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PANDEMIC PREPAREDNESS AMONG SUDANESE MIGRANTS IN GREATER CAIRO

By Yasmine Ahmed and Rebecca Dobb

**The Centre for Migration and Refugee Studies
(Formerly FMRS)**

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Table of Contents

List of Abbreviations and Terms	4
Acknowledgments	5
Executive Summary	6
Introduction	9
Definitions and Concepts	10
Migrants and Refugees	10
Avian Influenza and Human Avian Influenza	11
Epidemic and Pandemic	11
Pandemic Preparedness Plans	12
Background Information	14
Profile of Sudanese in Egypt	14
Access to Health Services	15
Methodology	17
Research Team	18
Limitations of the Study	19
Demographic Characteristics of the Sample	20
Literature Review	25
Health and Housing Situation of Sudanese Migrants in Greater Cairo	25
Pandemic and Pandemic Preparedness: International Approaches	27
Pandemic and Pandemic Preparedness: Egyptian Approaches	28
Communication Strategies for Pandemic Preparedness	28
Primary Research Findings	31
Egypt and Pandemic Preparedness: Stakeholders' Involvement and Viewpoints	31
The Status of Migrants in the NPPP of Egypt	32
Possible Impact of a Pandemic on Migrants	33
Knowledge, Attitudes, Practices and Behaviour (KAPB)	34
Gender and the Risk of Pandemic	39
Access to Public Services: Health-Seeking Behaviour and Perceptions of Health	39
Anticipated Actions of Sudanese Migrants during a Potential Pandemic Outbreak	40
Communication Strategies for Reaching the Sudanese Migrant Community	41
Conclusion	45
Recommendations	46
References	48
Appendixes	
Appendix 1-Access to Services	50
Appendix 2- Access to Services by Residency Status	52
Appendix 3-Survey Questionnaire	60
Appendix 4-Focus Group Discussion Guide	72
Appendix 5-In-Depth Interview Semi-Structured Questionnaire	75
Tables and Figures	
Table 1: Access to Health Care	16
Table 2: Geographical Distribution of Members of Households	20
Table 3: Distribution of Household Members by Relationship to Heads of Households	21
Table 4: Age of Household Members	22

Table 5: Highest Degree Obtained by Heads of Households	23
Table 6: Total Monthly Income of Household	23
Table 7: Index of Number of House facilities' Possession	24
Table 8: Participants' Access to Water	33
Table 9: Participants' Access to Sanitation	34
Table 10: Household Members at Risk by Governorate in Greater Cairo	36
Figure 1: Percentage of Possession of Household Facilities	24
Figure 2: Sources of Information	37

Abbreviations and Terms

AHI:	Human Avian Influenza
AI:	Avian Influenza
AMERA	African Middle East Refugee Assistance
AUC:	American University in Cairo
CBO:	Community-Based Organization
CCIP:	Cairo Community Interpreter Project
CMRS (FMRS):	Centre for Migration and Refugee Studies (formerly Forced Migration and Refugee Studies Centre)
FGD	Focus Group Discussion
IFRC:	International Federation of Red Cross and Red Crescent Societies
IOM:	International Organization for Migration
IEC:	Information, Education and Communication Material
KAPB:	Knowledge, Attitude, Practices and Behaviour
MOHP:	Ministry of Health and Population
NPPP:	National Pandemic Preparedness Plan
PIC:	Pandemic Influenza Contingency
PP:	Pandemic Preparedness
<i>Raodat Rifiat:</i>	Rural Female Community Health Workers
Refuge Egypt	Christian development organization that operates out of All Saints' Cathedral Episcopal Church in Zamalek, Cairo
SOP:	Standard Operating Procedures
STAR:	Student Action for Refugees
SUDIA:	Sudanese Development Initiative Abroad
TOT:	Training of Trainers
UNHCR:	United Nations High Commissioner for Refugees
UNICEF:	United Nations Children's Fund
UNOCHA:	UN Office for the Coordination of Humanitarian Affairs
USCRI:	US Committee for Refugees and Immigrants
WHO:	World Health Organization

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Executive Summary

This study looked at the perceptions and vulnerabilities of Sudanese migrants to an influenza pandemic in Egypt. Migrants' limited access to health and non-health public services in Egypt and the absence of a specific migrants' component in the Egyptian National Pandemic Preparedness Plan provide indication of the vulnerability of migrants, both in terms of prevention and actual protection during a pandemic.

This research project, commissioned by the International Organization for Migration (IOM) and conducted by the Centre for Migration and Refugee Studies (CMRS) at the American University in Cairo, aimed to provide a situational analysis of pandemic preparedness among the Sudanese population in Greater Cairo. There is limited research and documentation of migrants' particular needs in such events; therefore, exploring the vulnerability of Sudanese migrant populations to pandemics and learning about their individual and community-level resilience were invaluable steps to tackle pandemic preparedness from a community-based approach.

Structure of the Research

Survey and focus group participants in this research were migrants from different parts of Sudan currently living in Cairo. A survey that included **293** households, with a total of **1016** members, provided the baseline data for our study, which was complemented with **five** focus group discussions, with **46** Sudanese participants, and **six** in-depth interviews with national, international and community-level stakeholders.

Key Survey Findings

A knowledge, attitudes, practices and behaviour (KAPB) assessment showed that Sudanese heads of households and individuals in Egypt are vulnerable to a pandemic because they have limited access to information on a pandemic and its health and non-health consequences. Though the Sudanese in Cairo do not tend to rear poultry themselves, the majority do live in overcrowded neighbourhoods where poultry-rearing is common. This is coupled with low awareness of prophylaxis related to AHI pandemic. Furthermore, the lack of a migrant component in the National Preparedness Plan of Egypt would exacerbate the high level of migrant vulnerability during a potential pandemic. Specific findings show:

- **72%** of survey respondents said they had heard the word pandemic before (in Arabic '*waba*' '*alamy*'). Out of this group, **61.8%** reported some level of awareness about pandemic. However, when asked to provide examples, respondents often mentioned illnesses not classified as a pandemic.
- All research participants, survey and focus groups' participants claimed that they do not rear or breed poultry at home whereas **75.4%** of the survey respondents claimed that they still eat poultry and poultry products despite the potential threat.
- **91%** of survey respondents reported TV to be the main media through which they had gained knowledge of AHI. Radio and newspapers followed at **39%** and **32.4%** respectively.

- Asked for the places where they buy poultry, **57.7%** of the survey respondents replied they buy it open markets (*souks*), **13.3%** in supermarkets, **12.6%** in traditional poultry stores, **8.2 %** in restaurants. 3.1 % have no preferences and buy from all the above and **5.1 %** buy from unspecified other places.

Interviews Key Findings

Stakeholder interviews noted the danger in not having a migrant component as part of the National Pandemic Preparedness Plan of Egypt and stated that including migrants within the plan could improve their level of protection and resilience in the event of a pandemic.

Stakeholders and focus group participants noted the particular risk factors for the Sudanese migrant community, such as overcrowded living conditions that could facilitate the spread of a pandemic.

Preparing migrant communities for a pandemic involves creating communication strategies which ensure that messages reach communities and individuals. Stakeholders noted different means and channels of communication that would be useful but highlighted that the use of media must be combined with actions at the community level to ensure behavioural change.

Implications of the Study

The study was one part of an action-oriented research project designed: (i) to enhance overall understanding related to the KAPB of the community on pandemic; (ii) to inform the design of interventions and information, education and communication (IEC) material; and (iii) to advocate for greater inclusion of migrants in national preparedness plans.

Conclusion

While acknowledging the importance of including a migrants' component to national pandemic preparedness plans, this study revealed that national actions must be accompanied by simultaneous communication activities at the community level. Only combined efforts can ensure that the Sudanese community develops an awareness level sufficient for behavioural change. The study demonstrated a significant communication gap on pandemic preparedness in this community. Therefore, improving and designing well-adapted communication strategies is essential for raising the awareness level.

Recommendations to the Government of Egypt

- Create a surveillance system for the target population living in areas at high risk, such as informal urban settlements, particularly in Cairo;
- Establish a network including national and government stakeholders involved in pandemic work and community based organisations (CBOs) engaged with migrant groups;
- Ensure that among the Sudanese migrant population a clear reporting system is in place for Avian Influenza or Human Avian Influenza cases in their neighbourhoods;
- Ensure that non-health interventions are included in pandemic preparedness work regarding migrants;
- Extract lessons learnt and best practices from plans applied with other migrant populations in similar conditions;

- Ensure communication channels for coordinated dissemination of clear and information to avoid confusion and panic.

Recommendations to International Organisations and Non-Governmental Organisations

- Design appropriate communication strategies that do not exacerbate stigmatization but take into account the linguistic and social specificities of the Sudanese community;
- Advocate in cooperation with CBOs for the expansion of the provision of migrant-sensitive health policies, including public and private health care services to Sudanese migrants;
- In coordination with the Government of Egypt and CBOs, increase the level of inclusion and trust of the Sudanese vis-à-vis national health system;
- Implement mobile activities (i.e. home visits / mobile health clinics) to suit what is often a very mobile lifestyle among migrants;
- Monitor and evaluate any communication material, as well as communication strategies used with Sudanese migrants and ensure that it is having a sustained behavioural impact;
- Continue advocacy work with relevant stakeholders and ensure they include a migrant focus in their activities.

Recommendations to Community Based Organisations

- Cooperate with international and national actors, including the Government of Egypt to spread awareness of the concept of pandemic among Sudanese migrants;
- Ensure that health providers working with Sudanese migrants mainstream pandemic preparedness as part of their health awareness programmes;
- Identify community leaders as well as other individuals from the Sudanese community and ensure that an efficient communication chain is established to be used during emergency circumstances, such as a pandemic outbreak;
- Monitor the community to identify particularly vulnerable people who do not seem to be receiving information as well as confusing, frightening or contradictory messages, and establish a reporting system to identify dissemination gaps.

Introduction

In April 2008, the International Organization for Migration (IOM) commissioned the Centre for Migration and Refugee Studies (CMRS) to undertake a situational study on pandemic preparedness among the Sudanese population in Greater Cairo. The chief aim of this study was to explore the vulnerability of the Sudanese migrant population to pandemics, with a special focus on Pandemic Influenza, as well as to learn about their individual and community-level resilience. Moreover, the study also provides baseline data on the knowledge, attitudes and practices among the Sudanese in Greater Cairo regarding pandemic diseases in general and avian influenza (AI) and pandemic influenza in particular. While timing, severity and exact virus strain of the next influenza pandemic remain unknown and may not be perceived as a priority at this point, IOM's concern emerges from the fact that migrant populations in Egypt might very well be at risk because they are often excluded from national protection plans and have limited, if any, access to public health care and social services.

In addition, this study aims to contribute toward the expansion of health services as well as the development of national policies and guidelines to include migrants in response to crises. Furthermore, findings of this study will be used to mobilize efforts of national, international and civil society organizations to include migrants' specific needs in pandemic preparedness activities wherever appropriate.

The authors would like to emphasise that this report does by no means imply that migrants are more susceptible to a pandemic, or that they represent the likely source of a pandemic outbreak. This group may, however, be more vulnerable to it than the local population due to the fact that they live in urban centres where bird rearing is common and suffer limited access to public services and exclusion from Egyptian national health and social care agendas. Although this report only deals with Sudanese migrants in Cairo, it will surely yield some indication useful to provide assistance to other migrant populations in the fight against influenza pandemic.

Definitions and Concepts

For the purpose of this report it is necessary to provide conceptual definitions of the terms extensively used in the study to avoid confusion and to ensure clarity of their usage.

Migrants and Refugees

There is a long history of migration between Sudan and Egypt, which includes marked periods of mass migration as individuals fled the war in Sudan. Today, there is a large population of Sudanese in Egypt who migrated for a variety of reasons, though these are not necessarily mutually exclusive. For example, some individuals from the target population who took part in this study fled due to the unstable political situation in their place of origin but, at the same time, came to Egypt seeking better economic opportunities. The majority of Sudanese hosted in Egypt comes from the Centre and the North of Sudan.

Refugees are a particularly vulnerable group of aliens as they are deprived of the protection of their national state. It is this particular vulnerability that compels their protection under international law. A “refugee” is a person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR’s mandate, and/or in national legislation. A refugee is a person, who “owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (Geneva Convention relating to the Status of Refugees, Art. 1A (2), 1951 as modified by the 1967 Protocol). In Africa, the refugee definition has been broadened to encompass persons compelled to leave their country not only as a result of persecution, but also “owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality.” (Art. 1(2) Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa, 1969)

The term migrants, is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of ‘personal convenience’ and without intervention of an external, compelling factor. The term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and to improve the prospect for themselves or their family (Glossary on Migration, IOM, 2004). The United Nations offers a universal definition of an international migrant as “A person who moves to a country other than that of his or her usual residence for a period of at least a year (12 months), so that the country of destination effectively becomes his or her new country of usual residence.” (United Nations Economic and Social Council 1996, Demographic and Social Statistics: Demographic, Social and Migration Statistics, E/CN.3/1997/15/Add.1), regardless of the cause of migration. From that point of view, refugees are a particular sub-category of international migrants.

For ease of reference and for the purpose of the present report, the term migrant is used to encompass all individuals across this divide. In this report persons are defined as migrants by virtue of the fact that they move from their own country to another, regardless of the reasons. Simultaneously, when adopting this definition it should not be assumed that migrants are a homogeneous group or that the specificities of refugee status can be dismissed or denied to them. During the fieldwork it was noted that Sudanese, regardless of their migration status, may be facing similar circumstances as refugees. Therefore it should be acknowledged that the Sudanese community in Egypt is a diverse group with a diversity of needs that may differ according to gender, age or other factors. Finally, although migration in itself is neither individually nor collectively a risk factor to health, it still can result in vulnerability to physical and mental health problems, depending on the conditions the persons are exposed to (Migrant Health for the Benefit of All, IOM, Geneva, 2004).

It's important to point out that throughout the report, the term 'refugee' will be unavoidable as it was used by relevant stakeholders and in the literature reviewed.

Avian Influenza (AI) and Avian and Human Influenza (AHI)

This report will use the WHO definition of Avian Influenza (AI), or 'bird flu' as it is most commonly and popularly known, and of Avian and Human Influenza (AHI). Similarly in Arabic AI is known as *influenza a-tuyur*, which directly translated means 'bird flu'.

AI is defined as 'a contagious disease of animals caused by viruses that normally infect only birds and, less commonly, pigs. AI viruses are highly species-specific, but have, on rare occasions, crossed the species barrier to infect humans' (WHO, 2005c).

AHI refers to 'the risk avian influenza poses to humans when the virus transgresses the species barrier and causes severe illness.' If the virus transforms itself and changes into a form that can lead to human transmission, this may result in a pandemic on a large scale (WHO, 2005c).

Epidemic and Pandemic

The distinction between epidemic and pandemic in English is clarified by the United States Department of Health and Human Sciences and WHO. The former defines an epidemic as: 'a disease outbreak in which some or many people in a community or region become infected with the same disease' whereas pandemic is 'an epidemic that spreads throughout the world' (HSS, 2008). A pandemic therefore happens at a larger scale than an epidemic and the WHO further states that 'an influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulting in several, simultaneous epidemics worldwide with enormous numbers of deaths and illness' (WHO, 2005d).

According to WHO, due to the constantly changing nature of influenza viruses, including the H5N1 virus currently responsible for AHI, the time and severity of the next pandemic is difficult to predict. The final step – improved transmissibility among humans – can take place via a reassortment event, in which genetic material is exchanged between human and avian viruses during co-infection or via a more gradual process of adaptive mutation (WHO, 2005d).

