Egypt Report NCPI

NCPI **Header**

is indicator/topic relevant?: Yes
is data available?: Yes
Data measurement tool / source: NCPI
Other measurement tool / source:
From date: 03/31/2014
To date: 03/31/2014
Additional information related to entered data. e.g. reference to primary data source, methodological concerns::
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::
Data measurement tool / source: GARPR

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Dr. Walid Kamal

Postal address:

Telephone:

Fax:

E-mail:

Describe the process used for NCPI data gathering and validation: NCPI part A and B involved a process of desk review for a number of documents including national documents and studies done by multilateral agencies and international organizations. Regarding NCPI part A this was done by NAP manager who filled out the form with technical assistance from UNAIDS. As for NCPI part B, after identifying the stakeholders, an independent consultant was hired, who carried out interviews (face to face and telephone) with stakeholders, other stake holders received the form by email and where followed up by telephone. After collection of data from the different stakeholders, the independent consultant revised, analysed the data and provided a summary for all the collected data. The outcomes of the tool was discussed with the stakeholders in a workshop afterwards to validate the results in the NCPI part B.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A
National AIDS program (MOH)	Dr. Walid Kamal	A1,A2,A3,A4,A5,A6

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B
		B1,B2,B3,B4,B5
		B1

A.I Strategic plan

1. Has the country developed a national multisectoral strategy to respond to HIV?: Yes

IF YES, what is the period covered: It Covers the period 2012 -2016

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: • Re-ordering the prioritization areas and recognizing Most at Risk Population (MARPS) as priority groups referred to in clear statement in the strategic framework. • A clearer focus on PLHIV and prioritizing treatment and care for this group as one of the strategic priorities in the new plan.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: Ministry of Health

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Education:

Included in Strategy: Yes

Earmarked Budget: No

Health:

Included in Strategy: Yes

Earmarked Budget: No

Labour:

Included in Strategy: No

Earmarked Budget: No

Military/Police:

Included in Strategy: No

Earmarked Budget: No

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: No

Transportation:

Included in Strategy: No

Earmarked Budget: No

Women:

Included in Strategy: No

Earmarked Budget: No

Young People:

Included in Strategy: Yes

Earmarked Budget: No

Other: Higher education

Included in Strategy: Yes

Earmarked Budget: No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: No

HIV and poverty: No

Human rights protection: No

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?:

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]::

: No

1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?: No

1.6. Does the multisectoral strategy include an operational plan?: No

1.7. Does the multisectoral strategy or operational plan include:

a) **Formal programme goals?**: Yes

b) **Clear targets or milestones?**: Yes

c) **Detailed costs for each programmatic area?**: No

d) **An indication of funding sources to support programme implementation?**: No

e) **A monitoring and evaluation framework?**: Yes

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?:

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.:

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?: Yes

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: No

Poverty Reduction Strategy: No

National Social Protection Strategic Plan: No

Sector-wide approach: No

Other [write in]:

: N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the develop-ment plans?

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws:

HIV impact alleviation (including palliative care for adults and children):

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support:

Reduction of stigma and discrimination:

Treatment, care, and support (including social protection or other schemes): Yes

Women's economic empowerment (e.g. access to credit, access to land, training): Yes

Other [write in]:

:

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?: N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua¬tion informed resource allocation decisions?:

4. Does the country have a plan to strengthen health systems?: No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children:

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Few

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: None

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: None

e) ART and Tuberculosis: Many

f) ART and general outpatient care: None

g) ART and chronic Non-Communicable Diseases: None

h) PMTCT with Antenatal Care/Maternal & Child Health: Few

i) Other comments on HIV integration: :

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?: 7

Since 2011, what have been key achievements in this area:

What challenges remain in this area::

A.II Political support and leadership

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers: Yes

B. Other high officials at sub-national level: Yes

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: Attendance of the Minister of Health the launch of "UNAIDS 2013 Regional Report for the Middle East and North Africa" as part of World AIDS Day celebration in December 2013. This was considered a great demonstration of political leadership and support for HIV activities and programs in Egypt.

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?: Yes

IF NO, briefly explain why not and how HIV programmes are being managed::

2.1. IF YES, does the national multisectoral HIV coordination body:

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?: Dr. Amr Kandil

Have a defined membership?: No

IF YES, how many members?: 36 members

Include civil society representatives?: Yes

IF YES, how many?: 6

Include people living with HIV?: Yes

IF YES, how many?: 1

Include the private sector?: Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?: Yes

3. Does the country have a mechanism to promote coordinationbetween government, civil societyorganizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: The CCM works to coordinate partnership between private sector and CSO in areas related to outreach, VCT and provider care services in order to mobilize resources to support these activities.

