality (Art. 1 (2)). (OAU, 1969)

Expanding the definition to include individuals fleeing en masse from their country of origin allowed for the basis of recognizing groups of refugees rather than just granting individual claims (Bailey, 2004). As a result many refugees, especially when entering

African states, are recognized on the basis of *prima facie*<sup>1</sup> and this results in the ability to grant refugee status to large numbers of refugees fleeing to refugee camps (Bailey, 2004).

Under Article 23 of the 1951 Convention, host countries are expected to provide “equal and non-discriminatory access to existing health services for refugees” (UNAIDS et al., 2005). This, in conjunction with international human rights law, requires countries to provide individuals with the highest attainable standard of physical and mental health. However, despite this mandate, “health care” is not defined within the Convention, which leads to major discrepancies in interpretation between curative and preventative care (Eidenier, 2006). In regards to HIV/AIDS medical services the situation is even more abstract. Countries seldom include the HIV-related needs of refugees within their National Strategic Plans since countries already overburdened with HIV/AIDS within their own population are usually unwilling to provide additional services and do not include refugees in their National AIDS Policies (UNAIDS et al., 2005). This leaves refugees in an extremely vulnerable situation as they may not have access to HIV-testing, antiretroviral therapy or even basic HIV education and prevention strategies (UNAIDS et al., 2005). This is not only discriminatory but undermines prevention efforts within the country. Consequently, the integration of refugees into National AIDS Programs (NAPs) as well as the cooperation between host countries, intergovernmental organizations and nongovernmental agencies, is seen as a vital step towards helping HIV-positive refugees.

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<sup>1</sup> *Prima facie* is when refugee status is granted based on a refugee’s country of origin, rather than individual claim of personal persecution.

*Refugees, HIV/AIDS and Vulnerability*

As described above, refugees are particularly vulnerable to HIV/AIDS, and addressing their medical needs is essential to carrying-out an effective public health effort against HIV/AIDS. Although this topic has been gaining importance over the last decade, there continues to be limited literature available on the relationship between HIV/AIDS and refugees. Studies that are available acknowledge that as a marginalized group refugees can be inherently more vulnerable to HIV/AIDS, which is exacerbated through the loss of social stability and exposure to conflict (Spiegel, 2004). However due to the circumstantial nature of forced migration, the relationship between forced migration and HIV/AIDS depends on a variety of factors related to the specific circumstances of the refugee population and host countries.

The relationship between HIV/AIDS and forced migration is very complex and there is a multitude of factors that both increase and decrease refugees' vulnerability (Spiegel, 2004). Factors that increase vulnerability disrupt access to resources consequently impacting treatment, prevention efforts and coping mechanisms. These include the loss of physical, financial and societal security and the increase of sexual violence (Spiegel et al, 2004). Behavioral changes to deal with lack of income and instability can also occur, including transactional sex or increasing drug use, which can greatly increase the spread of HIV if the necessary preventative measures are not taken (UNAIDS et al., 2005). Finally the reduction in health and educational resources and services prevents refugees from taking the necessary preventative measures to stop the spread of HIV severely undermining prevention efforts for the entire community (Spiegel, 2004).

On the other hand, forced displacement can sometimes decrease vulnerability by decreasing exposure to HIV by reducing mobility as well as increasing access to services from humanitarian organizations. Refugees in refugee camps are confined within the boundaries of the camps, which can reduce their mobility, preventing them from being exposed to populations outside of the camp that may have higher HIV prevalence. As a result, refugees are less exposed to high-risk activities of prostitution or injection drug use that may increase HIV transmission (Spiegel, 2004). Refugee camps may also provide better HIV/AIDS services for refugees as compared to what was available in their countries of origins. While HIV services are not always provided in emergency response situations, long-term occupants of refugee camps may have better access to condoms or HIV testing that can actually allow refugees to take more preventative measures against the spread of HIV.

Ultimately, however, the vulnerability of refugees depends on HIV prevalence gaps between populations and whether or not refugees enter higher-or-lower risk environments (Spiegel, 2004). From this, the level of interaction between populations determines whether or not forced migrants are more vulnerable. For example, if refugees enter a country where the HIV prevalence is higher than that of their country of origin, their vulnerability is increased as they face greater exposure to HIV from the host population. Studies have shown that in general refugees migrate from countries with lower prevalence compared to the HIV prevalence of host countries (Spiegel, 2004). Therefore the common misconception that refugees bring HIV with them to host countries is often false.



With the vast number of competing and inter-related factors that impact the vulnerability of refugees, it is essential to use temporal and context-specific circumstances to understand how to guide HIV policies and programs (UNAIDS et al., 2005). Specifically, acknowledging and tracking the HIV prevalence among refugees and host populations is imperative both for the safety of the forced migrants and local populations to ensure effective preventative measures are designed and implemented. The availability of resources is also important to monitor, especially for refugees not living in refugee camps, since the material support for these individuals can be very limited (Spiegel, 2004).

#### *Policies Addressing HIV/AIDS and Refugees*

Until 1990, there was very little policy emphasis on the medical needs of HIV positive refugees. At the time, HIV prevention and response was considered secondary to the emergency response of providing shelter, food and protection, needed in refugee camps in war-torn areas. In addition, there was a fear that highlighting the needs of HIV positive refugees would cause host countries to reject refugees out of fear of spreading the virus (Spiegel et al, 2005). However as the immediate needs and importance of addressing HIV concerns have arisen, new policies have been implemented to address these issues. UNHCR and UNAIDS are the biggest actors in addressing the issue of HIV/AIDS and refugees. They work in coordination with governments to help create appropriate responses to refugee situations and provide the best and necessary HIV/AIDS related care for refugees (UNAIDS et al., 2005).

In the early 1990s, the protection mandate, “Policy Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)” was published by UNAIDS and mandated that refugees could not be expelled from a country based on their HIV status (UNHCR, 1990). Published in response to the growing practice of testing refugees for HIV before allowing them to travel internationally or apply for resettlement, this was the first policy to specifically target the issue of refugees and HIV/AIDS. Since then, UNHCR has continued to publish guidelines and strategic plans emphasizing the rights of refugees with regards to HIV and AIDS, including discouraging the use of mandatory testing and emphasizing the human rights of refugees.

According to UNHCR and UNAIDS protocol, there are three main time periods that determine the response to tackle the HIV-related needs of refugees (UNAIDS et al., 2005). The first phase is the emergency phase where the Inter-agency Standing Committee recommends a minimum set of interventions. These include (i) establishing coordination mechanisms; (ii) providing access to basic health care for the most vulnerable people; (iii) providing a safe blood supply; (iv) adhering to universal precautions; (v) providing basic HIV education materials; (vi) providing condoms; (vii) offering syndromic sexually transmitted infection treatment; (viii) providing appropriate care for intravenous drug users; (ix) managing the consequences of sexual violence: and (x) ensuring safe material deliveries (UNAIDS et al., 2005, 5). This initial response is particularly important as it is at this phase where refugees can be especially vulnerable due to the deprivation of housing, food, security and health services and information.

The second phase revolves around post emergency or stabilization conditions where more comprehensive interventions can be used to prevent HIV transmission as

well as provide the necessary support, care and treatment of HIV-positive persons (UNAIDS et al., 2005). Current recommended interventions include expanding comprehensive programs to prevent sexual violence, providing post-exposure prophylaxis ARVs, distributing education materials about HIV and providing voluntary confidential counseling and testing (VCCT) as well as services to prevent mother-to-child transmission. In ideal situations, this second phase would also provide necessary ARV therapy or the treatment of opportunistic infections in AIDS patients.

Whereas the two previous phases dealt with the provision of necessary HIV-related medical care and education, the last phase focuses on durable solutions that include repatriation, local integration and resettlement (UNAIDS et al., 2005). These solutions provide means to prevent HIV positive refugees from feeling vulnerable or isolated through this transitory phase. Part of these durable solutions requires that in order to prevent discrimination due to their HIV status, refugees are not forced to undergo mandatory testing or disclose their HIV status. Another issue is ensuring continued access to HIV/AIDS services for refugees once resettled or repatriated. Continuing ARV therapy is especially important since changes or lapses in this regime can significantly impact the medical progress of an individual (Spiegel, 2004). In response to these challenges, UNHCR and UNAIDS suggest that interventions should include continuing prevention efforts in refugee camps, public information campaigns, especially for refugees returning to areas with limited HIV programs, and comprehensive education campaigns to ensure that HIV status is not an issue for refugees attempting to repatriate, resettle or integrate into the local population (UNAIDS et al., 2005).

Despite the extensive list of recommended interventions, one of the biggest obstacles to providing necessary medical care and prevention efforts to refugees is the lack of resources available for these situations (UNAIDS et al., 2005). While humanitarian organizations do have some funding to provide emergency response interventions, especially for those recommended in the secondary phase, which are often more comprehensive, funding is limited and often inadequate. From this stems the question of who is ultimately responsible for the HIV-related needs for refugees, especially with regards to VCCT and ARV (Spiegel, 2004). As mentioned previously, many countries that host refugees are already overburdened by the HIV/AIDS epidemic and do not have the necessary means to provide additional services for a temporarily displaced population. In addition, due to prevalence gaps between populations, the HIV-related needs of refugees and host populations may not always match resulting in a discrepancy in available services. As a result, the majority of countries do not include refugees in their National AIDS Programs. These actions not only limit the availability of HIV/AIDS services for refugees, but also undermine national prevention efforts by ignoring the needs of a high-risk group. Importantly, this inaction inevitably places both refugee and host populations at greater risk to HIV.

Apart from developing policies to address HIV-related needs of refugees in emergency situations, in 2005 UNHCR and UNAIDS collaborated to develop specific strategies for countries to adopt to help address the HIV/AIDS-related needs of refugees on a long term basis. Through the publication of guidelines for governments and humanitarian organizations, this initiative was the first to propose comprehensive long-term solutions to the HIV/AIDS-related needs of refugees. Entitled “Strategies to support

the HIV-related needs of refugees and host populations”, the proposal outlines the three “best practices” for refugee-hosting countries which include: integrating refugee issues into national health and HIV programs, implementing sub-regional initiatives and combining funding streams (UNAIDS et al., 2005).

The first recommended initiative is the integration of refugee health issues into national health and HIV/AIDS programs. Over recent years, as conflicts have increased in complexity and scope, the average duration of refugee situations has increased from nine to 17 years (UNAIDS et al., 2005). As a result, host governments are increasingly responsible for the needs of refugees for longer periods of time and ignoring their presence undermines prevention efforts. UNHCR and UNAIDS recommend that National AIDS Programs should integrate refugees into their national health programs since this brings benefits to both the host population and refugees. First of all, integration can provide additional resources from humanitarian organizations to the country that would have previously been allocated to refugees. By combining programs, it prevents the formation of parallel services between national and refugee populations, which can lead to an inefficient use of funding. Through this, local health-care services can be improved since additional resources can be invested in specific areas strengthening the scope of the health sector. On the other hand, for the refugee population, this solution removes barriers in accessing necessary health care services. Not only would refugees have better access to VCCT and ARV therapy, but through an integrated system the perception that “HIV is not in our community, but their community” could be removed by creating a dialogue between the two populations and, ideally, decreasing stigma and discrimination (UNAIDS et al., 2005, 19).

A second more innovative approach is the implementation of sub-regional approaches. Responding to the realities of disease and migration, these approaches address the fact that HIV “crosses borders” and that the diffusion of HIV through migration must be addressed (UNAIDS et al., 2005, 21). Sub-regional approaches provide a solution that ensures regions have a more standardized system of care, allowing populations in that geographic region to provide equal standards of care. Consequently, refugee populations throughout the region can access the same standard of HIV-related care through the education, testing and treatment facilities implemented throughout the region. This initiative strengthens prevention efforts by providing continuity in the services available, as well as decreasing the vulnerability of marginalized groups. National programs also gain from this initiative since the HIV/AIDS services within the sub-regional approach would also be targeted towards the national populations. This would lower costs by creating a more efficient system of care and treatment, as well as creating opportunities for additional funding from humanitarian organizations (UNAIDS et al., 2005). Finally, this solution would also encourage the dialogue surrounding HIV/AIDS in the region, by providing an avenue for policy makers in the region to come together to discuss prevention methods and education initiatives to combat stigma and discrimination.