The erroneous use and interchange of the terms was common among the research participants, as will be shown later in this report. Epidemic is translated into Arabic as *waba'* whereas pandemic has two translations: the first is *ga'eha* and the second is *waba' 'alamy* or *waba' motafashi*. The former is used by expert circles working on pandemic preparedness, however completely unknown and unfamiliar to the public, even among physicians and public health specialists working with refugee groups. The latter is more common and is employed by the Information and Decision Support Centre (IDSC), an agency that reports to the Cabinet of Ministers¹. For the purpose of this research and after testing both translations during the pilot phase, the team agreed to use the Arabic term *waba' 'alamy* to refer to a pandemic for Arabic-speaking interviewees. However, as in the Arabic language both terms share the same name, 'waba,' however, when referring to pandemic, the adjectives 'alamy' or 'motafachi' are added to the term. For instance, the pandemic of AHI is referred to as 'waba' al-Influenza al-'Alamy' whereas the Cholera epidemic is referred to as 'Waba' al-Cholera.' Due to their similarity, Arabic-speaking research participants may have confused the terms when asked about their knowledge on pandemic and questioned on the difference between the two.

Pandemic Preparedness Plans

Pandemic preparedness (PP) is the preparation of society and the strengthening of its capacity in view of a potential pandemic before the pandemic is declared. It includes the development of solid plans to ensure that both medical and non-medical sectors will be able to respond to a pandemic outbreak. The WHO, which is coordinating the surveillance of human cases of avian influenza and monitors the threat of an influenza pandemic, has put together both the WHO Pandemic Guidelines (2005c) and the International Health Regulations (2005b) which 'provide a global framework to address these needs through a collective approach to prevention, detection and timely response to any public health emergency of international concern'. With these guidelines as a framework, each country should develop its own pandemic preparedness plans.

Due to the high number of cases of AI and AHI in Egypt, the government has put together the Integrated National Plan for Avian and Human Influenza (2007). The main objectives of Egypt's plan are to:

- a) Control the outbreak of AI in birds;
- b) Prevent transmission of AI from birds to humans;
- c) Minimize risk and consequences of a pandemic.

The United Nations Office for the Coordination of Humanitarian Affairs and its Pandemic Influenza Contingency (UNOCHA/PIC) suggest that a pandemic readiness framework needs to highlight all sectors at all levels and the coordination between essential services (PIC-OCHA 2008). The framework suggests the following principles to ensure (1) a whole-of-society approach, (2) preparedness at all levels, (3) attention to critical interdependencies, (4) severity-based response and (5) transparency' (PIC – OCHA 2008, p. 1). It also highlights that pandemics do not only impact on the health sector but can have a bearing on areas such as 'water, food, energy, telecom, transport, finance, public order, defence' (p.1). Migrants are often excluded from national pandemic preparedness plans (NPPP) and therefore in the

¹ See for instance: <http://www.idsc.gov.eg/>

event of an influenza pandemic, migrants will be a particularly vulnerable group. The exclusion of migrants from pandemic preparedness plans increases the risks faced by this group and its host society.

The plan does not specify a complete set of actions but rather outlines a general approach which covers many different sectors and activities. It is expected that more specific actions will emerge through the management and development of ministry-specific pandemic preparedness plans.

An Egyptian national pandemic preparedness plan exists in Arabic and an English version. Interviews with relevant stakeholders have indicated that the plan at its current stage needs to be shared more widely with stakeholders. The Information and Decision Support Centre (a government agency which reports to the Cabinet) has been delegated by the Egyptian government to ensure the different ministries are preparing their plans. They have been trusted with overseeing government planning, ensuring that other ministries which had focused on avian flu are now working toward pandemic preparedness as well. For example, the Ministry of Agriculture was very involved in working on avian influenza and its containment but was not as active in the field of pandemic. Stakeholders generally acknowledge that the development of different responses for avian influenza and pandemic will take time.

It should be stressed that neither the integrated plan nor the national pandemic preparedness plan of Egypt has included migrants as a group that needs to be mainstreamed into the government's pandemic preparedness planning.

Background Information

Profile of Sudanese in Egypt

Sudanese represent the biggest foreign population in Egypt although their exact number is unknown and is continuously disputed. Sudanese refugees and asylum seekers were estimated by the World Refugee Survey at 23,700 in 2008 and in 2007 at 24,700 (USCRI 2007, 2008). The UNHCR has estimated that Sudanese refugees and asylum seekers number 23,498 (UNHCR 2008). However, the Sudanese population at large is often estimated at a much larger number, even though population censuses do not corroborate these estimates. Grabska (2005) states 'although it is difficult to estimate how many Sudanese live in Egypt, the numbers predominantly quoted by various sources range from 2.2 – 4 million, with only a very small portion of them having an official refugee status' (p.17). This is the estimate usually quoted by the Ministry of Foreign Affairs in Egypt as well. It must be noted that this is not based on any kind of factual counting within the population itself and has therefore to be taken more an imagined than as a real figure.

The Sudanese population in Egypt is comprised of different groups who migrated to Egypt for a variety of reasons throughout history. 1955 saw the start of the civil war in Sudan and a wave of emigration continued into the mid 1980s due to another outbreak of civil war in Southern Sudan in 1983 and the overthrow of the government in 1989 (Grabska 2005). Recently, another wave has resulted from the ongoing civil war in Darfur. Beyond this, a continuous inflow has been observed throughout the years as thousands of Sudanese nationals migrate to Egypt due to the political situation in Sudan.

Historically, Sudan and Egypt have a history of reciprocal migration policies, manifested in the 1976 Wadi El-Nil Agreement (Nile Valley) which granted Sudanese nationals in Egypt rights on par with Egyptian nationals, including the right to enter and exit the country without visa requirements and unrestricted access to education, employment, health-care and ownership of property (Azzam 2006). This agreement was revoked in 1995 after an assassination attempt on Hosni Mubarak blamed on Sudanese Islamist extremists in Ethiopia. The sudden change in the law caused a number of Sudanese migrants, previously residing lawfully in Egypt, to find themselves within a very short space of time in an irregular situation. Freedoms previously granted to them were progressively restricted. A recognised refugee in Egypt now has a more stable situation than his or her fellow Sudanese migrant in Egypt. Likewise the recognized refugee has easier access to public services and some humanitarian and religious-based services. Our study revealed that refugees and asylum seekers were more likely to report that they have access to health, psychosocial and legal services than migrants.²

However, in 2004, Egypt signed the *Four Freedoms Agreement* with Sudan. The bilateral Agreement 'promised a partial return to the Wadi El-Nil Agreement of 1976' (Azzam 2006 p.10) and supports reciprocal treatment and rights of each other's nationals regarding the (1) freedom of movement, (2) residence, (3) work and (4) ownership of property. However, it is not yet clear how this agreement will be

² See Appendix 2.

implemented and, accordingly, the Sudanese continue to experience the problems in Egypt which the agreement set out to solve, including those related to the freedom of residence and movement. Azzam (2006) notes that it is not yet clear how the agreement will impact on asylum seekers and refugees and states that ‘many worried that its effect on them would be negative’ (Azzam 2006 p.10).

With the absence of a national asylum system in Egypt (UNHCR 2008), UNHCR has been granted responsibility for the administration of the Refugee Status Determination (RSD) process and currently runs one of the world’s largest resettlement operations in Cairo. This has been a motivating factor for many asylum-seekers, including Sudanese, who come to Egypt in hope of resettling in the West. In reality only approximately a quarter have actually been resettled. Since the ceasefire between the government of Sudan and the Sudan People’s Liberation Army (SPLA) in 2004, the UNHCR stopped its Refugee Status Determination (RSD) procedures for all Sudanese asylum seekers regardless of their place of origin in Sudan. Though the peace agreement paved the way for return and reintegration, it undermined the claims for refugee status in Egypt and, therefore, all asylum seekers from Sudan were offered a yellow card which grants temporary protection against *refoulement*. The UNHCR decision was a difficult blow for Sudanese asylum seekers ‘as it put a heavy damper on their hopes for resettlement and relegated them to longer waiting periods under difficult conditions in Egypt’ (Azzam 2006, p. 10).

Access to Health Services

Egypt is a party to and therefore bound upon various treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966 and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) of 1990.

Of particular interest to this report is article 12 of the ICESCR. It states that the States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee that vigilantes the implementation of this treaty, whilst enumerating the specific legal obligations the state parties have, highlights that “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services (...)”.

Additionally, article 28 of the ICRMW recognizes the right to medical emergency treatment for all migrant workers and members of their families regardless of whether their stay or employment is irregular. Emergency health care represents, nevertheless, a minimum standard for those migrants in an irregular situation. Further, the Convention provides for the right to equal treatment regarding access to social and health services among regular migrant workers (article 43) and members of their family (article 45) and nationals.

Depending on their legal status, Sudanese migrants in Cairo have different options in terms of accessing health services. Public primary and preventative health-care can be accessed by all foreigners in Egypt after the Ministry of Health decree in 2005. Recognised refugees would pay domestic fees and could only access free services in

emergency circumstances (USCRI 2007).³ Outside the public health system, Sudanese irrespective of their residency status could access the health programmes at Refuge Egypt at All Saint’s Cathedral. Recognised refugees could access the UNHCR subsidised services at Caritas. In addition to these, there are other religious- and community-based services that may offer basic health care services in the neighbourhoods of Sudanese migrants. It is important to highlight that these services are frequently overstretched. According to our survey covering 293 households, 46.4% of households have regular access to a health care provider, 47.4% do not have regular access to health care and 6.1 % sometimes have access to health care (See Table 1 below). 61.7% claimed that they would seek health care in religious-based institutions such as Refuge Egypt.

Table 1: Access to Health Care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	136	46.4	46.4	46.4
2 no	139	47.4	47.4	93.9
3 sometimes	18	6.1	6.1	100.0
Total	293	100.0	100.0	

It is noteworthy that although Sudanese migrants may have access to the Egyptian public health system, various factors lead to discriminatory treatment that may discourage or prevent them from accessing medical services. However, this is not to say that exclusion of migrants from services has been deliberately institutionalized in the Egyptian health system. Rather, the quality of service can be influenced by the fact that the national health system is significantly overburdened and stretched in its capacities, making it difficult to treat the sizeable Sudanese community whilst struggling to meet the needs of the local population. Moreover other factors, such as communication across cultures and previous incidences of mistreatment, may deter Sudanese from accessing public health services.

³ The concept of what constitutes an emergency in a health-care situation is discussed further in the literature review where it is highlighted how complex the term emergency is when applied to the migrant context in Egypt.

Methodology

This research took a multidisciplinary participatory approach using quantitative and qualitative methods of data collection. With regard to the quantitative component, an English standardized questionnaire was administered to 293 Sudanese households, which included 1016 individuals. The survey was implemented in various neighbourhoods of Cairo with high concentration of Sudanese migrants such as Hadayek al-Maadi, al-Haganna, Arbaa' wa Nos, 'Ain Shams, 6th of October, al-Agouza as well as other parts of Cairo, Helwan and Giza governorates. The research started by gathering applications of Sudanese candidates to the STAR Program at AUC.⁴ Then, applications were clustered according to place of origin in Sudan, namely Southern Sudan, Darfur and the rest of Sudan. Individuals were randomly selected using systematic sampling from these lists. The selected households were contacted by the research team and interviews were carried out with the heads of households. In order to ensure validity and reliability of the survey questionnaire, a training of interviewers was conducted in order to avoid misunderstandings and/or misinterpretation of questions and/or concepts. Then, a test survey was carried out with a small sample of 30 households. Based on this test, the survey was edited according to the gaps identified and a pre-established coding scheme was assigned to closed questions. Then, a snowball referral technique was adopted to widen the sample of the study.⁵ After the completed questionnaires were received from the field, data was validated and the data sets cleaned and organised according to household and individuals.

As for the qualitative component, field visits, in-depth interviews and focus group discussions with the targeted population were conducted simultaneously with the quantitative part. Three field visits were undertaken to al-Haganna informal urban settlement, a very densely populated area with severe poverty. The purpose of these visits was to gain a first-hand understanding of the living situation there.

Five focus group discussions were conducted with different migrant groups prior to, during and after administering the survey. A total number of 46 individuals participated in the focus group discussions, with an average number of eight to ten participants in each discussion. Participants of the focus groups were recruited by distributing flyers in various locations where Sudanese migrants are concentrated such as schools, churches, neighbourhoods, community associations as well as through classes at the Cairo Community Interpreter Project (CCIP). This exercise enabled the research team to collect data on knowledge, attitudes and practices (KAP) of the target group with respect to pandemic preparedness, with particular emphasis on the relationships between migration, development and health as well as the effect of variables such as gender, area of residence, legal status and social class. Focus group discussions undertaken prior to the survey proved useful in designing the questionnaire. Moreover, focus group discussions conducted after the completion of

⁴ STAR, the Student Action for Refugees is a student-run program at CMRS of AUC. It was established in 2001 to raise awareness about refugee issues and offer students the opportunity to work with refugees in practical ways through volunteering and education (FMRS Report of Activities 2006-2007).

⁵ Snowball sampling is a “non-probability sampling procedure that involves using members of the group of interest to identify other members of the group” (Adler and Clark 2003:130).

the survey allowed for more in-depth discussion about patterns that emerged from the survey findings and increased understanding of community-level interaction with respect to access to health care and pandemic influenza.

Six in-depth interviews were carried out with representatives of three international organizations (the World Health Organization, Save the Children-USA, the Egyptian Red Crescent Society), two non-governmental organizations (AMERA and SUDIA), and one religious- and community-based service provider (Refuge Egypt based in All Saints Cathedral). Organizations and interviewees were selected in close consultation with IOM.

Interviews with the international organizations provided insight into their particular experience in working on health communication as well as an insight into their ongoing and future work on pandemic preparedness in Egypt and how they view the position of migrants in this work. The interviews with the NGOs and service providers offered a particular understanding of the Sudanese community because they are in direct contact with the target group and supplied information on how this population may be at risk and how they may react in case of pandemic.

Both focus group discussions and in-depth interviews gave an opportunity to recruit potential participants from the target group as well as representatives from the organizations interviewed for the training of trainers, which took place upon the completion of this study.

In order to ensure confidentiality, names of the survey and focus group participants were replaced by pseudonyms.

Research Team

Data for this report was collected for over a period of two months, starting from April 13 to June 13th, 2008, by the CMRS at the American University in Cairo and in close collaboration with IOM's Cairo office. The research team was headed by two principal investigators: Dr. Philippe Fargues, Director of the CMRS and Dr. Ray Jureidini, Associate Director. Yasmine Ahmed and Rebecca Dibb were hired to coordinate the research and to complete the final report. Zakareya Yehya, a research assistant/gatekeeper and member of the Sudanese population was recruited to assist the research team. Researchers Carolyn Bancroft, Nohieir Nashaat, and Gehan Shaheen also contributed to the project on a task basis. Nine certified interpreters from the CCIP, representing different ethnic/linguistic backgrounds, were hired to carry out the survey. The research team decided to select certified community interpreters to ensure that the survey questions and responses were translated correctly from English to the local language and vice versa. Below is the list of interviewers and their native local languages.

Name	Local Language spoken
1- Abdelrahman Sidig	Zaghawa
2- Abdelmageed al-Tahir	Sudanese Arabic Dialect
3- James Mayak	Dinka
4- Francis Pitia	Bari and Dinka
5- Agot Ayuel Deng	Dinka
6- Elizabeth Gwang Laa	Dinka

7- Atif Ismail	Sudanese Arabic dialect
8- Musa Eisa	Fur
9- El-Sadig Goma'a	Nubian

Interpreters participated in extensive trainings on interview and survey methods prior to their entry to the field. Moreover, weekly follow-up sessions took place to ensure the survey was carried out as intended.

Limitations of the Study

Several limitations were encountered during the field work and drafting of the report. Like other research projects, the geographical scope of this research is on Sudanese migrant population in Greater Cairo and thus, it is not representative of the Sudanese population in Egypt.

The over-representation of literate people in the survey may reflect the fact that STAR database was used and most people contact STAR for English language which means the person is likely to have some degree of literacy in the first place. In addition, as the initial list mainly consisted of refugees, the Sudanese population who perceive themselves as refugees rather than migrants were over-represented in the sample. This is a cluster effect due to the fact that the initial list mainly consisted of refugees.