What challenges remain in this area:: The reporting mechanism and monitoring and evaluation tools are not unified for all partners Activity prioritization is not necessarily aligned with the NSF priority areas or activities

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 2

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: Yes

Technical guidance: Yes

Other [write in]:

: No

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?: No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?: No

IF YES, name and describe how the policies / laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies::

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?: 7

Since 2011, what have been key achievements in this area:: Despite the great political instability experienced by Egypt through 2011 and 2013, continued political support was demonstrated to the HIV program where a new NSP was designed to cover the period 2012-2016. The attendance of the Minister of Health the launch of "UNAIDS 2013 Regional Report for the Middle East and North Africa" as part of World AIDS Day celebration in December 2013. This was considered a great demonstration of political leadership and support for HIV activities and programs in Egypt.

What challenges remain in this area:: The continuous turn over in the government officials (Ministers of health) which reached 7 different ministers over the period 2011-2013 creates difficulties in timely follow up with the scheduled activities. The current security situation in the country interferes with many outreach activities related to the HIV programming. This is particularly relevant to the area of HIV activities where HIV program beneficiaries are threatened by the current situation.

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:: The Egyptian constitution includes an article that states clearly that "All citizens are equal before the Law. They are equal in rights, freedoms and general duties, without discrimination based on religion, belief, sex, origin, race, color, language, disability, social class, political or geographic affiliation or any other reason. Discrimination and incitement of hatred is a crime punished by Law. The State shall take necessary measures for eliminating all forms of discrimination, and the Law shall regulate creating an independent commission for this purpose." Article 53

Briefly explain what mechanisms are in place to ensure these laws are implemented:: Institutionalizing the process of ensuring non-discriminatory practices through establishing committees within governmental organizations responsible for receiving and investigating citizens' complaints related to discriminatory actions experienced through public and private entities in the country. Ensuring representation of minorities and vulnerable groups namely; youth, women and disabled in municipality councils. Law suits can be filed to be considered by the Supreme consititutional court in cases of violation of constitutional rights and discriminatory acts

Briefly comment on the degree to which they are currently implemented:: Given that currently the country is in a transitory stage where the new constitution has been operational since February 2014, and since the above mentioned mechanisms are novel additions to the constitution, the related executional laws are yet to be developed by the people's assembly that will be elected by the end of 2014. However it is always the right of any citizen to file a law suit to claim their rights against discriminatory acts.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: Yes

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: Article (278) of the Penal Code, which regulates adultery cases "habitual debauchery". Foreigners staying in Egypt to work, study, or for training for more than 3 months are stated in the law as and could thus be subjected to HIV tests without their consent

Briefly comment on how they pose barriers:: Concerning the domestic laws, there are few laws through their application, hindrances to preventive efforts for key populations exist. Firstly, the police in Egypt use article (278) of the Penal Code, which regulates adultery cases, against key populations. The police further use the modes of prevention (such as clean needles and condoms) as evidence of conducting adultery "habitual debauchery". This jeopardizes efforts for harm reduction and prevention strategies by putting both beneficiaries and outreach workers at risk of incarceration. The requirement of foreigners to carryout HIV testing that if found positive would result in their deportation is considered a violation of the rights of PLHIV and ultimately affects their livelihood. Likewise Egyptians are subject to similar law by other employing countries, and similarly Egyptian PLHIV livelihoods are negatively `affected. (This is also applicable for HBV, HCV)

A.IV Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?: Yes

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: No

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: No

Know your HIV status: Yes

Males to get circumcised under medical supervision: No

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: No

Reduce the number of sexual partners: Yes

Use clean needles and syringes: Yes

Use condoms consistently: Yes

Other [write in]::

: No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?: No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?: No

2.1. Is HIV education part of the curriculum in:

Primary schools?: Yes

Secondary schools?: Yes

Teacher training?: No

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

2.3. Does the country have an HIV education strategy for out-of-school young people?: Yes

3. Does the country have a policy or strategy to promote information, education and communi-cation and other preventive health interventions for key or other vulnerable sub-populations?: Yes

Briefly describe the content of this policy or strategy:: Refugees and Street children receive HIV awareness sessions which are conducted at NGOs working with these populations, and at VCT premises.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

People who inject drugs: Condom promotion,HIV testing and counseling,Needle & syringe exchange,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Men who have sex with men: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Sex workers: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Customers of sex workers: HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Prison inmates: HIV testing and counseling,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Other populations [write in]:: For PLHIV

: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?: 6

Since 2011, what have been key achievements in this area:: Efforts were made to conduct a feasibility study for OST, to inform a policy to introduce OST in Egypt Policy makers requested from UNAIDS a policy paper to advocate for removal of travel restrictions.