The last approach suggested is the combination of humanitarian and development funding to provide better resources for HIV/AIDS-related needs of refugees by increasing the availability of education, testing and treatment services (UNAIDS et al., 2005). Similar to the other two solutions, this practice would ensure that HIV/AIDS services for host and refugee populations were not being duplicated or funding was not lost by

coordinating and aligning humanitarian and development funds. Through this, humanitarian aid could be used to complement development aid for HIV interventions thus improving the availability of services for both populations. Combining these two funding streams would also lead to an increase of funding, meaning that together initiatives could target both short and long-term programs that were previously out of reach.

Current studies of refugees in East Africa have highlighted how implementing the UNHCR/UNAIDS proposed initiatives can improve the availability of HIV/AIDS services for refugees. One of the most well known sub-regional initiatives is the Great Lakes Initiative on AIDS (GLIA). The Great Lakes Region does not only suffer from high HIV prevalence of 4.1% - 8.8%, but has also been the site of intense conflict resulting in large numbers of refugees fleeing from Rwanda, Burundi and the Democratic Republic of Congo to the neighboring countries of Kenya, Tanzania and Rwanda (UNAIDS et al., 2005). Due to the high number of refugees continually crossing borders, the governments saw that a regionally focused response was needed to help attempt to halt the spread of the virus as well as create a higher standard of care for all refugees.

The Great Lakes Initiative on AIDS was developed in 1999 and has four main components: HIV support to refugees, support to HIV-related networks, support to regional health-sector collaboration and a managing and evaluating sector. Although still a relatively new project, benefits have been noticed including a stronger relationship between government, the UN, NGOs and bilateral and multilateral donors. But most importantly refugees now have better access to health care through HIV-related medical sites specifically for refugees in every country (UNAIDS et al., 2005).

Apart from medical services prevention efforts are also benefiting from these UNHCR/UNAIDS proposed strategies. Tanzania, a member of GLIA, has begun to integrate refugees into their national prevention programs, which is having important benefits in increasing prevention throughout the country (UNAIDS et al., 2005). A recent case study has shown that in Kobondo refugee camp in Tanzania, a local refugee organization, Stop AIDS, has begun to work with the Tanzanian Service Health and Development for People Living with HIV/AIDS. This coordination between a refugee and local population organizations works to provide HIV awareness and education to both refugees and the surrounding communities. This initiative has been very successful in organizing school activities, concerts, mass campaigns and public speakers. As a result, not only is HIV awareness increasing, but the cooperation of a local organization with a refugee organization, decreases the stigma surrounding the refugee population.

Although UNHCR and UNAIDS have made significant progress in addressing the issue of HIV/AIDS and refugees, the literature available primarily looks at response initiatives and programs in emergency situations. These initiatives are clearly beneficial and while they do discuss the factors that influence HIV risk of refugees, they fail to fully acknowledge the structural factors that influence the relationships between HIV/AIDS and refugees. Instead these initiatives simply focus on the technical implementation of programs instead of the theoretical reasons behind them. This lack of outside scholarly research needs to be addressed in order to build a more extensive body of literature and analyze the effectiveness of these programs. Continued research would also help build a greater understanding of HIV-related needs of refugees in different situations in an



attempt to further understand the relationship between HIV/AIDS, refugees and access to medical care.

### **Chapter III: Methodology**

With the limited literature available on health care services for HIV-positive refugees in Egypt, fieldwork was an essential component in my research in order to supplement the absence of current comprehensive data. During May and June 2007 I reviewed current program operations and policy reports from organizations working with HIV/AIDS and refugees in Egypt. This review was followed by semi-structured interviews with individuals from these NGOs in 2007, and follow up interviews in January 2009.

Interviews in qualitative geographic research are invaluable tools to gain access to information about events, opinions and experiences. According to Hay, interviews serve four purposes: to fill a gap in existing knowledge through other methods, to investigate how complex behaviors provide a way to examine a diversity of meanings and finally to allow informants with relevant information an avenue for respect and empowerment (Hay, 2005, 80). Due to the limited information available on HIV/AIDS services for refugees in Egypt coupled with the sensitivity of the topic, interviews were an optimal method to gain insight into the many complexities involved within the issue.

In qualitative research there is a continuum of interview practices that range from very structured to unstructured interviews. This allows researchers to determine the most appropriate and beneficial method to obtain information without jeopardizing rapport with the informant. For my research, I conducted semi-structured interviews, which Hay defined as “interviews with some predetermined order but which nonetheless has flexibility with regard to the position/time of questions” (Hay, 2005, 294). This method made my interviews primarily context focused allowing me to ask questions relevant to

my research question. However with the flexibility inherent in semi-structured interviews, when discussing key points I was able to either delve further into topics or tangent to related issues mentioned by my informants. By formulating a more open-ended dialogue, semi-structured interviews were invaluable. Despite my limited information on the topic, I was able to access a wide array of topics depending on the responses of my informants.

Another benefit of using semi-structured interviews was the chance to have personal interaction with individuals working with HIV/AIDS and refugees. With my research primarily taking place in a foreign country, this was particularly important as I was able to access first hand information that is normally very limited. As a result, by using semi-structured interviews that were more open-ended and flexible, I was very fortunate to be able to establish a comfortable rapport with these individuals, and to gain valuable insight into the operations of these organizations.

### *Prior Research*

My research began in May 2007 as an intern with the Forced Migration and Refugee Studies Department at the American University in Cairo, Egypt. Over a six-week period, I worked under the supervision of Dr. Barbara Harrell-Bond to research the current HIV/AIDS services available for refugees in Cairo. At the time, little information or data existed on the subject and my task was to coordinate a reference of resources for refugee organizations to use in assisting HIV-positive refugees. The first few weeks of my internship primarily consisted of reading literature on the refugee situation in Egypt as well as learning about current Egyptian and UNAIDS policies regarding refugees and

HIV/AIDS. After this policy review, the majority of my research centered around semi-structured interviews with individuals at NGOs working with refugees and HIV/AIDS.

During my fieldwork I conducted five semi-structured interviews with representatives from Caritas International, Africa and Middle East Refugee Assistance (AMERA), Family Health International, UNAIDS and Refuge Egypt. In addition, due to time constraints, I conducted an interview via email with a representative from UNHCR. Due to their involvement in both the refugee community and the issue of HIV/AIDS in Egypt, these six organizations were identified as important interview subjects for my research. I received their contact information from Dr. Barbara Harrell-Bond and was able to set up interviews with them through the American University in Cairo.

Family Health International and UNAIDS were important resources in learning about the current HIV/AIDS policies and programs currently in place in Egypt. While these two organizations did not have direct involvement with refugee programs, they did provide valuable information about the current prevalence of HIV/AIDS in Egypt and services available to the general population. On the other hand, Caritas International, AMERA and Refuge Egypt are the three prominent organizations that work with refugees in Cairo. They were invaluable resources for examining services offered to HIV-positive refugees and understanding the dynamics of HIV/AIDS within the refugee population.

The semi-structured interviews generally lasted between 45 minutes and an hour. They were all conducted in the offices of the individual organizations. Before each interview I compiled a list of interview questions specific to the organization (see Appendix A). Most interviews asked about current services available, services for refugees, issues of stigma and discrimination as well as current challenges in accessing

medical care. For privacy reasons, these interviews were not recorded but afterwards, I compiled detailed notes for all the interviews for reference purposes.

Apart from compiling a resource list for refugee organizations in Egypt, the other final product of my internship was an article describing my research findings. In order to ensure that each organization was represented appropriately in my article, each organization was given the opportunity to review the article prior to publication (see Appendix B). I received feedback from UNHCR and UNAIDS, which I took into consideration and then submitted the final version of the article to the *Forced Migration Review*. This article, "HIV/AIDS Services for Refugees in Cairo, Egypt," was then published in September 2008 (Popinchalk, 2008).

### *Current Research*

In January 2009 I returned to Egypt for follow-up interviews with the same organizations in order to evaluate any change that occurred over the past 18 months. While this visit was important to ensure that my project documented the current situation in Egypt, one of the main reasons for my return was because of a new HIV/AIDS program for refugees scheduled to start in the fall of 2008. During my initial fieldwork Refuge Egypt was beginning the process of establishing an antiretroviral (ARV) treatment program for refugees in cooperation with the Global Fund Initiative. This new program was the first of its kind in Egypt to provide long term ARVs to refugees therefore it was imperative to return to find out about the progress of the program and its impact on HIV/AIDS services for refugees.

Continuing a semi-structured interview method, the objective of the follow-up interviews was to assess changes in the medical care challenges facing HIV-positive refugees. These follow-up interviews focused on the changes in services for refugees, specifically at Refuge Egypt. Initially I planned to re-interview all the organizations, not only for continuity in my field work but also to see if there were changes in the HIV/AIDS programs at a national level that would impact the services for refugees. Unfortunately due to schedule conflicts, I was only able to contact and re-interview Refuge Egypt, UNAIDS and Family Health International. My questions again primarily focused on the current services available for refugees, issues of stigma and discrimination and challenges in accessing medical care. For privacy reasons these interviews were not recorded but were compiled into detailed notes afterwards. In addition, each interviewee was given a copy of my findings to ensure that their organization was represented accurately.

### *Limitations of Methodology*

The ability to meet and talk with NGO representatives working with HIV/AIDS and refugees was an invaluable part of my research, however there are several study limitations and biases inherent in this approach. First and foremost, since I only interviewed experts from NGOs, my research only offers one perspective on the complex situation of seropositive refugees in Egypt. As members of NGOs, the interviewees' perspectives are inevitably biased towards the protocol of their organizations. In addition, even though these individuals are experts they continue to be outsiders within the refugee community and are inevitably separated in some ways from the realities facing refugees.

Despite the limitations inherent in only interviewing representatives from NGOs, for security reasons I was not able to interview individual refugees. Due to the highly sensitive nature of HIV/AIDS in Egypt, the intense stigma and discrimination surrounding the virus and most importantly, the fear of deportation or *non-refoulement*<sup>2</sup>, interviewing refugees would have jeopardized the safety and privacy concerns of these individuals. As a result, experts from NGOs offered the best gateway into the lives of HIV-positive refugees without increasing their vulnerability.

Another limitation to my research was the difficulty of researching a very sensitive topic in a country with little dialogue surrounding the issue. With very high levels of stigma and discrimination towards carriers of the virus HIV/AIDS is a taboo subject in Egypt. Therefore throughout my fieldwork it was imperative to be aware of the cultural barriers surrounding HIV/AIDS and ensure that my approach to the topic was culturally and professionally appropriate. In addition, it was vital that the organizations I interviewed were represented correctly, to ensure that their policy positions did not contradict or criticize current policies of the Egyptian government and thus jeopardize their standing within the country.

Finally, the last limitation of my study was the issue of language. I was fortunate that all the individuals I interviewed spoke English and therefore I did not have to worry about meanings being misconstrued through an interpreter. However by not speaking Arabic, it meant I could only work with certain experts and also limited my interactions with other doctors or members of the NGOs.

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<sup>2</sup> *Non-refoulement* is when a refugee is forced to return to their country of origin against their will or not in the interest of their best safety.