Some of the survey questions, particularly those related to income, remittances and residency status, are sensitive questions. As many respondents might have been reluctant to discuss these issues, the answers were at times difficult to capture in one visit through few survey questions. Thus, it would have been interesting to supplement the survey with in-depth interviews with selected households on this issue. Moreover, field visits were conducted in one geographical area. It would have been beneficial to expand field visits to other areas.

The confusion of the pandemic and epidemic concepts in the Arabic translation made it difficult for the research team to fully capture the KAP of the research participants. As there is not a clear linguistic distinction between epidemic and the translation used for pandemic, it is hard to gauge the attitudes of the respondents and their awareness of the specific risk of a pandemic.

Finally, time constraints restricted the number of interviews conducted with organizations. It would have been beneficial to interview more organizations that work with Sudanese migrants at grassroots level.

Demographic Characteristics of the Sample

For the purpose of the study, the unit of analysis was the household.⁶ All households selected for the survey were located in urban areas, namely Cairo, Giza, 6th of October and Helwan Governorates. Interviews were conducted with heads of households, keeping in mind gender, age, place of residence, duration of stay and ethnic background as influential factors. The sample reflected a high concentration of Sudanese migrants in Ain Shams, 6th of October City, al-Hay al-Asher, as well as al-Barageel, Arba' wa Nos, al-Maadi and al-Agouza (detailed provided in Table 2).

Table 2: Geographical Distribution of Members of Households

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 6th of October	134	13.2	13.2	13.2
Abdeen, Down Town	12	1.2	1.2	14.4
Ain Shams	528	52.0	52.0	66.3
Al-Agouza	32	3.1	3.1	69.5
Al-Hay al-Asher	68	6.7	6.7	76.2
Al-Tagmo' al-Khamis	4	.4	.4	76.6
Arba wa Nos	29	2.9	2.9	79.4
Ard al-Lewa	1	.1	.1	79.5
Barageel	41	4.0	4.0	83.6
Bolak	17	1.7	1.7	85.2
Deir al-Malak	21	2.1	2.1	87.3
Dokki	4	.4	.4	87.7
Abbasseyia	5	.5	.5	88.2
Maadi	8	.8	.8	89.0
Mohandesin	3	.3	.3	89.3
Sheikh Zayed	2	.2	.2	89.5
Al-Sherouk	1	.1	.1	89.6
Faysal	4	.4	.4	90.0
Giza	1	.1	.1	90.1
Hadayek al-Maadi	34	3.3	3.3	93.4
Hadayek al-Qobba	14	1.4	1.4	94.8
Helmeyet al-Zaytoun	22	2.2	2.2	96.9
Helwan	1	.1	.1	97.0
Manial	1	.1	.1	97.1
Mansheyat al-Bakry	5	.5	.5	97.6
Matareya	8	.8	.8	98.4
Masr al-Gedida	3	.3	.3	98.7
Moqqatam	2	.2	.2	98.9
Nasr City	6	.6	.6	99.5
Thakanat al-Maadi	5	.5	.5	100.0
Total	1016	100.0	100.0	

As for the type of accommodation, the majority of respondents (76.8%) lived as one family in rented apartments with their nuclear family, whereas the remaining either lived in shared (also rented) apartments with other family members such as aunts,

⁶ We follow other researchers such as Grabska (2005) in conceptualizing the survival of individual migrants in the wider context of household.

uncles, nephews, nieces, etc (17.4 %) or with other Sudanese fellows and/or group of friends in collective accommodation (almost 8%). All apartments were rented by the participants. As for the relationship with the head of household, 31% were identified as heads of households, 14.5% s husbands or wives, 43% were either sons or daughters, 0.7% sons of husbands or daughters, 11% were grandsons or granddaughters, 2.9% were brothers or sisters, 3.1% other relatives, 3.2% other non-relatives, 0.3% were either mothers or fathers, 0.2% were either mothers in law or fathers in law (Table 3).

Table 3: Distribution of Household Members by Relationship to Heads of Households

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 head of household	315	31.0	31.0	31.0
2 husband or wife	147	14.5	14.5	45.5
3 son or daughter	437	43.0	43.0	88.5
4 child of husband or wife	7	.7	.7	89.2
5 grandson or grand daughter	11	1.1	1.1	90.3
6 mother or father	3	.3	.3	90.6
7 mother in law or father in law	2	.2	.2	90.7
8 brother or sister	29	2.9	2.9	93.6
10 other relatives	32	3.1	3.1	96.8
11 other non-relatives	33	3.2	3.2	100.0
Total	1016	100.0	100.0	

All household members were Sudanese and did not hold another citizenship, with the exception of two wives of heads of households: one Egyptian and one Moroccan. Household members represented a wide range of ethnic groups and came from different parts in Sudan, with 51.7% from Khartoum, 17.1% from Darfur, 10.4% from Central Sudan, and the rest from Nuba Mountains and Southern Sudan. Household members came from more than 50 tribes and ethnic groups. The largest ethnic group interviewed were Dinka (30.6%), followed by Fur, Falata, Massalit, and Nuba. The majority of household members were Muslims (94%), the remaining were either Christian (4.9%) or other (1.1%). As for the ethnic composition within the Sudanese households, the majority of respondents (almost 80.5%) include only one ethnic group whereas only 17.1% of the total percentage of survey respondents consists of two different ethnic groups and 0.7% of the total percentage of respondents lives in households with more than two ethnic groups. These findings reveal that the households of Sudanese migrants are characterized by homogeneity with regard to nationality; they hardly mix with Egyptians or other migrant population. Moreover, those who live in the same household are more likely to belong to the same ethnic group/tribe and thus enjoy intra-household homogeneity with regard to ethnicity.

As for the residency status in Egypt, the majority of respondents identified themselves as either refugees or asylum seekers (80%), with a small number of economic and labour migrants and students. This over-representation of refugees and asylum seekers in the sample is a cluster effect due to the fact that the original list from which households were selected was from STAR, a refugee-based service provider.

However, only 60 % of the household members were registered with the UNHCR. They left Sudan in different time periods, starting from 1986 till 2008. The peak years fell between 2002 and 2006. Almost 48% of the respondents reported that they were internally displaced in different parts of Sudan, mostly to Khartoum before fleeing across international borders.

The gender composition in the households was balanced, as 51.8% were males and 48.2% were females. This reflects a number of characteristics of the Sudanese migration to Egypt. First, it is an ancient movement and gender balance is partly the result of a population reproducing itself locally. As we stated earlier, for decades Sudanese migrants enjoyed freedom of movement and property rights in Egypt. Second, Sudanese males, like other economic migrants, are joined later on by their families. Third, Sudanese refugees, like most refugees, are moving across border with their families. Three quarters of the heads of household were male, one quarter female.

As for the age distribution of the respondents, almost 44.4% were between 0 and 18 years old, 41.7% between 19 and 39 years, 13.6% between 40 and 64 years and only three members (0.3%) were 65 years or older (Table 3).

Table 4: Age of Household Members

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 < 18 years	451	44.4	44.4	44.4
2 18-39 years	424	41.7	41.7	86.1
3 40 - 64 years	138	13.6	13.6	99.7
4 65 years and more	3	.3	.3	100.0
Total	1016	100.0	100.0	

Concerning the highest level of education attained, it was reported that respondents aged 15 years and above, 18.9 % of household members completed their university education, 36.6 % completed their secondary education, while the 33.1% completed their primary education. With regard to the heads of households only, the majority completed their secondary education (42.3%) whereas 24.2% completed their primary education and 21.8% completed their university education (table 4). Moreover, the gender of head of household did not affect the level of education attained.

Table 5: Highest Degree Obtained by Heads of Households

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Primary	71	24.2	27.4	27.4
2 Secondary	124	42.3	47.9	75.3
3 Universities	64	21.8	24.7	100.0
Total	259	88.4	100.0	
Missing System	34	11.6		
Total	293	100.0		

Most of the heads of households and their spouses reported that they were employed or seeking work. The majority were either self-employed or employed in the private sector. Domestic work, including cleaning, cooking and babysitting as well as other

low-skilled jobs in private companies, including positions as drivers and security guards, are a common occupation among the Sudanese population. Some of the participants reported that they were self-employed in the handicraft and hospitality fields.

As for the total household income generated from employment, the majority of respondents reported a total monthly income between 250 and 500 EGP (1 EGP = 0.18 USD), the remaining were divided into different income categories as indicated in Table 6 below. It should be noted that this figure excludes remittances, which are considered a main source of income for the sample selected. Remittances were sent mostly from siblings, children and non-relatives in Australia, Canada, Germany, Israel, Korea, Libya, Sudan, US, and the UK. Remittances were mostly sent through money transfer agents.

Table 6: Total Monthly Income of Household (L.E.)

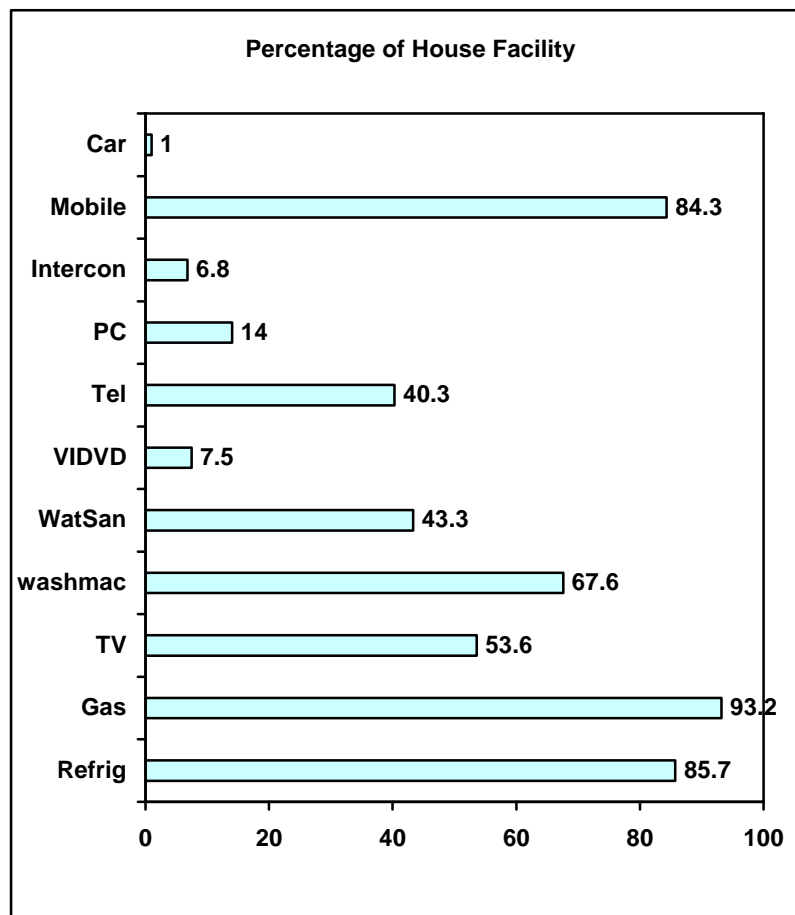
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 <250	29	2.9	2.9	2.9
2 250<500	733	72.1	72.1	75.0
3 500<1000	116	11.4	11.4	86.4
4 1000<2000	125	12.3	12.3	98.7
5 2000<4000	11	1.1	1.1	99.8
6 <4000	2	.2	.2	100.0
Total	1016	100.0	100.0	

With regards to school enrolment of Sudanese migrant children, it was reported that 41% of children under 16 of the households were enrolled in schools, with the majority in faith -based institutions such as al-Sakakini Church School. The survey showed a correlation between economic hardship and school non-attendance in that most of the household members at school age who did not attend school, were facing economic hardship. This was also supported in focus group discussions.

With regard to the items possessed by the household, it was reported, as shown in Table 6, that most households possess between 4 and 6 items (mean = 4.97). This means that most of them possess the necessary household appliances in Egypt. It should be noted that most of the basic house appliances were owned by the landlord and that the only devices owned by household members were usually mobile phones, personal computers, Internet connections and cars. As for the percentage of possession by household item, the survey demonstrated that most of the households have gas stoves (93%), refrigerators (85.7%), mobile phones (84.3%), followed by other items as indicated in Figure 1 below. The majority of households have access to housing, water, electricity, sanitation and food. On the other hand, a large number of households did not have access to education, health care, psychosocial care and legal assistance. Details are attached in Appendix 1.

Table 7: Index of Number of House Facilities' Possession

No. of house facility	Number	%
0 item	2	0.7
1 item	11	3.8
2 items	14	4.8
3 items	33	11.3
4 items	49	16.7
5 items	72	24.6
6 items	57	19.5
7 items	30	10.2
8 items	15	5.1
9 items	9	3.1
10 items	1	0.3
Total	293	100.0
Mean number of house facility	4.97	

Figure 1: Percentage of Possession of Household Facility

Literature Review

The literature review did not focus on medical aspects of pandemics or preparedness plans but rather on non-medical literature which dealt with the social and public health concerns related to a pandemic. Literature was sought from international organizations such as the United Nations (UN) and its specialized agency World Health Organization (WHO) created, within the terms of article 57 of the Charter of the UN, for the purpose of co-operation to promote and protect the health of all peoples. Academic sources and regional and national literature on the issue were also considered. Of the available literature on refugees in Cairo, much has been written about the Sudanese refugees (see Azzam 2006 and Grabska 2005, 2006). It was necessary to consult this literature to establish an understanding of their position in Egyptian society in terms of public services, in particular health, so that pandemic and pandemic preparedness plans / guidelines can be viewed within the context which is unique to their living situation in Cairo. However, it is important to note that most of (if not all of) the literature produced about Sudanese in Egypt was written about a purely refugee perspective and therefore represents only a small fraction of all mobility patterns experienced by the Sudanese community. Little work has been done to understand the experiences of the Sudanese population in Egypt as a whole. Moreover, literature focused on the Egyptian context has neither analyzed the rights of non-Egyptian nationals nor on the obligations of the state towards those who are not recognized refugees and do not fall within the refugee protection regime.

Health and Housing Situation of Sudanese Migrants in Greater Cairo

Migrants' access to public services in Egypt has been scrutinized in the literature available on refugees in Cairo, in particular their access to health services (see for example Eidenier 2006 and Grabska 2005, 2006).

The bilateral agreement of 2005, the Ministry of Health granted all foreigners in Egypt access to public primary and preventative health-care services. In spite of the stipulation that recognized refugees pay domestic fees only, it was noted that refugees thought they received better care at NGOs such as CARITAS than within public health services (Grabska 2006). It is frequently noted in the literature that there is a lot of mistrust of the public health services in Egypt among the Sudanese (Eidenier 2006 and Grabska 2005) and migrants and refugees. Statements are quoted about 'poor quality, disrespect and lack of proper attention to medical problems' (FMRS 2007 p. 14). The reviewed sources describe racism as part of everyday life in Cairo and deem racist attitudes are often perceived as institutionalized in areas such as healthcare and housing. Consequently Sudanese would assume they will not get the optimum service (Azzam 2006 and Grabska 2005, 2006). Eidenier (2006) argues that in many cases the often frustrated relationship between doctor and patient arises from communication problems and that 'though it seems that refugees are not experiencing positive relationships with their health providers, specific examples suggest that in some cases this has less to do with any sort of discriminatory intent on the part of the doctor, and far more to do with cultural differences in conceiving of proper treatment for specific ailments' (p 18). Grabska (2006) argues that when such mistrust occurs, it can be addressed by establishing mechanisms for mitigating mistrust between migrant

patients and their Egyptian health care providers. Mutual training and health care provision could, in fact, represent increased opportunities for cooperation.