What challenges remain in this area:: Lacking political stability. No Parliament present in 2013

4. Has the country identified specific needs for HIV prevention programmes?: Yes

IF YES, how were these specific needs determined?: Based on a situation and gap analysis study, the priority areas for NSP in the area of prevention were identified

IF YES, what are these specific needs? : • Increase coverage of prevention interventions for most at risk populations • Increase coverage, quality and effectiveness of prevention interventions for vulnerable populations

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Strongly agree

Condom promotion: Agree

Economic support e.g. cash transfers: N/A

Harm reduction for people who inject drugs: Agree

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Disagree

Prevention of mother-to-child transmission of HIV: Disagree

Prevention for people living with HIV: Strongly agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Agree

Reduction of gender based violence: N/A

School-based HIV education for young people: Disagree

Treatment as prevention: N/A

Universal precautions in health care settings: Strongly agree

Other [write in]::

:

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 8

A.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

If YES, Briefly identify the elements and what has been prioritized:: The clinical care package include the following (in order of their priority): Counselling, social and psychological support, preventive measures, clinical care and lab follow up, ARVs.

Briefly identify how HIV treatment, care and support services are being scaled-up?: Increase access to ART dispensing units and clinical care sites More adherence to WHO guidelines as demonstrated by adopting option B+ for PMTCT Currently the MOH is planning to change treatment eligibility criteria from 350 CD4 to 500CD4.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Strongly agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Strongly agree

Economic support: N/A

Family based care and support: N/A

HIV care and support in the workplace (including alternative working arrangements): N/A

HIV testing and counselling for people with TB: Agree

HIV treatment services in the workplace or treatment referral systems through the workplace: N/A

Nutritional care: N/A

Paediatric AIDS treatment: Strongly agree

Palliative care for children and adults Palliative care for children and adults: N/A

Post-delivery ART provision to women: Strongly agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): N/A

Post-exposure prophylaxis for occupational exposures to HIV: Agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Disagree

TB infection control in HIV treatment and care facilities: Strongly agree

TB preventive therapy for people living with HIV: Disagree

TB screening for people living with HIV: Disagree

Treatment of common HIV-related infections: Strongly agree

Other [write in]::

:

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?: Yes

Please clarify which social and economic support is provided: Support groups for PLHIV are integral part of the care package provided for PLHIV and their families. Counselling as part of VCT and ARV dispensing sites provided individualized support to PLHIV and at risk populations. Furthermore, social solidarity pension can be dispensed for PLHIV similar to that being dispensed for people with disabilities, if they are unable to work.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?: No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitu-tion medications?: No

IF YES, for which commodities?:

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 5

Since 2011, what have been key achievements in this area:: Increase coverage of PLHIV with treatment Expanding on ART dispensing sites which increased from six sites in 5 governorates to 11 sites in 11 governorates (3 in upper Egypt, 4 in Delta region, 2 in Cairo and Giza, 1 in Alexandria, and one in the Suez canal region)

What challenges remain in this area:: Logistic and supply chain management still needs more strengthening particularly with the plan to change the eligibility criteria to include those with 500 CD4 count. Fixed dose combination drugs are not constantly available. PMTCT care in peripheral sites is still of low coverage. Medical interventions namely surgical are still hardly provided to PLHIV at health facilities.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: No

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?:

Since 2011, what have been key achievements in this area::

What challenges remain in this area::

A.VI Monitoring and evaluation

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?: Yes

Briefly describe any challenges in development or implementation:: • A regular reporting mechanism is not yet in place • Lack of an automated system for data collection which is largely carried out in hard format interferes with availability of data for thorough analysis which in turn affects HIV programming Monitoring and Evaluation services. • Reporting from peripheral focal point is staggering particularly with current low national security level which interferes with regular supervisory visits which are critical in ensuring the continuous feedback and support for the peripheral focal points. • A high turn-over rate for the trained employees in M&E services has been experienced over the period 2011- 2013 which affected the continuity of the data collection and reporting process.