Despite the limitations to my research, these findings will be important as they provide insight into a phenomenon that has not previously been documented. Although research has been conducted surrounding HIV/AIDS services for refugees, it is very limited in its scope and there are still many questions unanswered about the relationship between forced migration and HIV/AIDS. Looking at services specifically for urban refugees is particularly rare and therefore this research will not only provide a better understanding of the situation but also begin a dialogue surrounding the circumstances facing urban refugees. With this there is an impetus for future policy changes as well as the potential to bring lessons from Egypt and apply them to other countries where refugees face similar challenges.



## **Chapter IV: Case study of refugees in Cairo, Egypt**

### *Forced Migration in Egypt*

With the increasing conflicts in the Middle East and in Sudan, Egypt has experienced an increase in refugees and asylum seekers entering the country since the 1990s (Grabska, 2006). According to 2008 UNHCR statistics, there are currently 112,515 persons of UNHCR concern living in Egypt and 27,556 receiving assistance from UNHCR (UNHCR, 2008). As shown in Figure 2, out of 30 different nationalities, Sudanese, Iraqis, Somalis and Palestinians constitute the vast majority of a refugee population (Zohry et al, 2003). However unofficial estimates of the refugee population in Egypt range from 500,000 to five million (UNHCR, 2007). This discrepancy results from the hundreds of thousands of ‘closed files,’<sup>3</sup> as well as many Sudanese and Palestinian refugees who have not applied for refugee status (Grabska, 2006).

Despite the fact that Egypt has signed the 1951 Convention Related to the Status of Refugees, 1967 Protocol and 1969 OAU Convention, there is currently no national legislation or government organization that deals directly with refugee issues (Grabska, 2006). As a result, the presence of refugees in Egypt is seen as purely temporary. By law, refugees cannot acquire Egyptian citizenship. This therefore eliminates the ability for refugees to assimilate into Egyptian society and results in the options of either repatriation or resettlement (Grabska, 2005). Egypt has had a fairly successful resettlement program with 18,400 refugees being resettled in 2004 (UNHCR, 2007). However this is only a very small percentage of the refugee population, leaving limited

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<sup>3</sup> Closed files refer to refugees that have applied for refugee status at UNHCR in Cairo, but have been denied status and therefore continue to live in Egypt illegally.



FIGURE 2: *Origins of Refugees in Egypt, 2007*

options for the remaining hundreds of thousands, if not millions, of refugees living in Egypt.

As a result of the lack of specific political legislation by the Egyptian government, UNHCR has assumed all responsibility for determining refugee status in Egypt. Currently it is estimated that it takes as long as 14 months before refugee status is officially determined (Grabska, 2005). During this process, applicants seeking refugee status are given a yellow card, which allows them to receive limited assistance from UNHCR and UNHCR implementing partners for a restricted amount of time. Once their status has been determined they are either approved and given an official blue card which will entitle them to continued support from UNHCR and its operating partners, or denied leaving them with few options. With the limited services available, the possession of a yellow or blue card is extremely important in allowing refugees to access necessary services since many organizations will not help refugees without the necessary documents (UNAIDS et al., 2005). In addition, these documents provide protection for refugees against *non-refoulement* or deportation from Egyptian authorities.

Reservations held by the government regarding the 1951 Convention means the Egyptian government offers little, if any, assistance to refugees in Egypt. The Egyptian government withheld reservations to article 12, 20, 23 and 24 dealing with personal status, access to primary education, access to public relief and assistance as well as labor legislation and social security (UNHCR, 2007). This means that refugees are not able to access subsidized public education and health services. Furthermore, according to law no.137 of Egypt's 1981 domestic legislation concerning the employment of foreigners, refugees, like other foreigners must obtain a work permit to work in Egypt (Grabska,

2006). With the difficulty in obtaining necessary documents and the bureaucratic procedures involved in applying for a work permit, refugees essentially are unable to work in the formal economy.

This position by the government can be attributed to the limited resources that the Egyptian government has to ensure a sufficient standard of living for the Egyptian population. Currently Egypt has a literacy rate of 69% and an unemployment rate of 20% and it is estimated that as many as 700,000 new workers enter the work force every year (Grabska, 2005). Therefore with the strained economic situation, pressure on the education and health systems and high levels of unemployment, the government is hesitant to attempt to provide humanitarian services to refugees. As Ambassador Mushira Khattab, the Secretary General of the National Council for Childhood and Motherhood said, "It is a matter of lack of resources rather than discrimination, we have to be realistic: refugees in Egypt will not have the same access to resources as refugees in Sweden or the UK" (Grabska 2006, 19). Therefore, all refugees are treated as foreigners in regards to their access to Egyptian resources. For example education is not subsidized only available with proper documentation, health care services are available but no financial assistance is offered, and in order to work refugees must obtain a work permit (Zohry, 2003).

Under these circumstances refugees in Egypt must depend on international NGOs or local organizations for necessary humanitarian assistance. UNHCR is the primary organization offering assistance to refugees. UNHCR bases its program initiatives on providing initial relief of cash assistance, medical care, primary education and some vocational training (Grabska, 2005). Through its program, UNHCR has many

implementing partners and refers refugees to these partners for additional services. These include both international organizations and faith-based organizations that provide a variety of services from medical care, legal advice and vocational training. Prominent organizations in Cairo include Caritas International, AMERA, and Refuge Egypt.

While these organizations are invaluable to refugees in Cairo, they generally only provide assistance to registered yellow or blue card holders or limit the availability of services for non-registered refugees. As a result, for the thousands of rejected refugees, ‘closed files,’ as well as many refugees who do not apply for status because of fear or lack of knowledge, there are only a few alternative options (UNHCR, 2007). On the one hand, certain faith-based institutions and community organizations provide services regardless of documentation. There are also a growing number of refugee-initiated organizations that provide assistance regardless of refugee status. However these limited options increase the need for refugees to work in the informal economy or other means of illegal employment (Grabska, 2006). These wages are generally very low and not sufficient for the high costs of living in Cairo. This results in the potential exploitation of refugees.

Apart from South Africa, Egypt is the only country in Africa where refugees live in the urban areas of the country instead of refugee camps (Bailey, 2004). This unique circumstance further complicates access to the limited resources and assistance available from the Egyptian government and international organizations. The biggest issue for urban refugees is receiving the protection to which they are entitled to as defined by the 1951 Convention. UNHCR assumes all responsibility for determining refugee status in Egypt and it is estimated that it takes as long as 14 months before refugee status is

officially determined (Grabska, 2005). This is problematized by illiteracy, language barriers and lack of education, and causes many refugees to not only be unaware of their rights but unable to fill out the appropriate forms or learn about other options like resettlement (Buscher, 2003). Furthermore, fear of deportation or rejection leaves many refugees without the necessary protection and many hide in urban areas of Cairo never attempting to apply for refugee status due to fear of *non-refoulement* (Buscher, 2003).

In urban settings there are also no designated housing settlements or areas allocated for refugee accommodation (Jacobsen, 2006). Instead, urban refugees in Egypt must find their own accommodations and with limited income and resources, they are severely disadvantaged in the housing market (Landau, 2004). Refugees compete with local residents in the low-cost housing market or resort to other options such as building makeshift housing in shanty towns, or subletting a room or sharing living spaces where they risk being exploited by their landlords (Landau, 2004). The lack of residential areas also causes urban refugees to be dispersed throughout Greater Cairo living among the urban poor in entrenched poverty. Refugees essentially become invisible within Egyptian society, making them harder to access and leaving many unaware of the services available through humanitarian organizations. This leaves refugees to compete for limited resources with local Egyptians, where they face discrimination and exploitation on a daily basis.

Finally, another impeding factor for refugees is the extreme xenophobia found in Cairo. Stemming from restricted resources in Cairo, locals are known to discriminate against refugees out of fear that they are taking away what is “rightfully Egyptian” (Sperl, 2001). In some cases this discrimination results from the misconception that

refugees are more privileged than local Egyptians as they are able to access international assistance from UNHCR and their implementing partners (Grabska, 2005). This anger is also exacerbated by racial discrimination, especially against black Africans. It is common for refugees to suffer from racial abuse from local Egyptians and/or employers. In addition, refugees often suffer exploitation. For example, refugees face higher costs for groceries or rent (Grabska, 2006). Yet they are unable to report these incidences to the local Egyptian authorities in fear of deportation as well as the discrimination exhibited by the Egyptian police forces. Unfortunately there is little attempt by the Egyptian government to try and integrate these two populations in an attempt to decrease discrimination and help create a more productive and cohesive society.

#### *HIV/AIDS in Egypt*

Egypt has an HIV prevalence between 0.007% and 0.02% in the general population (UNAIDS, 2007). This low prevalence rate is frequently attributed to the strong underlying cultural and religious values within society, leading to the misconception that those with HIV “deserve to have it” because of their promiscuous behavior or involvement in heterosexual and homosexual behaviors or injection drug use (UNHCR, 2007). Furthermore, there is a common misunderstanding that HIV is only a disease “brought in by foreigners” while believers and faithful persons are somehow protected from the virus. As a result, HIV/AIDS is a highly stigmatized disease within Egypt leading to a high lack of awareness around the disease and vast misunderstandings in regards to the modes of transmission and means of prevention (UNHCR, 2007).

Before 2004, most HIV cases were reported through the mandatory testing of blood donors, foreigners residing in Egypt for more than six months, and nationals applying for work permits to work abroad (UNHCR, 2007). While there was voluntary testing available, it was not anonymous and those who tested positive were reported to the Ministry of Health and Population (MOHP), which greatly discouraged the use of testing services. Egypt also has a strict policy where foreigners found to be HIV positive are deported within 48 hours in order to try and contain the extent of transmission of the virus in Egypt (FHI, 2007). However, as sexual behavior within the youth population has changed and prevalence within high-risk groups has increased, there has been a push for the National AIDS Program (NAP) of the MOHP to adopt voluntary confidential counseling and testing (VCCT) in order to de-stigmatize the disease and help prevent the onset of a widespread epidemic (FHI, 2007).

Since 2004, the MOHP, with the technical support of Family Health International (FHI), developed a system of VCCT and established national guidelines and a monitoring and evaluation plan to be followed by the MOHP and other cooperating organizations (FHI, personal communication, June 13, 2007). Currently, besides the original VCCT center within Cairo Central Laboratory, there are thirteen other fixed VCCT sites, nine managed by the MOHP and funded by various agencies including USAID, FHI, the Italian Cooperation, Ford Foundation and UNICEF. UNFPA has set up nine mobile VCCT vans that help provide access to people in remote areas. All VCCTs are based on anonymous testing that use a client code and while HIV-positive cases are reported to the Ministry for statistical and epidemiological purposes, no identifying information is provided (FHI, personal communication, June 13 2007). Current UNAIDS/WHO 2006



estimates place the number of Egyptians living with HIV/AIDS between 2,900 and 13,000 (UNHCR, 2007). In 2005, the NAP launched a long-term antiretrovirals (ARVs) program that offers free ARVs to nationals who clinically qualify for ARVs. Currently approximately 140 Egyptians are receiving treatment (UNHCR, 2007). Egypt also has a National HIV/AIDS hotline, which acts as a resource for nationals to learn general information about the virus as well as the services available.

Apart from the introduction of VCCT and access to antiretrovirals, the MOHP is continuing to take proactive steps to develop HIV/AIDS services available in Egypt. In 2008, Egypt was selected as a recipient of a grant from the Global Fund for AIDS, TB and Malaria (GFATM) and will receive funding over the next five years to strengthen the National AIDS Program. The objective of the Global Fund is to provide funding to the NAP to strengthen their initiatives as well as to help build the capacity of NGOs that work in partnership with the NAP (UNAIDS, personal communication, January 18, 2009). Major focuses of this grant have been to improve the standard of living for people living with HIV (PLHIV), and to provide antiretrovirals to refugees.