Migrants (including rejected asylum-seekers) do not receive any subsidized medical treatment in Egypt and therefore usually visit local neighbourhood clinics or charities (such as Refuge Egypt at All Saints Cathedral) where the fee is very low and the refugee status is not of concern (Grabska 2005). As mentioned earlier in the report, the issue of the right of access to pro bono emergency healthcare is a contested concept that IOM discusses in its publication 'Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments' (2007). It states that what constitutes an emergency is not always straightforward and that there may be illnesses which are life threatening but fall outside the traditional understanding of what constitutes an emergency. Although a pandemic is an emergency issue, there has not been any work advocating the inclusion of migrants in pandemic preparedness plans as an obligation of host countries.

Moreover, housing is a key issue in the context of the containment of a pandemic. A pandemic will more easily spread in an overcrowded environment where hygiene is difficult to maintain. For most Sudanese in Cairo, housing presents a big problem and because most of them 'do not have a stable income, they are forced into overcrowded living quarters, which results in poor sanitation, minimal personal security, and a stressful home environment' (Azzam 2006 p. 15). Coupled with poor housing standards, Sudanese (especially those without residency status in Egypt) are vulnerable to unfair treatment, which can lead to random evictions and the lack of a permanent house address (Azzam 2006). This compounds destitution, creating additional risk factors in case of a pandemic outbreak.

The reviewed literature needs to be viewed within the international legal framework, as briefly analysed before in this report. Several international treaties outline the obligations of state parties vis-à-vis non-nationals in terms of healthcare and health services, adequate housing and other public services. The abovementioned ICESCR establishes that states shall respect, protect and fulfil the rights of all individuals – regardless of legal status – to the enjoyment of the highest attainable standard of physical and mental health and other economic, social and cultural rights. However, developing countries can derogate from some of the obligations; as established in Article 2(3) of the ICESCR, Egypt is allowed, 'with due regard to human rights and their national economy', to 'determine to what extent they would guarantee the *economic* rights recognized in the [ICESCR] to non-nationals'. This exception may be made only with respect to economic rights and not to social and cultural rights (OHCHR, 1966). However, Weissbrodt (2007) argues that such exceptions 'must be narrowly construed so as to maintain the overall thrust of the human rights protections' (p. 224).

While migrants in Egypt have some form of access to health care, albeit insufficient and from various sources, issues relating to emergency treatment remain complex and contested. Moreover, while primary health provision can be provided by a wide range of governmental and non-governmental actors, emergency care is provided by the public health system. The 'International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families' guarantees the right to necessary medical emergency treatment to all migrant workers and members of their

families, regardless of the regularity of their stay or employment. However, it is not always easy to define what constitutes an emergency as many life-threatening illnesses might not become manifest in an “emergency”. According to various definitions emergency care can be noted from a strict interpretation of urgent care (essential treatment, which cannot reasonably be delayed) to a more flexible one evolving “necessary care” on the basis of which doctors consider regular follow-ups and vaccinations also to be part of “urgent treatment” (IOM, 2007). Regardless of these distinctions, migrants and refugees should have access to preventive, curative and palliative health services beyond the emergency response lest they become a segment of society particularly vulnerable to epidemic and pandemic diseases.

Pandemic and Pandemic Preparedness: International Approaches

The WHO is considered internationally as the leading expert and advisory organisation regarding pandemic preparedness. The organisation has produced the ‘WHO global influenza preparedness plan’ (2005) which has been divided into five categories corresponding to the six phases of pandemic threat levels.⁷ The categories are: 1) planning and coordination; 2) situation monitoring and assessment; 3) prevention and containment; 4) health system response and 5) communications. The WHO emphasises that these are merely guidelines and that ‘the responsibility for management of the national risk of pandemic influenza rests primarily with the relevant national authorities’ (WHO 2005 p.1). The guidelines are essentially targeted at public health professionals but an executive summary was produced for senior policy makers and officials in other government sectors, who may not have a public health background.

The WHO has also produced specific work on migrants which can be found in their report (2008), which highlighted the need to have a public health approach to ‘avoid disparities in health status and access to health services between migrants and the host population’(p.2). Prior to this document, the WHO also produced a document which looked at the pandemic preparedness in refugee and displaced populations (WHO 2006) as a response to the gap in most national pandemic preparedness plans ‘which may not sufficiently take refugee and displaced populations into account’ (p.4).

IOM upholds the well-being of migrants and has been working in promoting pandemic preparedness among its beneficiary groups. IOM’s Avian and Human Influenza Pandemic Preparedness for Migrants projects are part of a broader strategy of spreading awareness of pandemic preparedness among migrants. At the time of this report, IOM is implementing or has implemented respective projects in Cambodia, Egypt, Indonesia, Kenya, Lao PDR, Nigeria, Thailand and Vietnam. Part of these projects, for example, is the production and dissemination of migrant friendly Information, Education and Communication (IEC) materials. The project activities likewise comprise focus group discussions, community outreaches, training workshops and advocacy for the inclusion of migrants in national pandemic preparedness plans (IOM 2008b).

⁷ WHO pandemic alert phases: 1) Low risk of human cases; 2) Higher risk of human cases; 3) No or very limited human-to-human transmission; 4) Evidence of increased human-to-human transmission; 5) Evidence of significant human-to-human transmission and 6) Efficient and sustained human-to-human transmission.

Pandemic and Pandemic Preparedness: Egyptian Approaches

Grabska (2006) refers to an interview with a representative from the Ministry of Health, where the interviewee had highlighted the need to view the health problems of migrants as a national concern because, not taken into account, they could contribute to the spread of epidemics. As it stands now, however, migrants do not feature in the national plan for Egypt (Ministry of Health and Population - MoHP, 2007).

Egypt has produced the 'Integrated National Plan for Avian and Human Influenza' (MoHP, 2007). It consists of two components, namely the animal health plan produced by the Ministry of Agriculture and Land Reclamation and the human health plan developed by the Ministry of Health and Population. The latter component includes a section on human pandemic preparedness. Being of very broad nature, the integrated plan clearly states that it is not sufficient to fully prepare Egypt for a pandemic, because it does not replace a detailed national plan and the individual plans of the ministries. The integrated plan states 'other plans are being or will have to be developed' (p.9) and that the integrated plan is 'comprehensive in terms of broad sectoral coverage and general activity categories but not in terms of defining the complete set of actions and corresponding resource requirements to manage Avian and Human Influenza' (p.5). The plan outlines four planning areas, namely animal health, human health, communications and inter-ministerial cooperation. In the section on the human pandemic influenza, the main objectives are to 'prevent the spread of pandemic; reduce morbidity and mortality due to the pandemic and minimise the consequences of the pandemic' (p.41) The integrated plan states that the Ministry of Health and Population, the Ministry of Interior and the Ministry of Local Development in conjunction with the Ministry of Defence have developed the human influenza preparedness plan for Egypt. Some of this plan's elements are presented in the integrated plan (MoHP, 2007). It also notes that each ministry has prepared its own individual plans. For this research, the integrated national plan is the only national document which was analysed. The plans of other ministries could not be accessed. The aforementioned National Pandemic Preparedness Plan is not publicly available as was noted in interviews with relevant stakeholders. At the time of drafting this report, the plan only existed in Arabic. An English translation is in progress, but was not available for this study. Interviews with relevant stakeholders revealed certain deficiencies regarding the transparency of the plan (though one stakeholder reported having been shown the plan and commented that the table of contents indicated sufficient consideration had been granted to communication and health facilities).

Communication Strategies for Pandemic Preparedness

Communication strategies for pandemic preparedness and Avian Influenza feature in international and national guidelines (see WHO 2005 and Integrated National Plan for Avian and Human Influenza – Egypt 2007). The WHO (2005) guidelines discuss communication in general, referring mainly to the inter-governmental level as well as to the activation of emergency communication plans and coordination of communication between stakeholders. The human pandemic influenza section of the Integrated National Plan for Egypt (2007) contains a specific paragraph on communication that emphasizes the need for effective health communication including 'risk communication during outbreaks' (p.44) It stresses the need to have the public well-informed with factual and up to date information combined with an

intensive information campaign among health professionals. It is likely that the NPPP will have a large communication component.

UNICEF in Egypt has been particularly active in the field of communication. They researched and developed communication strategies specifically tailored to the issue of Avian and Human Influenza in Egypt. They carried out a survey (El Zanaty & Associates 2007) about the awareness and knowledge of transmission of AHI among a target group considered vulnerable to the AHI. The group consisted of females aged 15 or above who have regular contact with poultry through rearing, buying or cooking. Based on the findings from this study, UNICEF cooperated with the MoHP, State Information Services (SIS), Communication for Healthy Living Project (USAID) and the NGO Terre Des Hommes in the development of a national AHI communication intervention plan. UNICEF's intervention had a strong community component both in terms of using mass media and community health workers for addressing the target group. Subsequently a result study was done to 'point out the changes in the knowledge and the practices of rural farmers that took place following implementation of the communication intervention and would thus compare results with the baseline diagnostic study' (El Rabbat 2007). The study highlighted that communication had been key to filling some of the essential and most crucial knowledge gaps, albeit others still continued. Based on these studies UNICEF (2007) compiled the 'Communication Strategy and Work for Avian Influenza July, 2007 – December 2008', which lays out the organisation's future plans regarding AHI communication.

Although UNICEF did not specifically target migrants in its study and focused on a rural and not on an urban context, their findings are useful to identify best practices in AHI communication that could fill existing knowledge gaps. UNICEF's findings correspond to the data collected for this study in that they underscore the importance of the community component to achieve behavioural change. The UNICEF (2007) communication strategy plan specifies approaches to choose in specific communities in order to attain behaviour change, for example through community mobilization (possibly involving the religious and political leaders of each community). It further states that community outreach programmes must be followed by refresher trainings to ensure sustainable results. Such strategies would also apply to the numerous community workers (*radiat rifiat*) of the MOHP. Despite the similarities in findings, there are limitations in comparability of the UNICEF initiative with the context of Sudanese migrants as the communication materials used were all in Arabic and only targeted Egyptians (in this case specifically women aged 15 or above) living in rural areas. IEC materials for Sudanese migrants would have to be adapted to their specific context. They need to account for the linguistic heterogeneity of this group as well as of their urban living conditions in Cairo.

Moreover, 'findings of research showed that media is the most important source of information for Avian flu as well as other health related issues'. (UNICEF 2007, p 7). The baseline survey of women aged 15 or above (El Zanaty and Associates 2007) also highlights the importance of TV as a media tool and states that 'television is the main media channel Egyptians are exposed to' (p.3). It is also one of the main sources from which the target group had heard about AI. Importantly, the communication strategy (UNICEF 2007) comes to the conclusion that other communication components would not have the same effectiveness without involvement of the media as a major

component. Yet, including the media as part of any communication strategy requires detailed planning to ensure that the message is correct and informative and that it is not delivered from a 'news perspective only' (p.7). Moreover, the post-intervention study (El Rabbat 2007) highlights the importance of consistency in the governmental communication and that 'alternating between intensified activities and reluctant ones makes people feel lax' (p.3). The study also noted that participants mostly gained knowledge from TV and from the work conducted by the *Raedat Rifiat*, and that most 'participants when asked about their preferable sources of information expressed their preference for the TV' (p.17).

Primary Research Findings

Egypt and Pandemic Preparedness: Stakeholders' Involvement

The Egyptian Red Crescent Society, World Health Organization and Save the Children, all of which were interviewed for this study, are or will be involved in pandemic preparedness work in Egypt. These organizations' expertise in different fields can be considered a crucial element in the development of Egypt's NPPP. Below, each organisation's contribution is summarised.

The Egyptian Red Crescent Society: The Red Crescent Society in Egypt is represented in both the Egyptian High Committee for Disaster Management and the High Committee for the Avian Influenza in Egypt.⁸ The RC in Egypt has previously worked on AI and is now getting involved in pandemic preparedness by initiating an 18-month project which entails collaboration with governmental authorities in the fields of (1) public health, (2) livelihood and (3) food security with the goal to strengthen communities' capabilities to mitigate the humanitarian consequences of a pandemic. This project specifically aims at (1) developing contingency plans, (2) building capacity of the organization itself and of the local stakeholders in the area of PP and communication and (3) creating coordination mechanisms between stakeholders. At the time of the interview (29 May 2008), this project had not officially started.

Save the Children US – Egypt: Save the Children were selected for collaboration with the Red Crescent Society because of their expertise in the field of health communication. Save the Children will join the 18-month project for one year will act as the NGO representative. Their contribution will focus on capacity building and providing support to the RC in their project activities. Findings will then be shared with other actors. They have previously worked closely with the MoHP particularly on their project 'Communication for Healthy Living'.

World Health Organization, Regional Office for the Eastern Mediterranean: The WHO provided advice on pandemic preparedness to all countries in the Eastern Mediterranean Region including Egypt. Their support focused on (1) preparation for an emergency, (2) surveillance, (3) containment strategies, (4) continuity of essential services in a crisis and (5) research and evaluation. In addition, they provided advice on implementation, testing and revision of national plans. The WHO stated that influenza pandemic planning requires specific planning to address actions that should be taken by countries as well as by WHO and other partners according to the Pandemic Phases.⁹ WHO guidelines are not legally binding but rather serve as evidence-based information on issues such as travel restrictions or school closure during an influenza pandemic. The guidelines also emphasize that each member state is to plan for a pandemic according to its specific requirements. The WHO in Egypt started working on pandemic preparedness in 2006. According to the WHO, Egypt's current AHI strategy was essentially developed for rural communities. Therefore there may be a risk in the urban context where a pandemic may spread faster due to a higher population density. WHO further stated that some actors in pandemic preparedness

⁸ These national committees are government led initiatives.

⁹ See section of report *Pandemic and Pandemic Preparedness: International Approaches*

and response like physicians and UN staff need more awareness about the influenza pandemic.

Refuge Egypt, AMERA and SUDIA were interviewed for the project although they had not been involved in any direct pandemic preparedness work with the Egyptian government. All three organisations have their main offices in Cairo. They were chosen for the stakeholder interview, because they have daily contact with the target population of the IOM project.

Refuge Egypt provides health awareness programmes related to HIV, prenatal care, family planning and tuberculosis as well as vocational training. Refuge Egypt staff had participated in two trainings on AHI preparedness conducted by the UNHCR.

The African Middle East Refugee Assistance (AMERA) provides legal assistance and psycho-social support to refugees.

Although SUDIA has meanwhile ceased their activities (vocational training and HIV awareness), their representative's input was of interest with respect to the assistance they had provided specifically to the Sudanese refugee community. In the interview, the SUDIA representative said that working on pandemic preparedness was not a priority for the moment until the virus appeared in the Sudanese and other communities for the first time. In the meantime, SUDIA staff had attended trainings and the organization would be able to start working on pandemic preparedness if asked to do so.

The Status of Migrants in the NPPP of Egypt

According to one stakeholder migrants are not explicitly included in the NPPP of Egypt. All other stakeholder confirmed that this is as a particular danger, because not including them in preparedness planning would maintain the deficiencies of their awareness about pandemic influenza. Inclusion of a migrant component in the NPPP, however, would ensure that future communication strategies would be extended to this population and thus improve their protection during a pandemic. The interviewees agreed that political support is also crucial with regard to pharmaceutical interventions and supplies for migrant communities. By adding an annex on migrant protection to the NPPP, migrants' specific needs would be factored in. This component would need to be included whenever the NPPP is being tested. The increased vulnerability of migrant communities must be considered as an important factor regarding the spread of a pandemic. If excluded from pandemic preparedness plans, migrant communities might even become the starting point of a pandemic. This risk should be a motivating factor for a policy change. However, as pointed out by stakeholders, any advocacy for the inclusion of migrants in pandemic preparedness planning needs to avoid singling them out and stigmatizing migrant groups. Due to the short incubation period it would be anyway impossible to identify the first group affected at the onset of the outbreak. Given the foreseeable limitations of medical care and the scarcity of supplies in a pandemic situation, one interviewee further argued that it must be expected that in public health structures treatment of country nationals would have priority over migrants and other foreigners. In a pandemic situation, this would become even a more serious issue.