1.1. IF YES, years covered: Not specified

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Evaluation for Outreach and VCT services provided by some partners covers M&E indicator areas specified by NAP.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: No

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate): Yes

Guidelines on tools for data collection: Yes

3. Is there a budget for implementation of the M&E plan?: Yes

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?:

4. Is there a functional national M&E Unit?: In Progress

Briefly describe any obstacles:: • Low national security level which interferes with regular supervisory visits which are critical in ensuring the continuous feedback and support for the peripheral focal points. • High turn-over rate for the trained employees in M&E services has been experienced over the period 2011- 2013 which affected the continuity of the data collection and reporting process.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?: No

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
One central	Full-time	2009
27 Focal points at governorates	Temps plein	

POSITION [write in position titles]	Fulltime or Part-time?	Since when?

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?: No

Briefly describe the data-sharing mechanisms:: Namely through workshops and periodic meetings which involves different partners working in HIV programming in Egypt. In addition to GARPR report which is available for public sharing.

What are the major challenges in this area:: A specific mechanism or protocol for data dissemination does not exist up to date.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?: Yes

6. Is there a central national database with HIV- related data?: Yes

IF YES, briefly describe the national database and who manages it.: The data base is constructed from all the peripheral reports which are pooled centrally from the peripheral focal points. It is the responsibility of the M&E officer at the central office to solicit data from the peripheral focal points and coordinate their activities to ensure the completeness and timely reporting of required data.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?: Yes, all of the above

IF YES, but only some of the above, which aspects does it include?:

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: No

IF YES, at what level(s)?:

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

(a) IF YES, is coverage monitored by sex (male, female)?: Yes

(b) IF YES, is coverage monitored by population groups?: Yes

IF YES, for which population groups?: According to different age groups Geographical distribution (Governorate level) MARPs groups

Briefly explain how this information is used:: Used for planning and selecting priority areas for NSP Resource allocation including services geographical coverage Planning and up scaling of the provided prevention activities and curative care. Identifying training needs

(c) Is coverage monitored by geographical area?: Yes

IF YES, at which geographical levels (provincial, district, other)?: Governorate level

Briefly explain how this information is used:: Mapping of the MARPS against the available service delivery sites is used to identify areas that require extension of services. In addition it is used in extending the outreach for the upcoming BBSS survey to areas that were not reached in previous one in 2009.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?: No

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]::

: No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:: • Used for planning and selecting priority areas for NSP • Resource allocation including services geographical coverage • Planning and up scaling of the provided prevention activities and curative care. • Identifying training needs Challenges: • Lack of an automated system for data collection which is largely carried out in hard format interferes with availability of data for thorough analysis which in turn affects HIV programming Monitoring and Evaluation services. • Reporting from peripheral focal point is staggering particularly with current low national security level which interferes with regular supervisory visits which are critical in ensuring the continuous feedback and support for the peripheral focal points. • A high turn-over rate for the trained employees in M&E services has been experienced over the period 2011- 2013 which affected the continuity of the data collection and reporting process.

10. In the last year, was training in M&E conducted

At national level?: No

IF YES, what was the number trained::

At subnational level?: No

IF YES, what was the number trained:

At service delivery level including civil society?: Yes

IF YES, how many?:

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: Focal point training for sharing experiences, success stories, challenges and gaps in implementation

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 5

Since 2011, what have been key achievements in this area:: Providing continuous training to match the turnover rate at the focal points for data collection GARPR reporting process has continued and this year the process ensured involvement of more partners and soliciting more data from CSOs to ensure a comprehensive reporting process

What challenges remain in this area:: • A specific mechanism or protocol for data dissemination does not exist up to date. • Lack of an automated system for data collection which is largely carried out in hard format interferes with availability of data for thorough analysis which in turn affects HIV programming Monitoring and Evaluation services. • Reporting from peripheral focal point is staggering particularly with current low national security level which interferes with regular supervisory visits which are critical in ensuring the continuous feedback and support for the peripheral focal points. • A high turn-over rate for the trained employees in M&E services has been experienced over the period 2011- 2013 which affected the continuity of the data collection and reporting process. • A protocol does not exist to coordinate regular soliciting of data from CSOs.