Despite a low country-wide prevalence rate, prevalence among high-risk groups remains a concern for controlling the epidemic in Egypt. A recent case study of men who have sex with men (MSM) in Alexandria reported a concentrated epidemic within this high-risk group, with a prevalence of 6% (UNAIDS, personal communication, January 18, 2009). In response, in addition to improving medical services, both the government and international organizations have developed awareness initiatives in an attempt to stabilize the prevalence rate of high-risk groups and to prevent its spread to the wider

population. High-risk groups of greatest concern in Egypt include injection drug users (IDUs), MSM, and sex workers.

Family Health International has developed effective outreach programs that specifically target injection drug users. These programs hire recovering drug users as community health workers to go out in the community and inform IDUs about HIV/AIDS and refer them to drop in clinics (FHI, personal communication, January 19, 2009). These clinics offer peer education, VCCT, counseling and general clinic services. By providing both medical and social components to their services, these clinics incorporate a more comprehensive approach to address the epidemic. With the funding of three separate organizations, FHI has been able to establish three of these outreach programs throughout Greater Cairo, which has allowed for greater outreach contact with an important and high risk group (FHI, personal communication, January 19, 2009). In addition, although the program is targeted at IDUs, recently MSMs and sex workers have begun to use the services thereby increasing the effectiveness in the program.

Other outreach initiatives have focused on educating Egyptian youth. As the country is in the third stage of the demographic transition, Egypt has a very large youth population. Many health experts believe the biggest risk factor for a full blown HIV/AIDS epidemic in Egypt, is the large youth population due to limited information available on HIV/AIDS transmission and methods of prevention (UNHCR, 2007). As a result many awareness campaigns in Egypt are geared toward to the youth population to not only increase prevention, but to also remove false assumptions and misconceptions surrounding HIV/AIDS in the next generation. One of the most successful programs was the World AIDS Campaign and Ismailia Youth Camp, which provided a venue for peer-

led Youth Camps to raise awareness on HIV (UNHCR, 2007). This program was especially successful as it incorporated individuals from the media, government authorities and religious leaders from both the Muslim and Christian communities. Apart from outreach, FHI also worked with UNFPA and EFRA to establish youth clinics in four governates to provide youth education prevention programs and awareness campaigns. Two of these clinics also have access to VCCT, allowing for youth specific materials on reproductive health, STIs and HIV/AIDS to be disseminated among the youth population (FHI, personal communication, January 19, 2009).

UNAIDS has started another important initiative to address the standard of living for people living with HIV in Egypt (PLHIV) (UNAIDS, personal communication, January 18, 2009). One of the biggest issues for PLHIV in Egypt is the fact that they do not receive the care they need due to discrepancies in the national health care system. The main AIDS clinic in Egypt is located in the local fever hospitals, however HIV-positive patients are often refused treatment at public and private hospitals and referred to the AIDS clinic regardless of their medical needs (UNAIDS, personal communication, January 18, 2009). In response UNAIDS has begun training health administrators to help increase the doctors' knowledge about HIV/AIDS, PLHIV and how to deliver better health care.

The new HIV/AIDS initiatives by the government and international organizations have generally been well received by the Egyptian population. In particular, the introduction of VCCT has been particularly important, as it has created a safer environment for testing, which has encouraged individuals to use the services (FHI, personal communication, June 13, 2007). The awareness and education programs have

also gained attention within the Egyptian population with local media outlets reporting on the programs and more organizations becoming involved in World AIDS Campaigns. While these programs are having positive effects, the overall impact of these programs are small due the vast misconceptions still surrounding the disease in conjunction with the high levels of stigma and discrimination.

However while the HIV/AIDS situation in Egypt is being controlled and can be argued to be improving, there are still a number of challenges. HIV/AIDS is still a relatively new and taboo topic within Egyptian society causing new initiatives to constantly face local resistance and skepticism (FHI, personal communication, January 19, 2009). Cultural barriers provide additional obstacles in establishing trust in services and ensuring the protection of high-risk groups. As a result, although HIV/AIDS specific services are becoming more available, PLHIV still face barriers in accessing a high standard of living. The next step therefore should be to continue to improve the medical services, as well as establish a multi-sectoral plan to strengthen employment opportunities, reduce cultural barriers and improve the overall quality of life for PLHIV (UNAIDS, personal communication, January 18, 2009). In conjunction with focusing on high-risk groups this can ensure a more comprehensive approach that would help both prevention efforts and would strengthen national services. Addressing these cultural challenges will require more time and patience as they are ingrained in local society. However, if outreach and education projects continue as planned, there are encouraging signs that Egypt is headed in the right direction to prevent a major epidemic.

Logistical challenges inherent in the bureaucracy of the NAP also pose significant challenges in implementing effective HIV/AIDS programs in Egypt. Organizationally,

the NAP is very centralized and unfortunately there is a lack of communication and coordination between NAP programs and NGOs. This unfortunately leads to a lot of mismanagement and duplication of funds, which can lead to a lower quality of care (FHI, personal communication, January 19, 2009). These discrepancies in organization will play a large part in determining whether the Global Fund initiative is effective in Egypt, and therefore strong management and evaluation is key in order to streamline the process.

#### *HIV/AIDS and Refugees in Cairo*

The HIV/AIDS prevalence rate of refugees in Cairo is unknown due to the lack of comprehensive surveillance and medical care for the refugee population. The one set of statistics available from the testing facility at Refuge Egypt shows that out of 2,703 refugees tested there were 87 positive cases, leading to a 3% prevalence rate among those tested (Refuge Egypt, personal communication, June 25, 2007). This rate is only for refugees who have been tested at Refuge Egypt and therefore does not provide conclusive data on the entire refugee population. However, from this example, it may be inferred that refugees are likely to have higher rates of HIV than the Egyptian population due to the HIV prevalence rates in their country of origins. This would be particularly true for refugees from Ethiopia, Eritrea and Sudan, where HIV prevalence rates are 4.4%, 2.7% and 1.4% respectively (See Figure 3) (UNAIDS, 2005). While refugees in Egypt are at low risk from acquiring HIV from the Egyptian population, their vulnerability is increased through their displacement and possible interaction with other refugees.

Refugees are unable to access any of the Egyptian HIV/AIDS services and must depend on local NGOs and organizations (FHI, personal communication, June 13, 2007).



FIGURE 3: HIV/AIDS Prevalence from Refugee Countries of Origin

The three main organizations that provide HIV-related services are Caritas, AMERA and Refuge Egypt, which provide a variety of medical, psychosocial and humanitarian services (see Table 1). The main medical services available include HIV testing and treatment of opportunistic infections, however, as previously noted, a new ARV program for refugees was introduced in September 2008. Apart from NGOs, the Egyptian government offers the services of the national fever hospitals to treat opportunistic infections for registered HIV-positive refugees (Refuge Egypt, personal communication, June 25, 2007).

*Table 1: Summary of HIV/AIDS Services for Refugees in Cairo through UNHCR Implementing Partners*

<b>Providers</b>	<b>Services</b>
AMERA	Psychosocial support
Caritas International	Confidential testing, treatment for opportunistic infections, psychosocial support
Refuge Egypt	Voluntary confidential counseling and testing, treatment for opportunistic infections, psychosocial support, food packages, awareness education

AMERA, an independent NGO offering legal support to refugees in Egypt, provides psychosocial support services for HIV-positive refugees (AMERA, personal communication, June 6, 2007) (See Table 1). Caritas, another implementing partner of UNHCR, performs confidential HIV testing for refugees on request, but it is done through their own laboratories (Caritas, personal communication, May 31, 2007). Caritas also provides support and counseling on how to handle life with HIV, including how to tell family members and how to prevent the onset of AIDS through healthier eating habits

and lifestyle (Caritas, personal communication, May 31, 2007). Both these organizations are located in downtown Cairo in Garden City (see Figure 4).

Refuge Egypt is the only clinic in Egypt that provides VCCT to refugees with complete pre- and post-test counseling as mandated by UNAIDS (Refuge Egypt, personal communication, June 25, 2007). Located in Zamelek, near downtown Cairo, the VCCT program was established in 2003 (see Figure 4). This program also offers access to preventative antiretrovirals such as post-exposure prophylaxis (PEP) for rape victims and single doses of ARVs to prevent mother-to-child transmission. Refuge Egypt also offers a number of additional services that target high-risk groups within their family planning, positive pregnant mothers, they provide services to help prevent transmission to the baby through cesarean sections and by providing milk formula to prevent transmission through breastfeeding (Refuge Egypt, personal communication, June 25, 2007). Anyone living with HIV/AIDS is also eligible for food packages from Refuge Egypt, and are eligible for house visits from the clinic doctors.

Until September 2008, refugees had no access to long-term ARVs and were thus left with no options for ongoing treatment, except care for opportunistic infections and attempting to maintain a healthy lifestyle through proper nutrition and healthcare (Refuge Egypt, personal communication, January 17, 2009). However within the recent Global Fund for AIDS, Tuberculosis, Malaria (GFATM) initiative, the NAP submitted a proposal to provide ARVs to refugees. Within the grant proposal, the NAP applied for Refuge Egypt to receive antiretrovirals to give to 20 eligible refugees over five years (Refuge Egypt, personal communication, June 25, 2007).



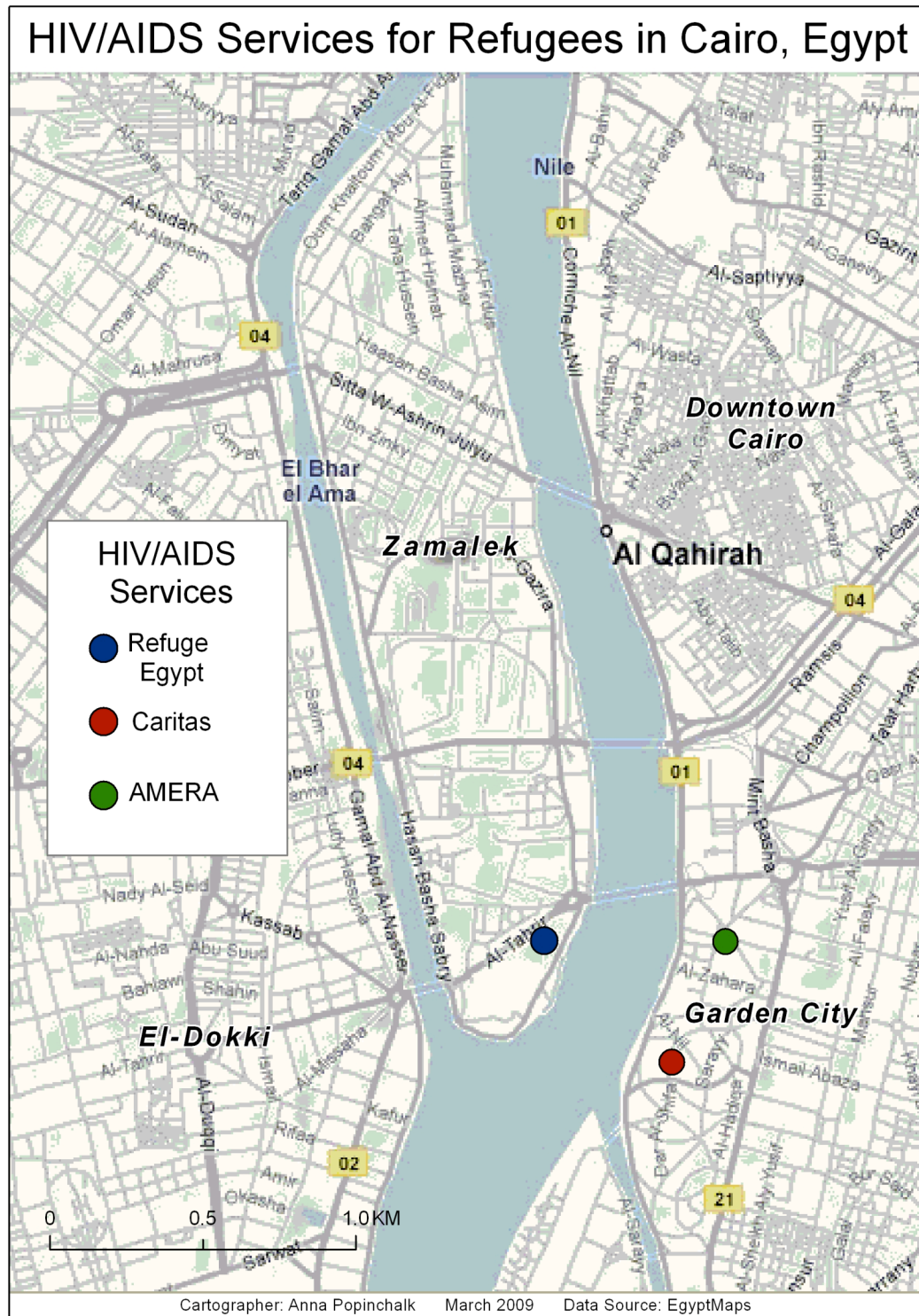


FIGURE 4: HIV/AIDS Services for Refugees in Cairo antenatal and TB clinics. For HIV