It was further highlighted that the NPPP of Egypt has a good design mainly addressing public health facilities and professionals. Consequently, the question of how to factor in the Sudanese community remains. This likewise applies to other national authorities. A great deal of liaison and support activities to communities at the grassroots level is required in order to obtain a clear picture of their capacities and resilience. Stakeholder interviewees also stressed that CBOs act as gatekeepers in the provision of health services and that many of them recognize the importance of being integrated in the NPPP.

Possible Impact of a Pandemic on Migrants

One participant of the focus groups said in any pandemic asylum seekers with rejected claims would be at great risk because they would not have access to any public services. This applies to every Sudanese in Cairo who is not a recognised refugee, including migrants and other Sudanese nationals that do not hold residency status. The same participant said: "We depend on ourselves, and if you don't have money, you are going to die". Others claimed that it is common for Sudanese children to play in streets where they can come in close contact with poultry raised by their Egyptian neighbours.

As highlighted by stakeholders, migrants are a specifically vulnerable group in Egyptian society. Therefore it is important that they know the risks of a pandemic. In course of the research for this study it was found that the knowledge migrants have about pandemic or avian influenza is in general very low. However, it was also noted that the target group would face the same risks as their Egyptian neighbours in the same overcrowded areas who rear chickens and who most likely will face the same difficulties as the Sudanese in accessing public health facilities, food and transportation during a possible pandemic. Most interviewed stakeholders said that overcrowding is a particular risk factor for the target group. Anecdotic evidence revealed instances of up to eight people living in a two-room apartment and, in at least one case, five families living in a single flat situated in an overpopulated area with precarious hygiene levels. These accounts of extremely difficult living conditions were confirmed by the researchers who attended focus group discussions in some of these areas. Most of the survey participants reported, though, that they have access to both water and sanitation (See tables 8 and 9 below).

Table 8: Participants' Access to Water

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	282	96.2	96.2	96.2
2 no	10	3.4	3.4	99.7
3 sometimes	1	.3	.3	100.0
Total	293	100.0	100.0	

Table 9: Participants' Access to Sanitation

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	282	96.2	96.2	96.2
2 no	11	3.8	3.8	100.0
Total	293	100.0	100.0	

These factors, combined with an insufficient awareness of risks related to AHI and pandemic and the lack of appropriate information channels, make Sudanese migrants particularly vulnerable to an outbreak of pandemic influenza. Furthermore, two stakeholders stated that in general lacking confidence in the authorities and in particular the mistrust in information obtained from them is a problem which puts migrants at even greater risk. Consequently, Sudanese would often refrain from using public services and will be reluctant to follow information from the Egyptian government.

Recognising that migrant communities are not homogenous, one stakeholder particularly emphasised that the pandemic may have different impact on other migrants depending on their respective community. For example, one stakeholder believes Sudanese migrants are better off than other migrant groups in Egypt because of their Arabic language skills. These would enable them to understand newspapers and TV and, in general, to be better aware of actual developments in Cairo. Likewise, they would be able to understand information disseminated by the Egyptian government. While the present survey revealed that three quarters of the Sudanese respondents interviewed held a secondary school diploma or above, it is important to bear in mind that significant pockets of low literacy rates exist within the Sudanese Community. This fact needs to be taken into account when designing communication material. One stakeholder interviewee saw a problem in the Egyptian government's media approach. The communication strategy on AI and pandemic influenza does not take into account the needs and perceptions of less well-off Egyptians, including people with lower educational levels. As the literacy rate among migrants and hence their level of awareness tend to be similar to this group of Egyptians, migrants and Egyptians with a low educational level would most likely find the communication material inadequate to meet their needs and environment.

Further to differences between migrant communities, one interviewee said that due to language issues Eritrean and Ethiopian migrants, for example, had much more difficulties than the Sudanese in obtaining information about AI and pandemic influenza. On the other hand, they usually live in better areas than the Sudanese do and hence were not so much exposed to the risks caused by overcrowding or insufficient sanitation. In turn, the Somali migrant community usually lives in poorer areas comparable to those of the Sudanese. These particularities needed to be taken into account to improve pandemic preparedness plans.

Knowledge, Attitudes, Practices and Behaviour

Most of the participants in the research said that they knew what a pandemic is when translated as *waba* 'alamy, however, none of them knew what *ga'eha* means. While

97.6% of the total number of survey participants reported having heard of AI and AHI. Only 72% mentioned that they heard the English word pandemic or the Arabic translation '*waba*' '*alamy*' before. Out of this percentage 61.8% claimed that they know something about it. However, when asked to give examples of a pandemic, they often referred to HIV/AIDS, malaria, cholera and ebola, which are not classified as pandemics. Only very few participants identified SARS (Severe Acute Respiratory Syndrome) and non-seasonal human influenza as pandemics. When asked to characterize a pandemic, respondents stated the following: (1) a contagious disease that affects both humans and animals; (2) it emerges suddenly; (3) it leads to death and (4) it can neither be prevented by vaccinations nor be cured with aspirins or antibiotics. They also mentioned that a pandemic is a disease which spreads widely and kills many people at the same time, and that it could be transmitted from an animal to a human through air. Human to human transmission was only mentioned once. The fact that a pandemic has a global impact as opposed to the regional one of an epidemic was known to respondents in one focus group discussion only.

Participants of all groups claimed that humans in close contact with poultry could be infected with the avian influenza virus. However, many deemed an AHI infection unlikely, especially at the beginning of the focus group sessions, before the participants received further information about AHI from the facilitator. Participants of one focus group, believed that they are not exposed to the risk of an AHI infection because they do not rear poultry. Similarly, despite the fact that almost 63.5% of the survey respondents live in neighbourhoods where breeding of poultry is common, only a small percentage (29.7%) thought that their household members might be at risk of an infection. With media coverage on AI dwindling and daily witnessing that local traditional poultry sellers do not take any protective measures, focus group participants found it hard to imagine that the AI virus is still present in Egypt. However, when the research team and the focus groups further discussed the purpose of the research and the ways the virus can be transmitted from birds to humans, almost all participants mentioned that they are exposed to poultry and birds in the open market, the streets and sometimes even the buildings they live in. Participants said they were often exposed to slaughtered chickens in locations like (1) the traditional poultry sellers on open markets, (2) in their buildings when neighbours who raise poultry slaughtered chickens and (3) in the street when cats take the leftovers of slaughtered chickens and carry them around. Field visits confirmed these statements. The survey also revealed that residents in certain areas more likely than in others are aware that their household members may be at risk of AHI. Table 8 shows that Cairo residents were more likely aware that their household members might be at risk than residents of other governorates of Greater Cairo.¹⁰

¹⁰ Pearson Chi-Square Sig. = 0.00.

Table 10: Household members at risk by Governorate in Greater Cairo

			MEMBRISK Members Most at Risk of AHI		Total
			1 yes	2 no	
RESGROUP residential in group	1 Cairo	Count	39	152	191
		% within MEMBRISK Members Most at Risk of AHI	44.8%	73.8%	65.2%
	2 Giza	Count	4	26	30
		% within MEMBRISK Members Most at Risk of AHI	4.6%	12.6%	10.2%
	3 6th October	Count	36	14	50
		% within MEMBRISK Members Most at Risk of AHI	41.4%	6.8%	17.1%
	4 Helwan	Count	8	14	22
		% within MEMBRISK Members Most at Risk of AHI	9.2%	6.8%	7.5%
Total		Count	87	206	293
		% within MEMBRISK Members Most at Risk of AHI	100.0%	100.0%	100.0%

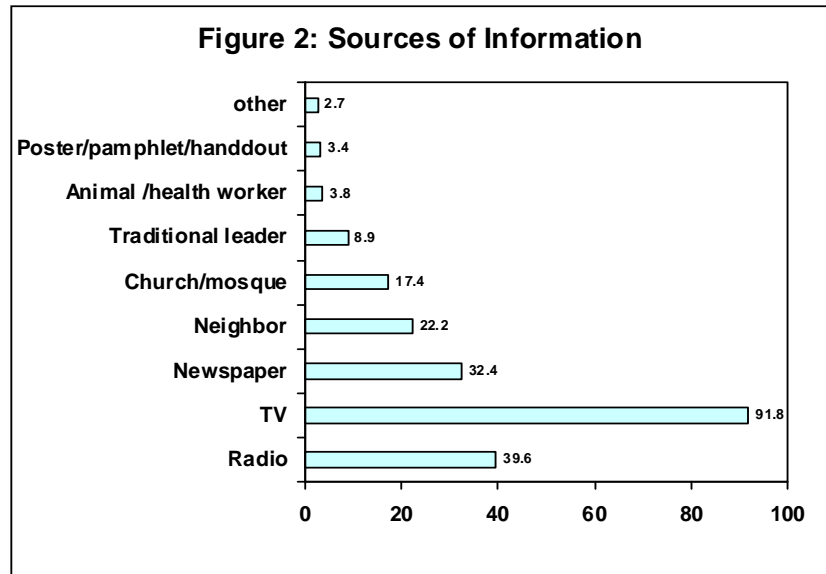
When survey respondents were asked to rank the communicable diseases that threaten their household members most, HIV was mentioned in the first place (49.5%), followed by Hepatitis C (22.9%), AHI (17.4%) and other diseases (9.2%).

Focus group participants characterized the symptoms of AHI as high fever, reduced immunity and fatigue as well as intense symptoms of seasonal influenza such as a running nose, sneezing and coughing. Similarly, a considerable number of survey respondents claimed to know how people get affected with AHI. In terms of symptoms identified by survey respondents, 22.9% mentioned dizziness, 35.5% high fever, 33.4% running nose and 4.1% mentioned other symptoms. With consideration to the identification of poultry suffering AI, focus group participants and 32% of the total number of survey respondents mentioned that birds affected with AI would look sick and have wounds under the wings.

Focus group participants acquired knowledge of AHI from a variety of sources. Most of the male participants mentioned the following as their main sources of information on AHI: TV, in particular the al-Jazeera satellite channel, newspapers, meetings with neighbours in coffee shops and the Internet. Also, noticing sudden closure of poultry stores in their neighbourhoods was mentioned. In addition to these sources, women added the exchange of information with neighbours whom they visit regularly. Focus group participants said they had not heard of any AI cases in their neighbourhoods.

Figure 2 shows the sources through which survey respondents obtained information on AHI.

According to stakeholder interviewees who have direct contact with them, Sudanese migrants do not tend to rear chickens but still may live next to Egyptian families who do so. They also might be exposed to the risk of an AHI infection when buying live chickens in their neighbourhoods. Moreover, they may be at risk due to dead chickens lying in the streets, as it happens in poor areas without or with



insufficient garbage collection. It was further highlighted that Sudanese migrants may visit Egyptian families who rear chickens. These observations were confirmed by respondents in the survey, as all focus groups' participants and 63.5% of survey respondents reported that they live in neighbourhoods where breeding of poultry is common among their Egyptian neighbours. The research team's field visits confirmed these statements. All research participants, survey and focus group respondents, claimed that they do not rear poultry at home. 75.4% of the survey respondents claimed, however, that they still eat poultry and poultry products despite the potential threat, because in Egypt chicken is cheaper than other types of meat. 42% of the survey respondents believed that eating poultry and poultry products is safe in general. 70.6 % of the survey respondents claimed they did not hear about cases of avian influenza in their neighbourhoods, 25.9% claimed they don't know whether or not there were cases in their neighbourhood, and 3.4% said they have heard about cases in their vicinity. Only 16.4% claimed they heard about suspected human cases in their neighbourhoods, although, some participants added, this was a 'rumour'. When survey respondents were asked about what should be done when sick poultry is suspected, 37.2% responded they would inform a veterinary officer, 34.1% would burn or bury poultry that died from avian influenza, and 26.3% would not know what to do.

The majority of the survey respondents claimed they would not know where to report suspect human cases of AHI. 23.5% mentioned that they would report to the health unit in the neighbourhood that are affiliated with organizations such as Caritas and Refuge Egypt whereas 26% claimed that they would report to government officials. Gender proved to have a slightly significant (Significance of Pearson Chi-Square=0.05) effect on respondents' reporting practices. Most of the female heads of households mentioned that they would report to the health unit in their neighbourhoods, whereas males were divided between reporting to governmental officials (37.5%), health unit (55.3%) and other.

As for the consumption of protein staples over the last month, 61.1% of all respondents said that they mostly consumed vegetarian food, whereas 13.7 % claimed that they mostly relied on meat as a source of protein over the last month. Focus group

participants added that meat is expensive in Egypt and that they cannot afford to buy it regularly. These results confirm findings of Ainsworth (2007) and Refuge Egypt suggesting that Sudanese actually do not like chicken or egg and would not eat them spontaneously were they not cheaper than other protein sources.

As for the habit of stocking non-perishable food, 32.4% of the respondents said they mainly stock small quantities of beans, sugar and tea. The remaining 67.6% did not stock food reserves mainly due to their low income that hardly covers basic needs. Since during a pandemic, commodities most likely become scarce, training on pandemic preparedness needs to include an instruction on how to secure staple foods during a pandemic or other crises.

Asked for the places where they buy poultry, 57.7% of the survey respondents replied they buy it in open markets (*souks*), 13.3% in supermarkets, 12.6% in traditional poultry stores, 8.2 % in restaurants. 3.1 % have no preferences and buy from all the above and 5.1 % buy from other places. During the focus group discussions, men and women reported that they are equally responsible for buying poultry for their households, depending on their work schedules. In three out of five focus groups, participants mentioned that they do not wash their hands directly after touching slaughtered poultry, specifically at poultry stores and *souks*. On the contrary, 75.4% survey respondents wash their hands before and after touching slaughtered poultry; 13.7% do not wash their hands; 10.9% do it occasionally. 77.1% of the survey respondents claimed that they wash eggs before eating them, 6.5% reported that they do so sometimes and 16.4% mentioned that they do not. However, two of the focus groups conducted with women revealed that they do so in order to clean the eggs from the dust and microbes, in other words, not necessarily to protect household members from AHI.

As for the means of protection, focus group participants said that they protect themselves by avoiding crowded places, having chickens slaughtered in front of them, never buying chickens that look sick and by avoiding walking in areas where poultry is raised. Female focus group participants added that they wash poultry with vinegar and lemon, boil chickens at more than 70 degrees before eating them, and that their traditional cooking style (overcooking chicken) prevents the disease from spreading. Eating chickens only that had been purchased from an accredited supermarket is another means of protection, yet, only for those who can afford them.

Concerning protective clothing, almost all focus group participants claimed that they do not wear protective clothing or footwear while handling poultry and poultry by-products. Similarly, 86 % of the survey respondents stated that they do so neither. The majority do not wear protective cloth because they do not have such equipment (72.7%), or because they did not know about the necessity of protection in general (8.2%), or because they are not aware that they should wear protective clothing or footwear (2%). The rest believed that they need no protective measures because they do not have direct contact with slaughtered poultry. As they do not rear poultry, they do not see themselves at risk

Gender and the Risk of Pandemic

The data collected from the survey participants were analyzed to find out whether gender has a significant effect in terms of pandemic preparedness. One stakeholder mentioned how gender relations change in the context of human mobility in that women find it easier to access work, particularly domestic work and cleaning services. This was confirmed by the survey according to which 25% of household heads were female. Therefore women would not necessarily be at more risk than male family members who often buy the chicken and do the cooking. A NGO interview found that given the fact that in the Sudanese community women still play a more important role in household and kitchen work, their risk exposure is proportionally higher than the men's. This notion was confirmed by focus group participants. The quantitative analysis, however, revealed no significant differences between male and female heads of households regarding their KAPB vis-à-vis AHI.