In June 2007, training began through the MOHP and UNHCR for doctors to educate these medical professionals about how to care for AIDS patients, distribute HIV awareness materials and VCCT. In addition, within reproductive health care, doctors received continuing education about preventing mother-to-child transmission, PEP, emergency contraception and case detection of STIs and HIV related illnesses (Refuge Egypt, personal communication, January 17, 2009). Following the physician education initiatives, viral load tests were conducted on HIV-positive patients to determine which refugees were eligible for ARVs. Although funded by the Global Fund, the ARVs come directly from the Ministry of Health and are provided to Refuge Egypt free of charge. The program was initially scheduled to start in March 2008 however, after many negotiations with the Egyptian government the program was finally ready to begin September (Refuge Egypt, personal communication, January 17, 2009). Refuge Egypt now has a six-month supply of ARVs that will be continued to be maintained over the next five years (Refuge Egypt, personal community, January 17, 2009).

Although still relatively new, the ARV program has been successful (Refuge Egypt, personal communication, January 17, 2009). Currently services are provided to two children, seven adults and two pregnant women. Only three doctors at Refuge Egypt provide ARV services in order to protect the anonymity of those receiving treatment. Through the introduction of these ARVs, Refuge Egypt was able to successfully prevent the transmission of HIV from a HIV-positive mother to her child. Overall, Refuge Egypt hopes to treat 28 cases over the next five years. To date the ARV program is only administered at the main Refuge Egypt compound in Zamalek, mainly because refugees have relationships with and trust the doctors at this clinic, however Refuge Egypt would

like to decentralize this program in the future (Refuge Egypt, personal communication, January 17, 2009).

As a part of the ARV program, Refuge Egypt has also begun a series of “awareness days” throughout the refugee community. Since September, Refuge Egypt has held 37 awareness days in churches, schools and community centers in areas where refugees live (Refuge Egypt, personal communication, January 17, 2009). These sessions not only inform refugees about the services available at Refuge Egypt, but also provide background information about methods of transmission and how to prevent the spread of HIV/AIDS. In the future, Refuge Egypt also hopes to start a PLHIV refugee group at the clinic to generate a dialogue surrounding HIV/AIDS and work to increase the standard of living for these patients.

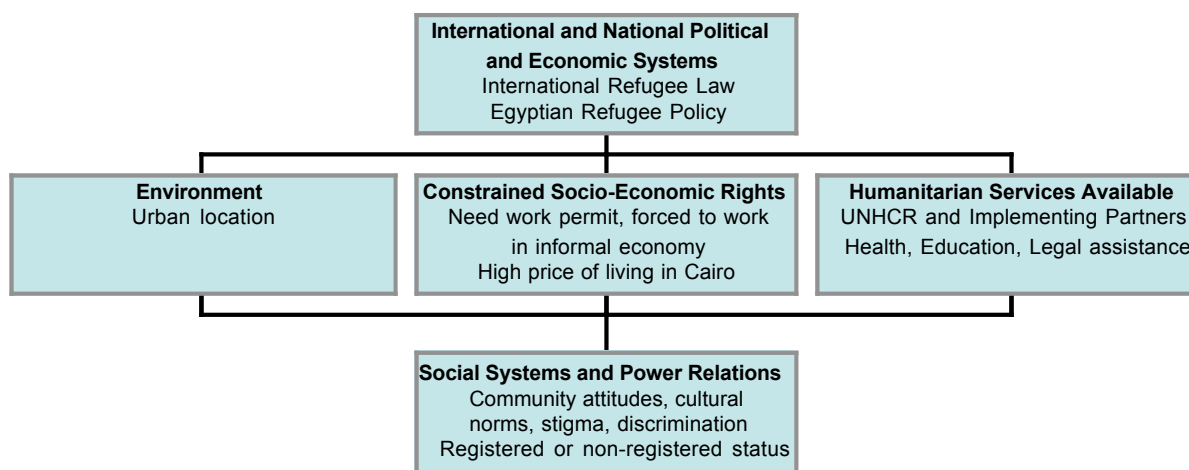
Other awareness initiatives among the refugee population have been undertaken by international organizations. In 2005, as a positive step in response to HIV/AIDS in refugee communities in Egypt, UNAIDS and UNHCR supported partner NGOs to implement a project aimed at HIV/AIDS prevention and impact mitigation among refugees in greater Cairo. Sudanese, Somali and Egyptian NGOs received training on promoting awareness, which was passed on to teachers, outreach workers, youth and children (UNHCR, 2007). Sudanese, Somali and Egyptian NGOs have also increased awareness through training outreach workers and peer to peer educators. With this framework, one NGO involved in the last project, the Sudanese Development Initiative Abroad (SUDIA), has begun a new project under the UNICEF global campaign “United with Children-United with AIDS,” a project focused on strengthening outreach programs, especially among youth.

Future initiatives targeting refugees are also being proposed. Specifically UNAIDS and Refuge Egypt are working together to try and provide outreach programs for refugee sex workers (UNAIDS, personal communication, January 18, 2009). Similar to the current outreach program for sex workers that UNAIDS oversees, this program would target refugee sex workers that have become active participants of the growing sex tourism industry in Egypt. Through this project, refugee women would learn about ways to protect themselves, have access to condoms and learn how to practice safe behavior to prevent the transmission of HIV/AIDS (UNAIDS, personal communication, January 18, 2009). Finally, a very new initiative that is in the beginning stages of being discussed is a behavioral survey looking at refugees in Egypt that will be designed to understand their risk of HIV transmission and the current prevalence among the population (FHI, personal communication, January 19, 2009).

## Chapter V: Analyzing the Vulnerability of Refugees in Egypt to HIV

Using the vulnerability perspective for the case study of refugees in Egypt allows for a more contextualized analysis of the vulnerability of urban refugees to HIV transmission by taking into account the larger structural factors that marginalize refugees in Egyptian society and limit their access to medical care. Despite the numerous models that incorporate the vulnerability perspective, the unique urban location of refugees in Egypt requires a more specific framework to look at refugees seeking HIV treatment within an urban environment. Therefore, using the basics of the vulnerability perspective in the Pressure and Release Model (Wisner et al., 2004), Access Model (2004) and current medical geography studies, Figure 5 is adapted from these previous models to account for the unique circumstances of urban refugees in Cairo. Using this visual representation, the case study of refugees in Egypt will be discussed following the hierarchal components of this framework through the following subsections. Through this, the vulnerability of refugees in Egypt to HIV transmission can be analyzed by assessing what factors impact their access to medical care.

**Figure 5: Visual Representation of Vulnerability of Refugees In Egypt to HIV Transmission**



*International and National Political and Economic Systems*

At an international and national scale, the political and economic systems in place determine the environment, rights and services that refugees have access to. In regards to international policy, although the Egyptian government has signed all international conventions regarding refugees and allows them to seek asylum within their borders, Egypt does not make requests for additional international aid, and thus there are no established refugee camps (Shafie, 2005). The lack of refugee camps is also related to international politics and relationships between Egypt and their neighboring countries (Grabska, 2005). With the majority of refugees coming Palestine and Sudan, Egypt refrains from establishing refugee camps in fear that by labeling these “brothers”<sup>4</sup> refugees, it would be a direct criticism of the Sudanese government and could hinder neighboring relations. Furthermore, as an Arab nation, it would be “inconceivable” for Egypt to treat Palestinian’s as “ordinary asylum seekers,” due to the Arab solidarity surrounding the Palestinian cause (Grabska, 2005, 293). As a result, these larger political forces have direct implications for the living environment and circumstances of refugees in Egypt.

On a national level, the lack of Egyptian policy regarding refugees dramatically influences their standard of living within the country. First and foremost, the reservations held by the Egyptian government on the 1951 Convention, means that the presence of refugees within Egypt is seen as purely temporary. These actions therefore prohibit the government from establishing refugee camps in fear that this would increase the

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<sup>4</sup> “Brothers” in this context refers to the historically close political relationship between Egypt and Sudan that has resulted in relatively lenient economic and migration policies between the countries. “Brothers” also references the solidarity between Arab nations based on their common ethnicity (Grabska, 2006).

likelihood of permanent integration between the refugee population and Egyptian population (Grabska, 2005). This option is undesirable to the Egyptian government because the country already faces resources shortages, and government officials fear that refugee integration would lead to an increasing economic difficulty. Apart from the lack of refugee camps, as discussed on page 34, the inability for refugees to acquire citizenships or work permits, increases the hardships refugees by defining them as foreigners within the country and thus limiting the options and services available to them (Zohry, 2003).

*Environment: The Urban Location*

The urban location of refugees complicates access to HIV/AIDS services for refugees, which in turn increases their vulnerability. Without defined residential areas, refugees in Cairo are forced to live wherever they can find affordable housing. As shown in Figure 6, this causes refugee residential patterns to be more dispersed throughout Greater Cairo, rather than concentrated in neighborhoods that could easily facilitate sharing of resources or exchange of information within the refugee community. With all the HIV/AIDS services clustered downtown, and refugees spread throughout the city, this causes refugees to be geographically more isolated from the available services (see Figure 6). Although there are private and public transportation services available, the increased travel distance between home and clinics for refugees increases the barriers in accessing care by not only increasing the cost of accessing services, but also due to the time commitment involved in reaching the services.