Access to Public Services and Training: Health-Seeking Behaviour and Perceptions of Health

Many migrants have access to English language courses and computer trainings organized by STAR and local associations known as *rabitah*, e.g. the Association of Nuba Mountains. Many women said they had attended health trainings on HIV, first aid and child care in Sudan. While none of the respondents attended previous trainings on pandemic preparedness, the majority (66.6%) claimed that they are willing to participate in relevant trainings.

The plight of Sudanese in the Egyptian health system was highlighted by the three organizations which have direct contact with the Sudanese population in Cairo. According to one organisation, recognised refugees are provided with good services through UNHCR-subsidised programs run by Caritas, for instance, albeit the latter is restrictive in that they only work with their own list of doctors and hospitals. The reason is that the organisation reimburses clients and therefore needs to work with trust-worthy doctors and hospitals. Due to resource constraints, the number of patients that Caritas or Refuge Egypt can handle is limited and consequently gaining access to their services can be extremely time-consuming. Therefore focus group participants expressed concerns that these services may fail in a pandemic.

Determining the exact position of Sudanese in the Egyptian health system can be difficult due to several issues related to their legal status. Therefore it is not surprising that 61.1% reported that they do not have access to public hospitals. This finding was further supported by focus group participants who claimed that they have limited or no access to public services. Although migrants could be admitted to public hospitals, many would be reluctant to make use of their services because they perceive the treatment there as discriminatory and find standards in Egyptian public hospitals very low, especially when compared to NGO clinics. As a result, many Sudanese will not go to public hospitals except in the case of an emergency. A stakeholder interviewee suggested they should be encouraged to use the services of MoHP clinics and report any discrimination to the authorities. It was recognized, though, that established perceptions and mistrust will make it very unlikely that the Sudanese would do so, at least in the immediate future. The same interviewee further claimed that there had been instances where HIV positive Sudanese patients who presented themselves to an Egyptian hospital were refused by staff. Therefore migrants and refugees with HIV-AIDS are advised to go to public hospitals in company of UN staff only. Although

HIV-AIDS has a far more stigmatising effect than influenza does, this demonstrates the challenges some migrants experience with the health system in Egypt. As most Sudanese due to a lack of awareness would not consider flu-like symptoms an emergency, they would not go to a public hospital.

According to the organizations interviewed, migrants and specifically Sudanese migrants take their health seriously despite the difficulties they have in accessing health services. As stressed in one of the interviews, previous health awareness training confirmed that migrants are eager to learn to change their behaviours once awareness has been established. Sudanese mothers would probably take health issues more seriously as they tend to be the breadwinners and responsible for bringing up the children. Furthermore, they are the ones most aware of their children's health needs.

The findings suggest that increasing the level of knowledge can prove vital in the event of a pandemic.

Anticipated Actions of Sudanese Migrants during a Potential Pandemic Outbreak

In two focus groups, participants mentioned that in case of a pandemic they do not have a specific place they would go to in order to seek assistance. Some participants reported that they would go to service providers they trust such as All Saints Cathedral (Refuge Egypt), Caritas, Saint Andrews, Sakakini Church, Sanabel hospital. A small number would stay in their houses or go to friends in neighbourhoods where the impact of the pandemic is the lowest. They also claimed they would substitute chicken with other meat or vegetables, consult health providers, take a vaccination, if available, and contact local health authorities. Similarly, 77.1% of survey respondents reported that they would seek advice and medical assistance from their health providers, 14.3% would go to church/mosque/NGO, 4.1% would consult local leaders, 2.4% would go to Egyptian authorities and 2% would seek for help at other places such as neighbours and trustworthy personalities in their neighbourhoods. In all focus group discussions, participants said they would not consult a physician in case they were to suffer from flu-like symptoms unless they knew that AHI was widespread in Egypt. Furthermore FGD facilitators observed that even after they had explained the term pandemic and its potential impact on society, participants often referred to AHI pandemic as an ordinary health problem only. It was often difficult for the researcher to shift this focus and widen the understanding of the pandemic concept beyond its mere medical aspects so that it would encompass non-medical aspects such as access to food, work and legal services. According to many respondents during a potential pandemic, services provision should prioritise health interventions such as health advice, vaccinations and immediate medical treatment. As second priority health awareness campaigns and trainings on how to best cope with a pandemic situation were mentioned. When asked specifically about whether or not they would consult community leaders in the event of a pandemic, 39.2% reported they would do so. However, only a small number of respondents agreed to give the research team contact information of their community leaders.

One of the stakeholders interviewees stated in reply to the same question that in crises, Sudanese often seek assistance from the UNHCR and would possibly do so in the event of a pandemic. However, due to the limitations set by their mandate, the UNHCR would not be in the position to provide them with the full range of assistance

needed in such a scenario. An effort of awareness raising among Sudanese may be able to remove the misconception that the UNHCR should act as the sole actor responsible during a pandemic. In any case, it would be imperative to address this problem in a communication strategy. It is noteworthy, though, that the view that UNHCR is the main reference place for refugees and migrants during a pandemic was not shared by the focus group or the survey participants.

Communication Strategies for Reaching the Sudanese Migrant Community

Focus group participants deem that the following communication means will be the most effective in their communities. An international organisation interviewed stated that although a pandemic could not be prevented and evolve at any time, at least its consequences could be mitigated, if appropriate communication strategies were in place on time. Awareness on pandemic could be achieved through:

- Egyptian National TV, Sudanese TV and satellite channels such as the widely-watched al-Jazeera;
- Radio;
- Simple illustrative posters and leaflets offered at service providers such as Caritas, Refuge Egypt, Star, etc. However, it should be noted that due to the diversity of local languages/dialects, it is more advisable to minimize the use of written text and prefer illustrations.
- Also t-shirts, caps, and similar items could be used as message carriers. This could best match the needs of beneficiaries with a low literacy level.
- Awareness lectures in the locations of service providers and *Rawabet* (Sudanese local associations);
- Pandemic hotline for Egyptians, Sudanese and other migrant populations. This could be used for reporting cases and/or inquire about specific issues;
- SMS messages on health issues sent via mobile phones.

Behavioural change could be realized through:

- Plays and documentaries that could be set up in different areas as the migrants are very mobile;
- Home visits (for instance, by female health promoters) for women, who are often busy with household tasks (common in different parts of Sudan);

The communication means suggested by focus group respondents match those reported by survey respondents as most common among the Sudanese migrants population in Egypt. In assessing the importance of communication means, 66.4% of these respondents put mobile phones at the top, followed by informal meetings and conversations at home (45.4%), landline phones (33.1%), communications issued through church and mosque (23.9%) and other means (20.5%).¹¹

It was suggested that trainings should be held either in neighbourhoods where Sudanese reside or on the premises of service providers. According to some respondents, granting formally accredited certificates to participants after the training may motivate them to attend it as well as to be further involved in the community work on this issue. This was confirmed in the interview with an NGO representative, who stated that migrants would appreciate to get certificates for courses or events they

¹¹ Participants often selected more than one means as highly important.

partake in as a way of building up certified skills and knowledge that could also assist them when they return to Sudan or resettle elsewhere.

With respect to their experience with the target group, communication was the main topic in the interviews with organizations and stakeholders. When discussing communication strategies, it became very apparent that before developing communication material, messages require a thorough assessment of their suitability for the targeted communities. Interviewees found that communication strategies must reflect the dynamics of the target community. Therefore strategies require periodical re-evaluation as their effectiveness on different communities in terms of behavioural changes might change. Furthermore, it would be important to include migrants' needs in the concept of any national communication plan. One basic need is to identify the key messages and the media to use for their dissemination. Existing community structures, TV, radio, leaflets and pamphlets were mentioned as potential communication channels to disseminate a ready-for-use communication strategy that would complement the triggers WHO has established for a pandemic.

One NGO recommended inclusion of water, sanitation and food as topics to any communication strategy for pandemic preparedness. In this context, the organisation suggested to intensify efforts on improving awareness of avian and human influenza among the target group without triggering unnecessary panic.

Media

Media can have an ambiguous effect in the context of pandemic preparedness. Stakeholder mentioned the need to balance awareness raising efforts with spreading panic. A balance could be achieved by moderating attention from rumours to facts, and providing simple, transparent and sound information on the risks of a pandemic. Interviewees also stressed the importance of communicating with the target group in a timely and accurate fashion. In this context they mentioned a tendency of policy makers to conceal information at the onset of emergency situations. Due to inevitable leakages, fragmentary information would reach the public, resulting in wide-spread panic and undermined credibility of authorities.

According to some interviewees, inconsistency and unsteadiness in media coverage pose another problem for the development of communication strategies. A UN official said that awareness of avian and human influenza would come in waves depending on media communication. Broadcasting on national television is costly in Egypt. As a consequence broadcastings on AHI occurred sporadically only which has led to increased awareness during communication campaigns and, in turn, decreases after the campaigns had finished. Interviewees concluded that stakeholders need to work with the media to ensure a continuous communication flow on avian and human influenza while ensuring that messages published are unified and not contradictory. To attain this goal, partnerships between a wide set of stakeholders was considered to be crucial.

According to several local NGOs, media and especially television play an important role in the lives of Sudanese who frequently watch TV in either their homes or in public places. Survey results and interviews with stakeholders confirm that among Sudanese migrants ownership of a TV set and a mobile phone is common even in

poorer areas of Greater Cairo. As shown in Figure 1 above, 53.6% of the survey respondents own a TV and 84.3% have mobile phones.

Although a large number of survey participants had various types of formal education, some stakeholder interviewees highlighted that illiteracy is still a problem in migrant communities. It is imperative that the design of communication material takes this into account. Audio-visual material such as short documentaries could be developed. The message they carry has to be differentiated and avoid any kind of stigmatisation. Reportedly, Public Service Announcements (PSA) had a good impact on educated urban people because their response strategy (culling of poultry raised in homes) did not represent a threat to their livelihood. For migrants living in a rural environment, this might be entirely different. One international NGO stated that large media campaigns should be complimented by communication at the community level and mentioned the cooperation between UNICEF and MoHP in the oral re-hydration media campaign for children, which was very successful due to the combination with a community-level approach.

Information Education and Communication Materials

As highlighted in interviews, media can be a powerful communication tool. IEC materials represent another effective tool in communication strategies. Leaflets, pamphlets and information sheets were explicitly mentioned. Stakeholder interviewees claimed that in previous projects leaflets with essential information presented in bullet-points had proven to be very effective. Simple, straightforward design would ensure the target group's comprehension of the core messages. It was argued, however, that awareness raising could best be achieved by direct contact in enlightenment sessions, for instance, rather than by distributing brochures and pamphlets that might fail to attract sufficient attention of the target group. Some interviewees stressed that although IEC resources are cost-effective, appropriate adaptation would still be needed. It was also suggested to provide participants with IEC material as an incentive or motivator to participate in information events. Items related to health care were mentioned, such as soap and tooth brushes.

Using Community Structures

In the stakeholder interviews, it was highlighted that engaging with the community in a 'hands-on approach' is the best way to deliver health messages. In order to optimize the effectiveness when using existing community structures, they would need to be assessed as to their relevance for the community and their strong and weak points.. Integrating a community component in communication strategies was particularly stressed by two local NGOs directly in contact with migrant populations. As the Sudanese community in Cairo is organized hierarchically according to tribal and community structures brought from Sudan to Egypt, a top-down approach can be useful in mobilizing communities. Using CBOs was considered key for effective dissemination of information to communities because they can call for meetings with community leaders. It was further argued that community leaders, in turn, would pass on crucial messages to their community. Schools in general with their multiplier effect were considered as optimal places for disseminating IEC materials.

While using community leaders in communication strategies has been recognised as an important method, they should not be automatically considered as the best communicators. In certain cases, community health workers might be the better

choice. Training of peer professionals and ‘training of trainers’ (TOT) can also be a suitable option for communicating the necessity of preparedness to the community. Training events could also contribute to reaching the community during a pandemic. As already mentioned, home visits can prove to be a useful way to reach people in the community, despite the logistic difficulties associated with this approach. However, it is important to bear in mind that movement might be restricted during a pandemic and basic structures such as schools and even primary health clinics might be closed or difficult to access.

Before carrying out any training, it is important to ensure that the targeted communities are equipped with the necessary resources (material and financial means) and that trainees have at least a basic understanding of the training goals. For example, one NGO remarked that usually psycho-social approaches to training are ignored and that very few agencies believe in the relevance of a psycho-social approach. The issue of sustainability of training results was also raised, stressing the importance of continuous training to allow for a high turnover in trainers because trainees may resettle to another country or return to Sudan at any time. An approach that aims to create “off the shelf” skills ready to be deployed in case of a pandemic can be very effective in building up preparedness capacity in migrant communities.

Communication Strategies among Stakeholders

Communication is a keystone to pandemic preparedness not only in terms of people at large but also among stakeholders. A robust communication network must be established to ensure the continuity of essential functions and an effective and coordinated approach. In this context, surveillance systems and standard operating procedures (SOPs) were mentioned.

Monitoring and Evaluation: Ensuring Behavioural Change

One of the purposes of communication strategies is to achieve behaviour changes that improve the pandemic preparedness. Typical behaviour changes could be hand-washing and other general personal and food hygiene measures. Any communication strategy should involve indicators for a pre- and post-evaluation of Knowledge, Attitude, Practice and Behaviour in order to measure the impact of the training.

Immediate Communication Strategies during a Pandemic

One UN stakeholder said that creating a hotline had proven useful during previous AHI outbreaks. In the event of a pandemic, a hotline will be crucial for coping with the mobility restrictions that most probably would be imposed. Moreover a hotline is a cost-effective way to ensure that people have access to accurate information.

Avoiding Stigmatization in Communication Strategies

Stakeholders were asked whether communication strategies should be specifically designed for Sudanese migrants. The majority of the interviewees said that this would lead to further marginalization within the Egyptian society, especially, if there were separate Public Service Announcements. One international stakeholder said, however, that communication also needs to address the specific target group directly. This could be done through home visits, which would avoid stigmatisation.

Conclusion

This study looked at the level of awareness and vulnerability of Sudanese migrants to a possible Avian Influenza Pandemic outbreak in Greater Cairo. The study aimed to identify the best ways to prepare this population for a pandemic with a special emphasis on communication issues and health and non-health services required.

Communication is the key to prepare a community for a pandemic and through a standardised survey, focus group discussions and stakeholder semi-structured in-depth interviews this study examined what would be the best communication channels to increasing the awareness of pandemic preparedness among Sudanese migrants. Findings revealed that Sudanese migrants would be vulnerable to a pandemic, not only because they do not feature in the NPPP of Egypt but also because they do not have sufficient level of awareness of pandemic and they are rarely mainstreamed into the work of civil society and international organizations involved in pandemic preparedness work. Moreover, migrant- and refugee-based organisations are prioritising other health concerns which, for the time being, are more urgent, such as providing access to basic health care and conducting awareness sessions on pressing health issues such as Hepatitis C and HIV-Aids.

A common pattern that emerged during the fieldwork is wide-spread confusion and misinformation as to what a pandemic is. This problem partially arises from the lack of an accessible translation for pandemic that could be understood by multiple publics. The available translations of pandemic are either understood only in expert circles (*ga'eha*) or not linguistically separated from the Arabic translation of epidemic (*waba' alamy or motafashi*). This will increase the risk factor of individuals as they do not understand the speed and the ease at which a pandemic may spread as well as its consequences in non-health areas such as for example access to work, nutrition and transportation. In fact, when participants were asked about services they think should be made available during a pandemic, they mainly mentioned health-related services such as medications; vaccinations and health advice, which shows a clear underestimation of non-health precautions such as food security and awareness.

This study can conclude that intensified awareness raising efforts need to be conducted among Sudanese migrants to guarantee that they are prepared as a community for a potential pandemic. This can best be done through using effective communication strategies which mainstream the community component throughout communication channels such as TOT, community health/social workers, communication tools such as leaflets and pamphlets and lastly the media. Ensuring that the community component is part of any communication strategy will ensure that Sudanese migrants are targeted in future pandemic preparedness efforts aimed at integration with the rest of Egyptian society in the struggle to prevent a pandemic and to lessen their vulnerability in case of a pandemic outbreak.