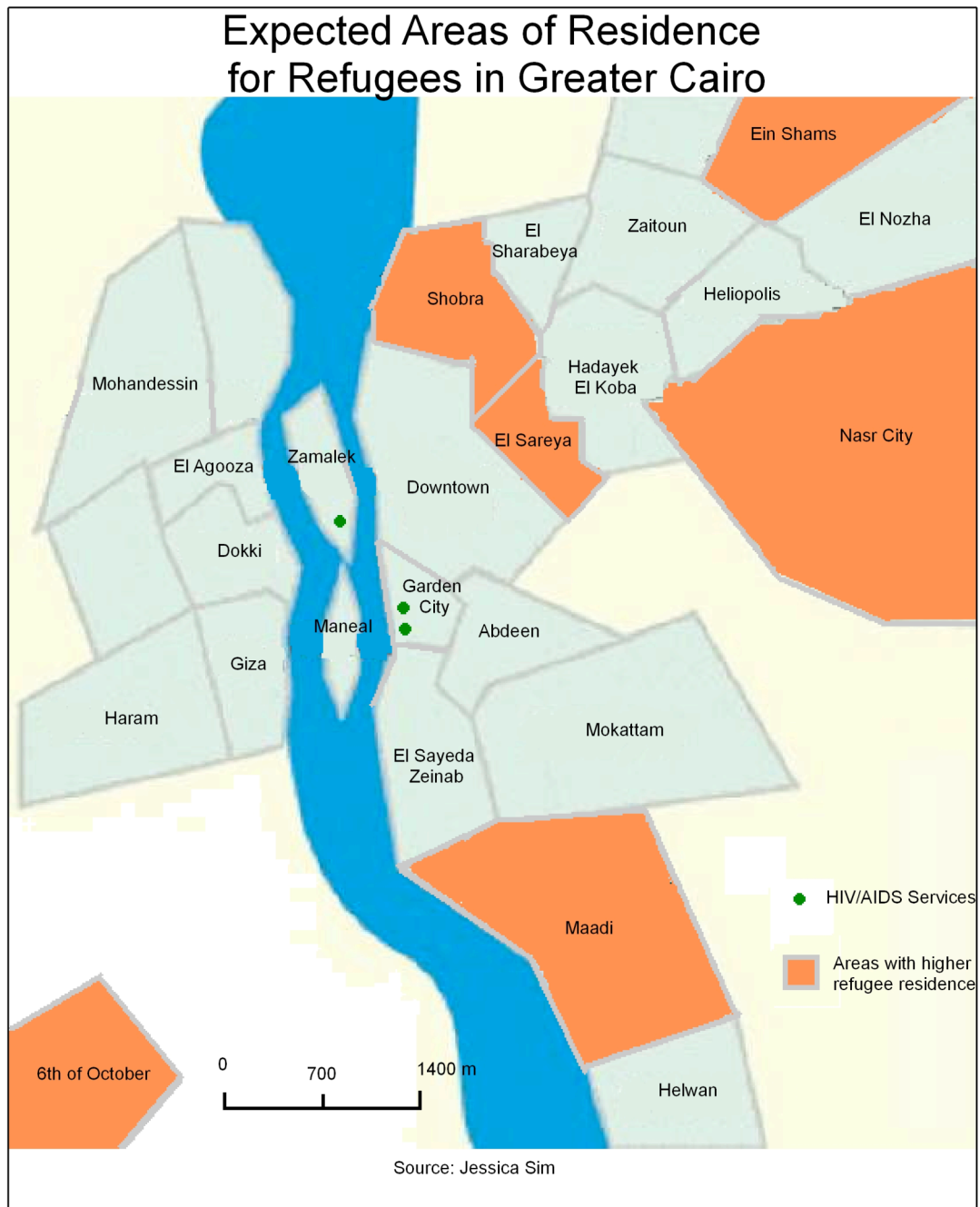


Figure 6: Expected Areas of Residence for Refugees in Greater Cairo



From the perspective of NGOs and any other organization desiring to provide services to refugees, the urban location also creates significant challenges in providing services. Living dispersed throughout Greater Cairo enables refugees to hide among the urban poor, making them essentially invisible to humanitarian organizations. This means that organizations working with refugees are not able to easily target high-risk populations by location to increase awareness and help provide better access to services. As a result, there is limited knowledge about the availability of HIV/AIDS medical services within the refugee community. While UNHCR does provide referrals to their organizing partners that provide health care, without access to UNHCR personnel, many refugees are unaware of the different types of medical options available to them (Coker et al, 2003). In addition, lack of education and language barriers prevent many refugees from accessing information about medical services. The language barrier inhibits the willingness of refugees to access health care since with limited language skills, many refugees cannot understand the doctors or the procedures and therefore become very skeptical about the care that they are receiving (Eidenier, 2005).

Finally, the urban location of refugees also increases social isolation among refugees and often prevents them from forming supportive communities. A supportive community can be essential when battling HIV/AIDS in order to provide a safe space for support and comfort. For example, patients receiving ARV treatment from Refuge Egypt are required to have a sponsor that they trust to help them keep up with their medications and appointments (Refuge Egypt, personal communication, January 17, 2009). While the Sudanese and Somalis generally live in closer proximity to one another and have created refugee communities, refugees from other origin nations are more dispersed which results

in a lack of support among these other nationalities. This leaves many refugees without the social support to battle the disease (Refuge Egypt, personal communication, January 17, 2009).

### *Constrained Socio-Economic Rights*

Employment opportunities for refugees in Egypt are strictly limited by Egypt's local labor legislation (Safie, 2005). These legal stipulations by the Egyptian government are a direct result of the struggling economic climate within Egypt, which includes a high rate of unemployment and a rapidly growing population, causing economic opportunities within the country to be very limited. According to law no.137 of Egypt's 1981 domestic legislation concerning the employment of foreigners, refugees, like other foreigners must obtain a work permit to work in Egypt (Grabska, 2006). However applying for a work permit is a very complicated bureaucratic procedure as it requires refugees to obtain resident permits which can be unattainable with current refugee status determination procedures. Furthermore, with rising unemployment in Egypt jobs in the formal sector are generally not available for refugees leaving many to work in the shadow economy or black market (Grabska, 2006).

These economic restrictions play a significant role in determining the vulnerability of refugees, and can be one of the biggest factors in their access to necessary medical care. While partner organizations of UNHCR, such as Caritas International and Refuge Egypt generally provide subsidized medical services to refugees, the high cost of living in Egypt, forces many refugees to utilize the payment of medical treatment in order to pay for rent or food. The lack of necessary monetary

assistance coupled with the lack of employment options, limits the ability of refugees to lead healthy lives as they can be forced to participate in high-risk behavior. This high-risk behavior increases vulnerability to contracting diseases such as STDs and HIV/AIDS. For example with limited economic opportunities, many refugee women are forced to work as sex workers in order to earn a living and financially support themselves and their families (Refuge Egypt, personal communication, January 17, 2009). This activity greatly increases the possibility of transmission and represents a significant challenge in combating HIV/AIDS within the refugee population.

#### *Humanitarian Services Available*

Vulnerability to HIV transmission is also influenced by the availability of services for refugees. As mentioned previously, the reservations held by the government on the 1951 Convention limit the responsibility of the Egyptian government for providing humanitarian services, leaving the responsibility to UNHCR and its implementing partners. In regards to health care, the majority of refugees do access services through humanitarian organizations, however in 2005 a bilateral agreement with the MOHP and UNHCR, allowed registered refugees to have access to public and preventative health care services (Ahmed et al., 2004). Following this, registered refugees have been able to access the fever hospitals to treat opportunistic infections. However the lack of trust between the refugee community and Egyptian medical staff prevents many refugees from using these facilities in fear of discrimination and possible deportation. For example, in the summer of 2007, a refugee contacted Dr. Harrell-Bond for support in treating an opportunistic infection (Dr. Harrell-Bond, personal communication, June 5 2007).

Although he had been referred to the Abbassia Fever Hospital to receive oxygen for his failing lungs, he was afraid to go since he believed he would be “locked in and never allowed to leave”. Although a medical intern who worked with refugees agreed to escort him to the hospital the following day in order to reassure him of his safety, he refused to go and said he would wait for his friends to collect enough money to send him back to his country of origin to be treated. This fear surrounding Egyptian services further compounds the limited availability of services and prevents refugees from receiving the care they need.

Apart from the lack of trust, many refugees refrain from using the Egyptian services as they believe they receive better quality of care from humanitarian organizations. The organization, however, continue to be overworked and receive limited funding. Regardless, while the services available for refugees through humanitarian organizations in Cairo are improving, the biggest challenge for refugees continues to be the limited treatment options available. Relative to the hundreds of thousands of refugees living in Cairo, the supply of HIV/AIDS related services are extremely low, especially as refugees can only access services from international organizations. Both Refuge Egypt and Caritas provide confidential testing, however, Refuge Egypt is the only program with proper VCCT standards as defined by UNAIDS. Apart from the few providers that offer HIV testing and/or counseling, there are also only a limited supply of ARVs available for 28 refugees over the next five years.

*Social Systems and Power Relations*

The influence of social systems and power relations influence refugee vulnerability by determining cultural norms within a country. In Egypt this is characterized by stigma and discrimination surrounding the HIV virus. One of the largest barriers to accessing services is the low awareness and high stigma and discrimination surrounding HIV/AIDS that together create a culture of secrecy and further prevent refugees from being tested or gaining access to the available HIV/AIDS services. With limited information on modes of transmission and risk factors, many refugees refrain from being tested. The low awareness is exacerbated by the extreme stigma surrounding the virus, which also prevents many refugees from being tested in fear of being shunned from their community. Following this pattern, HIV-positive refugees refrain from disclosing their status (if known) and while this protects them from being cast out of their community, it continues the spread of lack of awareness and skepticism about the disease (AMERA, personal communication, June 6, 2007). Furthermore, it places HIV-positive refugees and other individuals at risk for increasing transmission of HIV without the knowledge and tools to protect themselves. This in turn hampers prevention efforts.

This secrecy within the refugee community also prevents HIV-positive refugees from forming a supportive community to deal with the challenges of living with HIV. After the start of ARV treatment at Refuge Egypt in 2008, the medical staff attempted to form a discussion group of the patients receiving ARVs to provide a dialogue and support network for PLHIV. However the patients were so scared to even talk amongst other HIV positive refugees that each patient refused to participate (Refuge Egypt, personal communication, January 17, 2009). This powerful stigma surrounding the disease, even

in this case among HIV positive refugees therefore leaves HIV-positive refugees with limited coping options.

Discrimination by Egyptians also strengthens the culture of secrecy surrounding HIV/AIDS within the refugee community. For example, there is a common misconception within the Egyptian population that all African women are HIV positive. This type of discrimination, in conjunction with the strict deportation policy regarding HIV-positive foreigners, strengthens the belief that foreigners are responsible for the HIV/AIDS epidemic in Egypt and that the Egyptian nationals are not vulnerable. The culmination of these factors encourages refugees to refusing testing or disclosing their status, in order to decrease their exposure to discrimination and harassment.

Finally, fear of deportation often prevents refugees from being tested. Until 2004, refugees found to be HIV positive were under threat of being deported by the government like other foreigners. However in March 2004, UNHCR shared with Egypt's National AIDS Program its concerns that a key part of refugee protection included access to asylum status and prevention of *refoulement* despite HIV positive status. NAP endorsed UNHCR's position and enacted regulations and policies exempting any registered refugee or persons under protection of UNHCR from regulations applying to foreigners. Yet, any non-registered refugees found to be HIV positive have no protection from deportation because of their illegal status in the country. This results in a constant fear within the refugee population. As a result, many organizations, including AMERA, encourage refugees to keep their HIV status confidential within their immediate family and AMERA never includes such information on file (AMERA, personal communication, June 6, 2007).

Apart from stigma and discrimination, immigration status determines the power of individuals to take appropriate measures to decrease their own vulnerability. The challenges that HIV-positive refugees face in accessing HIV/AIDS services are only applicable to registered refugees. The hundreds of thousands of non-registered refugees and 'closed files' face an entirely different set of challenges that leave them even more vulnerable than registered refugees. In general all the medical services discussed, and those partnered with UNHCR, are only available for registered refugees. Refuge Egypt is the only organization that allows non-registered refugees to receive care. As a result, non-registered refugees are placed in more vulnerable circumstances since they cannot access the humanitarian assistance from international organizations at national hospitals (Refuge Egypt, personal communication, June 25, 2007). This leaves non-registered refugees with very few health care options. The majority of these individuals are forced to depend on limited resources of church and community organizations that may cater to non-registered refugees or face trying to pay for private health care which they normally cannot afford (Coker et al, 2003). Their medical situation is also exacerbated by their lack of legal status, as they could be deported at any time if found by Egyptian authorities.

### *Summary*

From this analysis, it is evident that the vulnerability of refugees in Egypt to HIV transmission is increased due to the combination of policy, structural factors and social relations. As outlined in Figure 5, this chain of causation follows a hierarchical progression from macro- to micro-level social processes, resulting in a differential access to resources for refugees. On the largest scale, the policies of international humanitarian

law and the Egyptian government impacts the urban location of refugees in Egypt, as well as their constrained socio-economic rights and access to humanitarian services. As a result, refugees in Egypt consequently become the poorest of the urban poor, making them extremely disadvantaged members of Egyptian society (Zohry, 2003).

Finally, looking at the social systems and power relations evident in the Egyptian and refugee populations further marginalizes refugees in Egyptian society due to the high stigma and discrimination surrounding refugees and HIV/AIDS. These social processes cause refugees to essentially exist “in limbo” socially, economically and culturally in Egyptian society and determine unequal access to resources (Coker et al., 2003). This unequal access consequently limits their access to HIV/AIDS services, inevitably increasing their vulnerability to HIV transmission. This contextualized analysis of vulnerability and access to medical care, therefore highlights the potential to not only address the issue of HIV/AIDS services for refugees, but also to help address the underlying forces of vulnerability that can benefit the standard of living for refugees in general.



## **Chapter VI: Conclusion and Policy Recommendations**

This case study of HIV/AIDS services for refugees in Cairo provides valuable insight into understanding the challenges refugees face in accessing HIV/AIDS services. Despite recent improvements, HIV-positive refugees in Cairo continue to deal with a vast array of challenges in accessing necessary HIV/AIDS education, prevention and treatment services that stems from the limited availability of services, as well as barriers of constrained socio-economic rights, urban isolation and high stigma and discrimination. By using a vulnerability perspective, this case study highlights how the availability of medical services is not the only challenge. Rather, a complex combination of economic, social and cultural factors, marginalize refugees in Egyptian society and consequently increase their risk to HIV.

Yet, because refugees live in the urban centers of Egypt, refugees are an integral part of Egyptian society. For both their health rights and national prevention efforts, more must be done to increase access to HIV/AIDS services for refugees. Since HIV/AIDS services include health education, primary health care and reproductive health care, increasing access to HIV/AIDS would also strengthen the general health care for the refugee population. Therefore promoting effective public health HIV prevention practices within the refugee population would also provide an avenue to increase the services available for reproductive and prenatal health care, STIs and preventative health promotion, education and screening.

However for an effective long-term solution to increase HIV/AIDS services in Egypt, a multi-faceted solution must be adopted that addresses the underlying vulnerabilities that causes unequal access to health care for refugees. Factors that

increase vulnerability of refugees to HIV within Egyptian society are a part of chain of causation that stems from political, economic and social processes that marginalize refugees in Egyptian society. Contextualizing the HIV/AIDS issue for refugees in Egypt within this larger framework offers a way to consolidate efforts to address larger issues apart from health care and facilitate improvements of the economic, social and cultural standard of living for refugees in Cairo. As a result, by addressing the factors that increase vulnerability to HIV, like economic independence and cultural stigma, will provide an avenue for broader societal change beyond the implications of the HIV/AIDS epidemic.

Due to the urban location of refugees in Egypt, a multi-faceted approach would also benefit the Egyptian population. Since the refugee and Egyptian populations share the same urban space, the economic, social and cultural realities they face are similar. Therefore improving health education for the refugee population could improve knowledge and decrease stigma and discrimination surrounding HIV/AIDS therefore promoting a more tolerant community. On a larger scale, efforts aimed at improving urban economic conditions for refugees would also benefit the Egyptian urban poor. Thus, addressing the issue of HIV/AIDS through preventative public health methods would provide an avenue to achieve empowerment in various sectors and address larger challenges in Egyptian society.

### *Policy Recommendations*

One of the first steps in addressing access to HIV/AIDS services for refugees is to improve the services that are available. With limited information about the prevalence

rate among refugees in conjunction with the high levels of stigma and discrimination surrounding HIV/AIDS within the refugee community, improving education and prevention is essential. Although lack of proper surveillance prohibits experts from knowing the exact HIV prevalence and situation of HIV/AIDS among the refugee population, current trends show prevention efforts could still have an important part in preventing a widespread epidemic. Therefore, focusing on providing education and testing to the wider refugee population should be the main priority as a smaller percentage of the population will need long-term HIV-related services such as ARVs. Emphasizing prevention measures would not only increase awareness, but would be economically effective in the long-run by preventing transmission of HIV within the refugee population and general Egyptian population. Finally, while refugees in Egypt can access proper VCCT with pre- and post-test counseling, these services are only found at Refuge Egypt. Therefore UNHCR should encourage Caritas International to adopt these standards as well as attempt to open other testing facilities throughout Greater Cairo for refugees to access.

In terms of HIV/AIDS medical services, it can be argued that the situation is improving with the opening of the ARV clinic at Refuge Egypt, however testing and treatment options continue to be centralized in two medical clinics with limited resources. Furthermore there remains a large discrepancy between the supply and demand for HIV/AIDS services, as only three organizations attempt to provide HIV/AIDS-related services to the hundreds of thousands of refugees residing in Cairo. Unfortunately the biggest barrier to increasing services is the limited availability of funding necessary to implement services and ensure that they are sustained. Even the new ARV program at

Refuge Egypt currently only has funding for the next five years. It is imperative that the importance of this issue be recognized and that funding continues so that the progress made to date is not lost. The political ambiguities of humanitarian aid, in addition the current economic climate, however, will increase the difficulty of securing appropriate funds.

In the future as more services are introduced, it would be ideal if more clinics in addition to Refuge Egypt would have proper VCCT and ARV facilities for refugees. Tailoring the services available to specific needs and populations would also help strengthen the level of care currently offered to refugees. Specifically one gap that Refuge Egypt noticed in their ARV program is the lack of child ARV specialists (Refuge Egypt, personal community, January 17, 2009). Bringing in specialists to continue staff training is an important step to broaden existing programs. Following these improvements, not only should services increase and specialize but attempt to relocate outside the downtown area to increase accessibility of HIV/AIDS services.

One solution to increasing the HIV/AIDS services for refugees would be to follow UNAIDS/UNHCR strategies and integrate the national and refugee services in Egypt. In conjunction with outreach programs targeting high-risk groups, granting refugees access to the new VCCT system established in 2004, would exponentially increase the number of facilities and services that refugees could access. These centers are located throughout Cairo, so access could also be increased by diminishing the barrier of urban isolation. However, the major benefit of this proposition would be the combination of funding streams between the government and humanitarian organizations. This measure would significantly improve Egypt's prevention efforts, as funds allocated to helping refugee

services can also be used to strengthen the Egyptian sector. In turn, this would create a stronger base of VCCT, outreach and ARVs to help all those infected with HIV and increase the overall quality of care for all HIV-positive individuals in Egypt.

Despite the potential benefits of the proposed solution, it can be argued that Egypt does not have the resources available to include refugees in their NAP when PLHIV in Egypt continue to face barriers in accessing high levels of care. As evident in the reservations held by the Egyptian government concerning the 1951 Convention, the lack of resources in the country prohibits the Egyptian government from allocating additional resources to non-nationals (Zohry et al., 2003). However, it is irresponsible and shortsighted to deny the fact that refugees are a part of Egyptian society. Being urban based, refugees in Cairo are constantly mixing with the local population. Instead, integration of refugees into national HIV/AIDS services should not be seen as the re-allocation of resources but rather a way to strengthen Egypt's prevention efforts. This measure would lead to an increase in funding through the combination of funding streams and the NAP programs would potentially gain more from the integration of services while at the same time addressing the needs of a high-risk group. This win-win situation would therefore be a more efficient way to strengthen prevention efforts while increasing access to HIV/AIDS services for refugees.

However, if this plan was adopted, a major challenge to integration of national and refugee services is the issue of discrimination towards refugees from Egyptian health professionals. While the integration of services should increase access to services for refugees, if the care available is lower in quality due to the discriminatory practices of

health officials, these efforts would be in vain and only create another barrier for refugees in accessing HIV/AIDS services. As the case of the Ethiopian refugee exhibited, refugees are already very skeptical about accessing Egyptian medical care and there have been reports of refugees being mistreated in Egyptian hospitals. If integration is going to be a durable solution, not only must these services be integrated but national providers must be trained to treat all patients equally and ensure that nationals and refugees receive the same standard of care.

While increasing medical services for refugees is an important step, these initiatives will only be effective if the barriers that prevent refugees from accessing care are addressed. First of all, more must be done to address the economic vulnerability of refugees in Egypt as the constrained socio-economic rights of refugees perpetuates their vulnerability by placing them in risky situations in order to obtain housing, income and consequently medical care. Not only does limited income force refugees to forgo medical care but, as mentioned previously, with more female refugees turning to sex work in order to provide income to their family, they will continually be placed in circumstances that increase their risk to HIV/AIDS. This not only increases the chances of transmission of HIV within the refugee population, but as a high-risk group, these vulnerabilities to HIV could directly impact the spread of HIV within Egypt.

A durable solution to this issue ultimately rests on the legal stipulations of the Egyptian government however organizations working with refugees should continually encourage the government and other organizations to help find more employment opportunities for refugees. For example, within the Refuge Egypt establishment, refugees have opened a handicraft store called “Tukul Craft” where refugees are able to produce

handicrafts, sell them, and use their profits to pay for living expenses. Organizing self-sufficiency programs like this are important in increasing the economic independence of refugees which would inevitably allow them to establish a healthier lifestyle and decrease their vulnerability to the transmission of HIV/AIDS.

In order to address social and cultural vulnerability, programs must be implemented to decrease stigma and discrimination surrounding HIV/AIDS in the refugee population. The geographic and social isolation created by living in urban areas can only be addressed by establishing awareness initiatives to bring refugee communities together to not only understand transmission and prevention of HIV/AIDS, but also to provide a supportive environment for PLHIV. Currently the secrecy surrounding HIV/AIDS in the refugee community prohibits PLHIV from living in a supportive and open environment. Therefore, education is key in order to break the cycle of secrecy surrounding the virus and build a trusting and supportive community. This measure would also benefit the Egyptian population as addressing the secrecy around HIV/AIDS, would prevent increased transmission of the virus among the refugee population. Decreasing transmission within this high-risk group is essential in order to prevent the onset of an epidemic in Egypt.

Along these lines, decreasing discrimination in the refugee population in Egypt is also essential. The discrimination towards refugees coupled with the existing cultural stigma around HIV/AIDS puts refugees in an unsafe society. Actions by the Egyptian government to allow registered refugees to access some services is a step in the right direction but this emphasis on tolerance and community must continue in order to create a more accepting society. With such an active role in refugee status determination,

UNHCR should also continue to try and increase communication between these two populations, in an attempt to encourage a dialogue. Increasing education about HIV/AIDS within the Egyptian population would also benefit efforts by the MOHP to prevent the onset of a major epidemic. Low awareness and high stigma and discrimination remains a major barrier in implementing effective and accepted HIV/AIDS services for the Egyptian population. Therefore these education initiatives could also encourage a dialogue surrounding HIV/AIDS within the Egyptian population, and help promote testing and other preventative measures in the general population.

Finally, when developing initiatives to improve the HIV/AIDS services for refugees in Cairo, it is important to acknowledge the vulnerability inherent in forced displacement. While increased funding and attention to the issue of HIV/AIDS services for refugees may ultimately lead to more access in funding and the potential for a broader range of services, with the current stigma surrounding both HIV/AIDS and refugees, it is imperative to ensure the safety of refugees is not put in jeopardy. In light of a history of discrimination and violence, these initiatives must be undertaken in a careful manner to ensure protection and not endanger the standing of refugees in Egypt. This issue is further complicated by the discrepancy between registered and non-registered refugees. Organizations must be aware that non-registered refugees are significantly more vulnerable due to their lack of legal status and recognize that their actions will affect these two groups differently.