Recommendations

Based on the findings from this study, the researchers have compiled a list of recommendations to best prepare the migrant community for a pandemic, particularly Sudanese migrants, as they were the primary focus of this research.

To the Government of Egypt

- Create a surveillance system for the target population living in areas at high risk such as informal urban settlements, particularly in Cairo;
- Establish a network including national and government stakeholders involved in pandemic work and community based organisations (CBOs) engaged with migrant groups;
- Ensure that a clear reporting system is in place and that the Sudanese migrant population is aware of how to report cases of AI or AHI in their neighbourhoods;
- Ensure that non-health interventions are included in pandemic preparedness work regarding migrants;
- Extract lessons and best practices from plans applied with other migrant populations in similar conditions;
- Ensure that information is disseminated widely and efficiently in a unified way to ensure that no confusing messages are spread and panic is avoided.

To International Organisations and Non-Governmental Organisations

- Produce appropriate communication strategies that avoid stigmatization while taking into account the linguistic and social specificities of the Sudanese community;
- Advocate in cooperation with CBOs for the expansion of the provision of migrant-sensitive health policies, including public and private health care services to Sudanese migrants;
- In coordination with the Government of Egypt and CBOs, increase the level of inclusion and trust of the Sudanese vis-à-vis national health system;
- Implement mobile activities (i.e. home visits / mobile health clinics) to suit what is often a very mobile lifestyle among migrants;
- Monitor and evaluate any communication material, as well as communication strategies used with Sudanese migrants and ensure that it is having a sustained behavioural impact;
- Continue advocacy work with relevant stakeholders and ensure they include a migrant focus in their activities.

To Community Based Organisations

- Cooperate with international and national actors, including the Government of Egypt to spread awareness of the concept of pandemic among Sudanese migrants;
- Ensure that health providers working with Sudanese migrants mainstream pandemic preparedness as part of their health awareness programmes;
- Identify community leaders as well as other individuals from the Sudanese community and ensure that an efficient communication chain is established to be used during emergency circumstances, such as a pandemic outbreak;

- Monitoring the community to identify particularly vulnerable people who do not seem to be receiving information as well as confusing, frightening or contradictory messages, and establish a reporting system to identify dissemination gaps.

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Appendix 1 Access to Services

Access to Housing

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	283	96.6	96.6	96.6
2 no	7	2.4	2.4	99.0
3 sometimes	3	1.0	1.0	100.0
Total	293	100.0	100.0	

ACCWATER Access to Water

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	282	96.2	96.2	96.2
2 no	10	3.4	3.4	99.7
3 sometimes	1	.3	.3	100.0
Total	293	100.0	100.0	

ACCELECT Access to Electricity

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	282	96.2	96.2	96.2
2 no	10	3.4	3.4	99.7
3 sometimes	1	.3	.3	100.0
Total	293	100.0	100.0	

ACCFOOD Access to Food

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 yes	277	94.5	94.5	94.5
2 no	15	5.1	5.1	99.7
12	1	.3	.3	100.0
Total	293	100.0	100.0	

ACCEDU Access to Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 yes	145	49.5	49.8	49.8
	2 no	143	48.8	49.1	99.0
	3 sometimes	3	1.0	1.0	100.0
	Total	291	99.3	100.0	
Missing	System	2	.7		
Total		293	100.0		

ACCTOHEA Access to Health Care Provider

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 yes	136	46.4	46.4	46.4
	2 no	139	47.4	47.4	93.9
	3 sometimes	18	6.1	6.1	100.0
	Total	293	100.0	100.0	

ACCTOPSY Access to Psychological Care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 yes	47	16.0	16.1	16.1
	2 no	239	81.6	81.8	97.9
	3 sometimes	6	2.0	2.1	100.0
	Total	292	99.7	100.0	
Missing	System	1	.3		
Total		293	100.0		

ACCTOLEG Access to Legal Assistance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 yes	39	13.3	13.4	13.4
	2 no	241	82.3	82.5	95.9
	3 sometimes	12	4.1	4.1	100.0
	Total	292	99.7	100.0	
Missing	System	1	.3		
Total		293	100.0		

Appendix 2 Access to Services by Residency Status

Access to Housing

			ACCHOUSI Access to Housing			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	114	5		119
		% within ACCHOUSI Access to Housing	40.3%	71.4%		40.6%
	2 Refugees	Count	109	1	3	113
		% within ACCHOUSI Access to Housing	38.5%	14.3%	100.0%	38.6%
	3 Rejected CF	Count	39			39
	% within ACCHOUSI Access to Housing	13.8%			13.3%	
	4 Economic migrant	Count	16	1		17
	% within ACCHOUSI Access to Housing	5.7%	14.3%		5.8%	
	5 Stranded students	Count	5			5
	% within ACCHOUSI Access to Housing	1.8%			1.7%	
Total		Count	283	7	3	293
		% within ACCHOUSI Access to Housing	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.477 ^a	8	.304
Likelihood Ratio	11.249	8	.188
Linear-by-Linear Association	.156	1	.693
N of Valid Cases	293		

a. 11 cells (73.3%) have expected count less than 5. The minimum expected count is .05.

Access to Water

			ACCWATER Access to Water			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	114	5		119
		% within ACCWATER Access to Water	40.4%	50.0%		40.6%
	2 Refugee	Count	109	4		113
		% within ACCWATER Access to Water	38.7%	40.0%		38.6%
	3 Rejected CF	Count	39			39
	% within ACCWATER Access to Water	13.8%			13.3%	
4 Economic migrant	Count	15	1	1	17	
	% within ACCWATER Access to Water	5.3%	10.0%	100.0%	5.8%	
5 Stranded student	Count	5			5	
	% within ACCWATER Access to Water	1.8%			1.7%	
Total	Count	282	10	1	293	
	% within ACCWATER Access to Water	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.444 ^a	8	.018
Likelihood Ratio	9.337	8	.315
Linear-by-Linear Association	.416	1	.519
N of Valid Cases	293		

a. 11 cells (73.3%) have expected count less than 5. The minimum expected count is .02.

Access to Electricity

			ACCELECT Access to Electricity			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	114	5		119
		% within ACCELECT Access to Electricity	40.4%	50.0%		40.6%
	2 Refugee	Count	109	4		113
		% within ACCELECT Access to Electricity	38.7%	40.0%		38.6%
	3 Rejected CF	Count	39			39
	% within ACCELECT Access to Electricity	13.8%			13.3%	
	4 Economic migrant	Count	15	1	1	17
	% within ACCELECT Access to Electricity	5.3%	10.0%	100.0%		5.8%
	5 Stranded student	Count	5			5
	% within ACCELECT Access to Electricity	1.8%				1.7%
Total		Count	282	10	1	293
		% within ACCELECT Access to Electricity	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.444 ^a	8	.018
Likelihood Ratio	9.337	8	.315
Linear-by-Linear Association	.416	1	.519
N of Valid Cases	293		

a. 11 cells (73.3%) have expected count less than 5. The minimum expected count is .02.

Access to Sanitation

			ACCSANIT Access to Sanitation		Total
			1 yes	2 no	
RESIDSTA Residency Status	1 Asylum seeker	Count	114	5	119
		% within ACCSANIT Access to Sanitation	40.4%	45.5%	40.6%
	2 Refugee	Count	109	4	113
		% within ACCSANIT Access to Sanitation	38.7%	36.4%	38.6%
	3 Rejected CF	Count	39		39
	% within ACCSANIT Access to Sanitation	13.8%		13.3%	
4 Economic migrant	Count	15	2	17	
	% within ACCSANIT Access to Sanitation	5.3%	18.2%	5.8%	
5 Stranded student	Count	5		5	
	% within ACCSANIT Access to Sanitation	1.8%		1.7%	
Total		Count	282	11	293
		% within ACCSANIT Access to Sanitation	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.816 ^a	4	.307
Likelihood Ratio	5.407	4	.248
Linear-by-Linear Association	.003	1	.958
N of Valid Cases	293		

a. 6 cells (60.0%) have expected count less than 5. The minimum expected count is .19.

Access to Food

			ACCFOOD Access to Food			Total
			1 yes	2 no	12	
RESIDSTA Residency Status	1 Asylum seeker	Count	112	6	1	119
		% within ACCFOOD Access to Food	40.4%	40.0%	100.0%	40.6%
	2 Refugee	Count	108	5		113
		% within ACCFOOD Access to Food	39.0%	33.3%		38.6%
	3 Rejected CF	Count	38	1		39
	% within ACCFOOD Access to Food	13.7%	6.7%		13.3%	
4 Economic migrant	Count	14	3		17	
	% within ACCFOOD Access to Food	5.1%	20.0%		5.8%	
5 Stranded student	Count	5			5	
	% within ACCFOOD Access to Food	1.8%			1.7%	
Total	Count	277	15	1	293	
	% within ACCFOOD Access to Food	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.867 ^a	8	.447
Likelihood Ratio	6.547	8	.586
Linear-by-Linear Association	.429	1	.513
N of Valid Cases	293		

a. 9 cells (60.0%) have expected count less than 5. The minimum expected count is .02.

Access to Health Care Provider

			ACCTOHEA Access to Health Care Provider			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	52	59	8	119
		% within ACCTOHEA Access to Health Care Provider	38.2%	42.4%	44.4%	40.6%
	2 Refugee	Count	60	44	9	113
		% within ACCTOHEA Access to Health Care Provider	44.1%	31.7%	50.0%	38.6%
	3 Rejected CF	Count	16	23		39
	% within ACCTOHEA Access to Health Care Provider	11.8%	16.5%		13.3%	
	4 Economic migrant	Count	5	11	1	17
		% within ACCTOHEA Access to Health Care Provider	3.7%	7.9%	5.6%	5.8%
	5 Stranded student	Count	3	2		5
		% within ACCTOHEA Access to Health Care Provider	2.2%	1.4%		1.7%
Total		Count	136	139	18	293
		% within ACCTOHEA Access to Health Care Provider	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.215 ^a	8	.250
Likelihood Ratio	12.897	8	.115
Linear-by-Linear Association	.023	1	.881
N of Valid Cases	293		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is .31.

Access to Psychosocial Care

			ACCTOPSY Access to Psychological Care			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	16	98	4	118
		% within ACCTOPSY Access to Psychological Care	34.0%	41.0%	66.7%	40.4%
	2 Refugee	Count	24	88	1	113
		% within ACCTOPSY Access to Psychological Care	51.1%	36.8%	16.7%	38.7%
	3 Rejected CF	Count	5	33	1	39
	% within ACCTOPSY Access to Psychological Care	10.6%	13.8%	16.7%	13.4%	
	4 Economic migrant	Count	1	16		17
		% within ACCTOPSY Access to Psychological Care	2.1%	6.7%		5.8%
	5 Stranded student	Count	1	4		5
		% within ACCTOPSY Access to Psychological Care	2.1%	1.7%		1.7%
Total		Count	47	239	6	292
		% within ACCTOPSY Access to Psychological Care	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.605 ^a	8	.580
Likelihood Ratio	7.309	8	.504
Linear-by-Linear Association	.034	1	.854
N of Valid Cases	292		

a. 8 cells (53.3%) have expected count less than 5. The minimum expected count is .10.

Access to Legal Assistance

			ACCTOLEG Access to Legal Assistance			Total
			1 yes	2 no	3 sometimes	
RESIDSTA Residency Status	1 Asylum seeker	Count	15	101	2	118
		% within ACCTOLEG Access to Legal Assistance	38.5%	41.9%	16.7%	40.4%
	2 Refugee	Count	18	88	7	113
		% within ACCTOLEG Access to Legal Assistance	46.2%	36.5%	58.3%	38.7%
	3 Rejected CF	Count	5	31	3	39
	% within ACCTOLEG Access to Legal Assistance	12.8%	12.9%	25.0%	13.4%	
	4 Economic migrant	Count		17		17
		% within ACCTOLEG Access to Legal Assistance		7.1%		5.8%
	5 Stranded student	Count	1	4		5
		% within ACCTOLEG Access to Legal Assistance	2.6%	1.7%		1.7%
Total		Count	39	241	12	292
		% within ACCTOLEG Access to Legal Assistance	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.140 ^a	8	.331
Likelihood Ratio	12.293	8	.139
Linear-by-Linear Association	.614	1	.433
N of Valid Cases	292		

a. 8 cells (53.3%) have expected count less than 5. The minimum expected count is .21.

Appendix 3 Survey Questionnaire

Informed Consent

Introduction

Hello, My name is I am working in a joint research project between the Forced Migration and Refugee Studies Program (AUC) and the International Organization for Migration. The project aims to identify the main characteristics of the Sudanese population in Egypt (both migrants and refugees) and to discuss the elements affecting their migration choices (staying in Egypt, voluntarily returning to Sudan or resettling in a third country). Moreover, as the avian influenza (AI) is representing a serious threat to the world, part of this questionnaire will be dedicated to discuss the vulnerability of the Sudanese migrant population to pandemics as such in order to ensure their coping capacity in the event of this pandemic or any other crisis.

I will take approximately one hour and a half of your time. All information given will be treated strictly confidential.

..... I agree to participate in your research.

..... I disagree to participate in your research.

Interviewer	
Governorate (office use)	
Residential area in Egypt	
ID NO. Housing Unit (filled by office)	
Visit NO.(1 first visit, 2 second visit)	
Date of filling Questionnaire	Day/Month/Year
Time for start of interview	... a.m.p.m.
Time for end of interviewa.m.p.m.
Result of interview	Interview Completed
	Partly completed
	Housing unit does not exist
	No eligible person
	Refusal to conduct the interview

ID N0. Housing Unit	
Q1 Accomodation (Check only ONE)	Rented Appartment
	Shared appartment with other family members
	Collective accomodation
	University Campus
	Other, specify..
Q2 Monthly Rent	
Q3 No. of rooms (excluding kitchen and bathrooms)	
Q4 Items owned by the Household (identify what is owned by interviewee and what is owned by landlord). Owned by Landlord= LL , Owned by interviewer leave BLANK . Enter NUMBER of Equipments i.e. 1 refrigerator, 2 Mobile Phones etc.	Refrigerator
	Gas/Electric Oven
	Electric Washing Machine
	Television
	Satellite antenna
	Video/DVD Player
	Telephone land line
	Personal Computer
	Internet Connection
	Mobile Phone
Private Car	

ID N0. Housing Unit				
<i>Part IV: Remittances from and to Sudan</i>				
Q37 Have you received financial assistance from relatives/friends to support your stay in Egypt over the last three months? 1=yes (go to Q38) 2=no (go to Q40)	Q38 specify country & relationship	Q39 How do you receive this financial assistance 1= bank transfer 2= traders 3= family or acquaintances 4= money transfer agent	Q40 Do you send financial assistance to relatives/friends to support their stay in Sudan? 1=yes, relationship (go to Q41) 2=no (go to Q42)	Q41 How do you send this financial assistance? 1= bank transfer 2= traders 3= family or acquaintances 4= money transfer agent

Part V: Assistance and Access to full/partial Services

Q42 Does your household have access to the following basic services in Egypt? (Check all that applies) and list service provider when applicable (1= yes, 2= no, 3=sometimes).

Service	1= Yes, 2=No, 3=sometimes	NAME of Service Provider/s (institution/s)	NAME of Service Provider/s (individual/s)
Housing			
Water			
Electricity			
Sanitation			
Food			
Education			
Health care and services			
Psychosocial care			
Legal assistance			
Other, please specify:			

ID N0. Housing Unit			
Part VI: Prospects of Voluntary Return			
Q43 Which is better for you in terms of living conditions and the general economic and social situation?	1=stay in Egypt	2= to return back to Sudan	3= to resettle in a third country, specify COUNTRY
Q44 Given the conditions in Sudan within the next five years, are you planning to return to Sudan?	1= yes	2= no	3=don't know
Q45 Have you ever heard of the International Organization for Migration (IOM)?	1= yes	2= no (go to Q47)	
Q46 What IOM activities have you heard of ?	1= Referral System	2= Provision services while in Sudan	3= Provision of services while in Egypt
been beneficiary for?	1= Referral System	2= Provision services while in Sudan	3= Provision of services while in Egypt 4= other, specify
Q47 If a programme was created to assist Sudanese in Cairo/Egypt to voluntary return and reintegrate in Sudan (pre-departure and transport in Sudan (pre-departure and transport assistance as well as job placement/integration assistance), would you be interested in such a programme?			1= yes (go to Q48) 4= no (go to Q53)
Q48 What type of reinsertion and/or reintegration assistance would require if you decided to return to Sudan? (check all that applies)	1= job placement 5= access to health care	2= buisness set up assistance 6= follow-up program in sudan	3= vocational training 7= security and protection 4= psychosocial support 8=transportation
Q49 Please rank the assistance would you require upon your return to Sudan? (1=not important at all; 2=slightly important, 3=important, 4= extremely important)	1= job placement () 5= access to health care ()	2= buisness set up assistance () 6= follow-up program in sudan ()	3= vocational training () 7= security and protection () 4= psychosocial support () 8= transportation ()
Q50 What type of further assistance would you require? (check all that applies)		1=own land 4=buy house	2=Grant to continue education 5= financial support to meet basic needs 3= micro-loans schemes 6=other, specify
Q51 Please rank the further required assistance? (1=not important at all; 2=slightly important, 3=important, 4= extremely important).		1=own land () 4= buy house ()	2=Grant to continue education () 5= financial support to meet basic needs () 3= micro-credit schemes () 6=other, specify ()
Q52 If you return to Sudan would you?	1= return to area of origin	2= settle in khartoum	3= settle elsewhere, specify PLACE 4=not sure

ID NO. Housing Unit		
Part IX: AHI Pandemic Preparedness, Knowledge, Behavior and Attitudes		
Q75 In your neighborhood, is it common to rear poultry or any other type of birds?	1=yes	2=no 3=don't know
Q76 Do you buy live poultry for consumption?	1= yes	2= no
Q77 Do you keep live poultry/birds at home?	1= yes(go to Q78)	2= no (go to Q82)
Q78 Who takes care of the poultry at your home?		
Q79 What poultry do you keep?	1= Chicken 3= Geese 5=Pigeons	2= Ducks 4=Turkey 6=other,specify
Q80 For what reason/s do you keep poultry?	1=consumption 3=prestige/wealth	2=sales or trade 4=other, specify
Q81 Where do you keep your poultry?	1=on the roof 3=in the house	2=backyard 4=other, specify
Q82 Do you wear protective clothing or footwear when handling poultry and poultry-by-products (eggs)?	1=yes	2=no 3=sometimes
Q83 Why don't you use protective clothing or footwear?		
Q84 Do you eat poultry or poultry-by- products?	1= yes	2= no
Q85 Over the last month, what did you eat more?	1= Meat 3=Fish and sea food	2= Poultry 4= vegetarian food 5=other,specify
Q86 Where do you buy your poultry from?	1=tradition poultry store 3=Restaurants	2= supermarket 4= open market (souk) 5=other, specify
Q87 Do you wash your hands before or after touching slaughtered poultry?	1=yes	2=no 3=sometimes
Q88 Do you usually wash poultry and/or eggs before cooking?	1= yes	2=no 3=sometimes

ID Housing Unit

Part IX (2)

Q89 What do you think should be done where there is a sick or dead poultry in your neighborhood?	1= get a veterinary officer	2= slaughter and eat poultry	3= sell to inspecting customers	4= burn or bury diseased/sick poultry	5=other, specify
Q90 Do you know where to report poultry and wild birds' deaths?	1=yes	2=no (go to Q92)			
Q91 I could report to:	1= government official	2=health unit in the neighborhood	3= family head	4= other, specify	
Q92 Do you believe it is safe to eat poultry and poultry products?	1=yes	2=no	3= don't know		
Q93 Have you heard about the Bird Flu?	1=yes	2=no			
Q94 From what sources was knowledge on AHI/Bird Flu acquired? (check all that apply)	1= Radio	2= TV	3= newspapers	4= neighbors	5=church/mosque
		6=traditional leader	7=animal/health worker	8= poster/pamphlet/handout	9=other, specify
Q95 Do you know that a bird has influenza?	1= I know, explain how			2= don't know	
Q96 Are there any bird flu cases in your neighborhood?	1=yes	2=no	3= don't know		
Q97 Do you know how do people get infected with bird flu?	1= I know, explain how			2= don't know	
Q98 Do you know what are the symptoms of bird flu in humans? (check all that apply)	1=dizziness	2=high fever	3=running nose	4=other,specify	5= don't know
Q99 Did you attend any training session on bird's flu?	1=yes	2=no			
Q100 Have you heard of any AHI in your neighborhood?	1=yes	2=no			

ID Housing Unit Part X(3)			
Q101 Do you think that you or your family is at high risk of being affected with AHI?	1=yes	2=no	
Q102 Which of the following communicable diseases you perceive as a bigger threat (from least = (1) to more important (4)) (1,2,3,4)	1= HIV aids ()	2= Hepatitis C ()	3= AHI Pandemic () 4= other, specify ()
Q103 Who is most at risk of AHI in your household? (check only ONE)	1= HH	2= husband or wife	3= son or daughter 4=child of husband or wife
	5= grandson or granddaughter	6= mother or father	7= mother in law or father in law 8= brother or sister 9= no one
Q104 Do you protect yourself and your household from bird flu and other similar disease?	1= yes, how		2= no, explain
Q 105 Have you hear the word "pandemic" before?	1=yes	2=no (go to Q108)	
Q106 Do you know anything about it?	1= yes, specify		2= no
Q107 Could you give me examples of pandemics?	1=yes, state examples		2= no
Q108 did you take any training on how to prepare for a pandemic or other crisis?	1=yes	2=no	
Q109 Would you be interested to learn more about how to prepare for a pandemic?	1=yes	2=no	3=not sure
Q110 In case of pandemic, where will you go first to get info/services?	1=health provider, specify	2=church/mosque/NGO, specify	3=local leader, specify 4=Egyptian authorities, specify 5=other, specify
Q111 What types of services do you think you should be provided with?			
Q112 How do you communicate with people from your community? (check all that apply)	1=mobile phone	2= Landline phone	3=meeting in church/mosque/NGO 4= meeting in houses 5=other, specify
Q113 Is there someone you consider your community leader?	1=yes	Name of CL:	Would you seek his/her help? 2= no
Q114 Do you stock up non-perishable food at home?	1=yes, indicate quantity		2= no,why
THANK YOU NOTE!			
Q115 Name of two contacts:			
Name 1:	Phone	Address:	
Name 2:	Phone:	Address:	

Appendix 4

Focus Group Discussion Guide

AHI Pandemic Preparedness

Background

This focus group discussion is part of a larger study that intends to assess the vulnerability of the Sudanese and migrant population to pandemics, including influenza like pandemic) as well as to learn about their coping capacities as individuals and communities, in case it spreads in Egypt. This concern emerges from the fact that migrant and refugee populations in Egypt might very well be at risk of pandemics as such because they are often excluded from national protection plans, have limited, if any, access to health care and social services, and may not have the necessary awareness needed for such situations. This is due to a combination of legal, socio-cultural, behavioural language/communications and economic barriers.

This study aims to contribute to the development and reforms of health services as well as the formulation of national policies and guidelines for migrants and mobile populations, which would enable them to draw upon their knowledge and experience in order to deal with such events. Furthermore, findings of this study will be used by IOM to place missions and operations in an efficient manner and to design Training of Trainers (TOT) programs on pandemic preparedness with the aim of responding to the needs of Sudanese migrants and refugees in Egypt.

The objective of this focus group is to gain an in-depth understanding about: 1) the perceptions, attitudes, perceptions and behaviours of the Sudanese population in Egypt on pandemics (including influenza like illnesses); 2) the degree to which the Sudanese population in Egypt is vulnerable in case of the widespread of pandemics as such in the future; and 3) the capacity of the Sudanese population in Egypt, both refugees and migrations, for community based surveillance, prevention, home based management of communicable disease (including influenza like illnesses) and social wellbeing of migrant communities in the event of a pandemic or other crisis and 4) their recommendations for suitable services in case of an event as such.

The researcher should be aware that most of the refugees and migrants lack access to adequate health care and services in Egypt. S/he should also be aware that other communicable diseases such as HIV and Hepatitis C and non-communicable diseases such as malnutrition and diabetes are health priorities among the Sudanese refugee and migrant population in Egypt. Therefore, the researcher should highlight that s/he does not suggest that AHI is common among the Sudanese population, because they might feel scapegoated in such events. Rather, it should be clear for the participants that pandemics as such may occur and that they might be more vulnerable to it than their fellow Egyptians due to the fact that they live in urban centres where bird rearing is common among their neighbours and that they have limited access to

services and are often excluded from the Egyptian National health and social care agendas.

Targeted Group: 8 to 12 persons who are members of the Sudanese migrant and refugee population in Egypt. Variables such as legal status, age, gender, religion, duration of stay in Egypt, family situation, occupation and ethnicity will be considered while selecting focus group participants. Each participant will receive an incentive amounting L.E. 20. Incentives will be given to participants on individual basis after the completion of the discussion.

Logistics: The researcher will need: 1) a room that may accommodate 20 persons; 2) refreshments for 20 persons (Coffee, tea and a light snack); 3) a board and markers; a digital recorder that could be used upon participants' agreement.

Research team: 1 facilitator (main researcher)

1 assistant (minutes taker). In case of non-English and non-Arabic speaker focus group participants, the assistant will also act as a translator.

1 IOM representative to answer questions about IOM and inquiries related to the role of the study in IOM future operations.

Steps of Implementation:

- **Introductions:** facilitator (lead researcher) introduces herself, other members of the research team in the room and the project to the group. Research participants introduce themselves through an ice-breaking game. They will be asked to state their names, duration of stay in Egypt, occupation, family situation and place of residence. The researcher will mention that participants' names will remain confidential and will only be used inside the room for facilitating the discussion. The researcher will mention that the discussion will take approximately two hours. S/he will also mention that refreshments will be served throughout the session. S/he will give participants the option of whether or not they like the discussion to be audio-recorded using a digital recorder. Note takers are requested to review the purpose and questions of the discussion guide in advance in order to follow the conversation. Finally, note takers should be familiar with the Sudanese Arabic/English accent or local language used in the discussion.
- **Prompting the discussion with throwing the following questions:** The facilitator will then raise questions regarding the following key themes:
 - 1) What is your understanding of the word pandemic?
 - 2) Have you heard of a pandemic before? When did this pandemic occur and where?
 - 3) Which diseases can be pandemic? Can there be pandemic among animals?
Among humans?
 - 4) What types of pandemics do you think that you/your community is vulnerable to?
 - 5) Have you heard of the bird's flu? What did you hear about it? And where did you get this information from?

- 6) Do you think you/your community is at risk of birds' flu? Why? (This question may include some sub-questions like 1) is it common among your Egyptian neighbours to rear chicken or any other type of birds? Do you keep poultry at home? If so why do you keep them and who takes care of them? Have you heard of any bird's flu cases in your neighbourhood or among the circle of people you know?
 - 7) Do you believe it is safe to eat poultry and poultry products?
 - 8) If you hear that a pandemic (like influenza), what would you do?
 - 9) How should your community prepare for a pandemic like bird's flu or others? (Women, men and children)?
 - 10) How can you/ we prepare for a pandemic?
 - 11) Do you think you can cope during a pandemic?
 - 12) How have you coped in other crisis?
 - 13) Can you use the same skills to cope in a pandemic?
 - 14) How do you think the coping skills differ in a pandemic?
 - 15) Do want to know more about how you can be better prepared for a pandemic or any other crisis
 - 16) What services (for the community at large and for groups i.e. children and women) would you like to be in place now to ensure that your community copes during a pandemic or any other crisis?
 - 17) Will you be willing to participate in a pandemic preparedness capacity building activity?
 - 18) Would you like to add any other comments on that issue?
- **Thank you note:** The facilitator will thank the focus group participants for their participation and would disburse the incentives.

Appendix 5

In-Depth Interview Semi-Structured Questionnaire

NOTE: This questionnaire was sometimes modified depending on what organisations were interviewed.

Questionnaire for Service Providers and Community, National and International Organisations on the issue of Pandemic Preparedness and Migrants and Refugees

GENERAL INFORMATION QUESTIONS

19) Please give some details about your organisation:

- What is the objective of your organisation?
- When was your organisation formed?
- What are the activities of your organisation in the field of health and / or migrants and refugees? *(Please describe any specific programmes you have relating to this target group. Additional information: working with any partners? Funding is coming from where? Any specific women and children programmes?)*

2) What nationalities do you see and what are the number of refugees / migrants you see on a daily, monthly, yearly basis? (Remember to get specific information about Sudanese, if the organisation being interviewed is not Sudanese specific.)

- Do you see women? (If so what are the number of clients?)
- Do you see children? (If so what are the number of clients?)

3) How do you reach out to the migrants/refugees with your work / programmes/ activities? What is the best communication strategy for migrants?

- Specific communication strategies?

- Word of mouth

4) How do you maintain contact / have a relationship with the target group?

- Specific communication strategies?
- Particular administrative systems (e.g. good contacts database, regular contact by phone.... Etc.)

PANDEMIC & PANDEMIC PREPAREDNESS QUESTIONS

5) What is your understanding of what a “pandemic” is and how does it differ from “epidemic”? *(Leave this question quite open-ended because we want to establish what the respondent knows about pandemics and whether there is any misinformation.)*

6) In your opinion, how would a pandemic impact differently on mobile populations such as migrants / refugees? And how may it impact differently on women and children within these groups?

7) Have you worked on pandemic preparedness before? How, when and where?

8) What is your understanding of what pandemic preparedness is? *(leave this question quite open-ended because we want to establish what the respondent knows about pandemics and if there is any misinformation)*

9) What is the situation for Sudanese in Egypt in terms of their ability to access health care services and what their view is on the health service situation available?

10) Among your client group, what do you think is their knowledge of what a pandemic is as well as what pandemic preparedness is? What would their approach be to the issue of a pandemic *(find out whether they view it as something not so serious?)*

11) Do you think that the Sudanese population in Egypt is at risk of a pandemic? If yes, how are they at risk? (*Living in neighbourhoods where rearing chickens or other birds? People they work with keep poultry at home*)

12) Have you come across any cases where there have been bird's flu or human flu incidents in neighbourhoods where Sudanese live?

13) If a pandemic was to take place tomorrow, what do you think the Sudanese migrant / refugee population would do?

14) How do you think a pandemic should be tackled should it happen, both in general and with the Sudanese population in Egypt?

15) How could your organization prepare for a pandemic?

16) What services do you think should be in place to ensure that the Sudanese community can cope during a pandemic?

STRATEGIES & RECOMMENDATIONS FOR PANDEMIC PREPAREDNESS

17) What do you think would be the best ways to improve pandemic preparedness among the Sudanese community?

18) What communication strategies would best work with the Sudanese community, in creating awareness about pandemic preparedness? What kind of communication material would you need in order to create awareness about pandemic preparedness? Would the Sudanese community respond to existing communication material available?

- 19) What is the role of men and women in pandemic preparedness?**
- 20) What do you think are the gaps in pandemic preparedness among organisations working with refugee communities and what methods are best to use to fill this gap?**
- 21) Have you received any training or specific information before regarding coping during an epidemic or pandemic? If so, what did you learn in this training, what was useful and not useful, and how did you communicate it to people you work and your patients / clients?**
- 22) Will you be willing to participate in a pandemic preparedness capacity building activity? *(Provide more details about this interview)***
- 23) Would you like to add any other comments on the issue of pandemics and pandemic preparedness?**