*Implications*

With the limited literature available on refugees and HIV/AIDS, this case study continues to explore the larger implications of the complex relationship between HIV/AIDS and refugees on a number of scales. Apart from providing country specific recommendations, these findings also fill a gap in the literature surrounding urban refugees and what specific barriers they face in accessing HIV/AIDS services. Finally this research offers more context-specific examples of the challenges refugees face in accessing HIV/AIDS services and how access to medical care is intertwined with a variety of larger structural issues. Analyzing how these challenges interact with the complex relationship between HIV/AIDS and refugees highlights appropriate solutions that can be adopted to increase access on a broader scale.

Despite the growing number of urban refugees, there remains very little research surrounding the HIV/AIDS services available to urban refugees. This case study is successful in offering an introduction to the realities faced by urban refugees in accessing HIV/AIDS services and what additional measures should be adopted when working with urban refugees. Two main challenges that are unique to urban refugees are the lack of community as well as constrained economic rights. Although forced migration disrupts social connections in all circumstances, in the case of urban refugees, the isolation inherent in being dispersed throughout a city significantly impacts the formation of new communities. Consequently efforts to establish community groups to strengthen dialogues and education would help. Effective measures in Egypt, especially among Sudanese and Somali refugees have included the formation of religious groups that perform community activities and outreach to new refugees (Grabska, 2005). Identifying

similar common characteristics among urban refugee populations is important in an attempt to find ways to bridge the social gaps in their dispersed urban location.

The limited economic rights of urban refugees are also a significant problem and one that differs from refugees in camps. Although it can be argued that urban refugees regain more autonomy living in an urban environment, this freedom of movement is unfortunately offset by uneven access to services. Compared to refugee camps where humanitarian aid is allocated throughout the camp, access in urban areas can be more challenging with services being geographically dispersed (Bailey, 2004). Furthermore with no defined residential areas, urban refugees have additional economic expenses to maintain as well as paying for the standard of living within their country of asylum. Therefore ways to provide economic opportunities for urban refugees can help increase autonomy and decrease forces of vulnerability that cause refugees to live on the margins of society. A focus on these factors, in conjunction with continuing education to combat stigma and discrimination, would have beneficial impacts and decrease the barriers that urban refugees face in accessing HIV/AIDS services.

Within the context of the larger issue of HIV/AIDS and refugees, the findings from this case study concur with other studies that characterize the relationship between HIV/AIDS and refugees as very complex (Spiegel, 2004; UNAIDS et al., 2005). The number of factors that decrease or increase risk to HIV/AIDS, as well as the issue of prevalence gap between refugees and host populations, means that effective programs and initiatives must take into consideration country specific circumstances. While this makes it difficult to find overarching tangible solutions to increasing access to HIV/AIDS services for all refugees, full recognition of the importance of circumstantial factors

unique to different geographic contexts is important in order to not overlook the varying factors that produce risk and vulnerability. As still a relatively new topic of research, a continued examination of different case studies is necessary to broaden the literature available and help inform policy decisions.

Finally, the most important insight from this case study is the acknowledgement that the availability of medical services does not guarantee access. In reality, the interplay of economic, social and cultural factors results in differential access to resources, which consequently increases the vulnerability of refugees and host populations to HIV/AIDS. It is only by addressing these underlying causes of vulnerability that better access to HIV/AIDS services can occur. With this in mind, larger initiatives must adopt multi-faceted approaches to not only increase available services but also identify initiatives to empower refugees. With these steps the HIV/AIDS needs of refugees will be more comprehensively addressed, strengthening prevention and treatment efforts for both refugee population and host populations.

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## Appendix A

### Potential Interview Questions

*Questions varied depending on what organization the interviewee is a part of, but in general interviews consisted of the following questions:*

1. What HIV/AIDS services are available in Egypt?
2. Are these services offered only for Egyptian nationals or do they also include refugees?
3. How do individuals find out about these services?
4. What is the next step in addressing HIV/AIDS here in Egypt?
5. What HIV/AIDS services do you provide?
6. What causes refugees to come and be tested?
7. Are there any other clinics, NGOs or hospitals that you refer patients to?
8. If a refugee is found to be HIV positive, what is the next step in treatment?
9. What is the knowledge level about HIV/AIDS among refugees? Do you provide educational programs to spread awareness?
10. What is your source of funding for HIV/AIDS services?
11. What barriers prevent refugees from being tested?
12. What is the next step in addressing the HIV/AIDS issue for refugees in Cairo?
13. What are the challenges facing refugees in accessing HIV/AIDS services?

## Appendix B

*\*Note: Final version of article published in Forced Migration Review Vol 31*

### **HIV/AIDS services for refugees in Egypt**

Anna Popinchalk

*HIV-positive refugees' access to medical care in Egypt is impeded by the lack of medical services and by the intense stigma and discrimination associated with HIV/AIDS.*

While there is no evidence to support the claim that refugee populations have an increased prevalence of HIV, it is true that refugees are inherently more vulnerable to HIV – due to social instability, loss of relatives and breadwinners, increased risk of sexual assault or involvement in commercial sexual activities, as well as a lack of resources and services in education and health.

Before the 1990s, there was little focus on the risks of HIV/AIDS within refugee populations due to the fear that highlighting these risks would cause governments to resist accepting refugees. As countries began to consider the necessity to test refugees for HIV before allowing international travel and resettlement, UNHCR strove to protect refugees against expulsion due to their HIV status by publishing its Policy Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS).<sup>i</sup> Since then UNHCR has continued to publish guidelines and strategic plans promoting the rights of refugees with regard to HIV and AIDS, including discouraging the use of mandatory testing.

According to the 1951 Refugee Convention, host countries are required to provide non-discriminatory social and medical assistance to refugees equal to that for nationals. However, countries already overburdened with HIV/AIDS within their own population are usually unwilling to provide additional services for refugees and seldom include refugees in their National AIDS policies.

#### Stigma and misconceptions

As of March 2007, there were some 39,400 refugees and persons of concern registered with UNHCR in Cairo. Among those, Sudanese, Iraqis and Somalis constitute the vast majority (93%), with other nationalities representing the remaining 7%.<sup>ii</sup> Refugees enjoy very few socio-economic rights in Egypt and therefore depend mainly on UNHCR and other NGO partners for assistance – and, in the crowded urban areas of Cairo and Alexandria, compete with local Egyptians for limited resources.

Refugees are impeded not only by the lack of medical services, but also by the intense stigma and discrimination associated with HIV/AIDS within both the Egyptian and refugee populations. Egypt's estimated low HIV prevalence can be attributed to the strong underlying cultural and religious values within society. As a result there is a lack of awareness about the disease and vast misconceptions with regard to modes of transmission and ways of prevention. It is commonly held that those with HIV must be

promiscuous or drug-users and that HIV is a disease brought in by foreigners. As a result, HIV/AIDS is a highly stigmatised disease.

Before 2004, most HIV cases were reported as a result of the mandatory testing of blood donors, foreigners residing for more than six months and nationals applying for work permits to work abroad. While voluntary testing was available, those who tested positive were reported to the Ministry of Health and Population (MOHP), thereby greatly discouraging the use of such services. In addition, foreigners found to be HIV-positive were deported within 48 hours in order to try to contain the extent of the virus in Egypt. In March 2004, following discussions with UNHCR, MOHP's National AIDS Programme (NAP) exempted any registered refugee or person under protection of UNHCR from this same threat – but non-registered refugees found to be HIV-positive still have no protection from deportation. As a result, many organisations, including AMERA, encourage refugees to keep their HIV status confidential.

Only in the past three years has the Ministry of Health and Population (MOHP),<sup>iii</sup> with the support of Family Health International,<sup>iv</sup> developed a system of voluntary confidential counselling and testing (VCCT) and established national guidelines and a monitoring and evaluation plan. There are currently 14 VCCT sites, nine managed by the MOHP, plus nine UNFPA-funded mobile VCCT vans to provide access to people in remote areas. All VCCTs provide anonymous testing; while HIV-positive cases are reported to the Ministry for statistical and epidemiological purposes, no identifying information is provided.

Unfortunately, as foreigners are not allowed access to national HIV/AIDS services, refugees are left to depend on local NGOs and organizations – such as Refuge Egypt, which introduced a VCCT service at their clinic in 2003. While anyone who comes to Refuge Egypt can access VCCT, the organisation mainly targets high-risk groups within their family planning, antenatal and TB clinics. For HIV-positive pregnant mothers, they help prevent transmission to the baby through caesarean sections and by providing milk formula to prevent transmission through breastfeeding. Anyone living with HIV/AIDS is also eligible for food packages and can obtain house visits from the clinic doctors. Refuge Egypt is the only organisation offering pre- and post-test counselling.

Caritas, another implementing partner of UNHCR, performs confidential HIV testing for refugees on request and also provides support and counselling on how to handle life with HIV. Similarly, AMERA, an independent NGO offering legal support to refugees in Egypt, provides psychosocial support services for HIV-positive refugees. Since 2005, MOHP's NAP has allowed refugees to be treated at Abbassia Fever Hospital for HIV-related illnesses or infections necessitating hospitalisation – but fear of deportation still prevents many from attending.

In 2007, an Ethiopian refugee called on Dr Harrell-Bond, founder of AMERA, to explain that he – an HIV-positive refugee – had been referred to the Abbassia Fever Hospital but was afraid to go. He believed he would be locked in and never allowed to leave. The next



day, a medical intern escorted him to Abbassia but he refused to go in. He said that his friends would instead collect money for him to return to his country where he could get medicine. His condition was such, however, that it is unlikely that he would survive any delay.

Despite these initiatives, refugees have no access to antiretrovirals to prevent the onset of AIDS. While Refuge Egypt does have preventative antiretrovirals such as post-exposure prophylaxis (PEP) for rape victims and single doses of ARVs to prevent mother-to-child transmission, there are no long-term therapeutic ARVs, leaving very limited options for treatment apart from treating any infections that may arise.

Recently however, the Global Fund for AIDS, Tuberculosis, Malaria (GFATM)<sup>v</sup> provided funding for around 20 refugees to receive ARVs over a period of 5 years at Refuge Egypt starting in the fall of 2008. The Ministry of Health, with UNHCR support, has started training doctors in HIV awareness, VCCT, prevention of mother-to-child transmission, PEP, emergency contraception and case detection of STIs and HIV-related illnesses.

#### Removing discrimination

The situation has improved over the last three years as the Egyptian government has begun to extend their services to registered refugees, coupled with the new ARV programme at Refuge Egypt. These examples of integration of refugees into national HIV/AIDS services are key to helping HIV-positive refugees in Cairo, not only for the refugee population but also to help strengthen Egypt's prevention efforts.

However education is vital in order to attempt to remove the stigma and discrimination surrounding not only HIV/AIDS but also refugees. The secrecy that is created by advising refugees to reveal their HIV status only to their immediate family and doctor unfortunately only continues to stigmatise the disease. This reinforces discrimination within the community and forces the disease underground, affecting prevention efforts. It is only through education and outreach programmes that awareness can be raised and misconceptions dispelled to promote a better understanding of the situation.

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<sup>i</sup> [http://data.unaids.org/pub/Report/2005/unhcr\\_strategic\\_plan2005\\_2007.pdf](http://data.unaids.org/pub/Report/2005/unhcr_strategic_plan2005_2007.pdf)

<sup>ii</sup> These numbers exclude the hundreds of thousands of 'closed files', not to mention the thousands of Palestinians residing in Egypt. UNAIDS, UNHCR. *Report on Project: HIV/AIDS prevention and impact mitigation among refugees in Greater Cairo, Egypt.* January 2006

<sup>iii</sup> [www.mohp.gov.eg](http://www.mohp.gov.eg)

<sup>iv</sup> [www.fhi.org](http://www.fhi.org)

<sup>v</sup> [www.theglobalfund.org/](http://www.theglobalfund.org/)