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?: 2

Comments and examples:: CSO played an active role in service delivery rather than in influencing the political commitment or shaping national strategies. With the exception of some meetings hosted by the National AIDS Program (NAP) in 2013 (such as the HIV Co-Infections Workshop and the National Clinical Care Guidelines Workshop in May and April 2013 respectively), the NAP showed no real effort to involve CSO in strategy/policy formulation and their recommendations were not taken into account for implementation. Key challenges brought forward by civil society were undermined which further hindered their role as service providers or effective partners in the AIDS response on the national level. There were no opportunities for dialogue with leaders beyond the NAP, such as the Ministers of Health, Interior, Justice, and Education, whose involvement is essential for an effective response. UNHCR and Refugee Egypt with UNAIDS and NAP support, was successful in ensuring that refugees and persons of concern to UNHCR were included in key priority responses and are protected from or deportation. CSO represented in the Country Coordinating Mechanism (CCM) had a better opportunity to influence strategy/policy and to provide some oversight to the implementation of the national plan but evidence revealed they were actively excluded and were not able to effectively participate in decision-making. As a result, the Global Fund has required the CCM to undergo reform to strengthen the participation of CSO. CSO representatives believe the commitment they have shown over the past 5-10 years to keeping the government informed and pressuring them to address key issues more intensely contributed eventually to the restructure of NAP. This took place late in 2013 so it is still in an early stage to measure increased civil society involvement. The new management has so far shown a much greater commitment to involving civil society in revising and updating national strategy and policies.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society repre¬sentatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?: 2

Comments and examples:: Some civil society representatives have been involved during the drafting phase of the current National Strategic Framework 2012-2016 through consultative meetings and emails soliciting input but drafting the national strategy. However, the process was not inclusive of all relevant civil society actors and those who participated did not feel their recommendations were taken into account. Some civil society actors are not aware of any written national strategy and conduct their activities based on the findings of Egypt's 2010 HIV/AIDS Biological & Behavioural Surveillance Survey (BBSS 2010) or their own needs assessment within the geographical area or population where they operate and depending on available funding. There is a wide consensus that since civil society was not effectively involved in the process, the National Strategy does not reflect the true situation on the ground and must be revisited under the new NAP management. The majority of civil society organizations were not involved in the budgeting of the National Strategic Plan for HIV. However the establishment of the Strategic Theme Group (STG) and the Operational Theme Group (OTG) are seen as a positive initiative by the NAP to consult with technical partners and civil society groups but were still not very representative of civil society and the outcomes of their activities were not clear. There is now an opportunity following the restructuring of the NAP to reinforce the role of these two groups or convene one inclusive forum for all national stakeholders to enhance coordination and inclusiveness and foster a transparent country dialogue.

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 3

b. The national HIV budget?: 1

c. The national HIV reports?: 2

Comments and examples:: The services provided by civil society are explicitly included in the 2012-2016 National Strategic Framework under the key activities of each of the priority areas identified. This includes the need for capacity building and ensuring sustainability of NGOs who wish to engage in or are already providing services to Key Populations. However these are mainly prevention and awareness services and the role of CSOs in treatment and care for PLHIV is far less clear in the national strategy. The National Strategic Plan (NSP) was not operationalized nor coasted. However two organizations, Cartias and Al-Shehab received funding as sub-recipients of the Global Fund grant but this support was limited and there was no evidence that it was effective in reaching the target populations. While the national strategy does rely mostly on civil society especially with outreach work on Key Populations, there is no clear strategy how these activities will be funded. As a result the coverage is low and the targets are not being reached. Services provided by civil society are reflected in national reports but there is no clear mechanism for documentation and reporting of activities or how they are selected for inclusion in such reports. The government was reluctant to consider reports of violations of rights of PLHIV for example. Civil society activities were not periodically reported to the NAP under the previous structure but with the better communication that came with the new management towards the end of 2013, CSOs are more encouraged to report their activities regularly.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?: 1

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 1

c. Participate in using data for decision-making?: 1

Comments and examples:: A Monitoring and Evaluation Reference Group (MERG) was established to develop and M&E plan and included some civil society organizations, technical partners (including UNAIDS and FHI360) and respresentatives from academia. However this group has not been active in 2013 and the outcome of the establishment of the MERG is not clear. Most CSOs have not been involved and are not aware of any national M&E plans. Those who were involved in the process feel their involvement did not inform the decision making process. A national M&E plan has recently been developed with the help of FHI but has not been put into effect yet. There were some sporadic M&E efforts linking some project based data and indicators with the national ones. But these only covered limited projects covering Key Populations (KPs) and have been carried out on an ad hoc basis rather than in accordance with a systematic national plan. Most of the international and UN organizations carry out monitoring and evaluation for programs they support independently from the NAP. Data was not being communicated effectively between civil society and the government. Many NGOs feel their data should be protected rather than shared, out for protection for the populations the serve or due to competition for limited available funding. Similarly, the NAP does not share data from the VCT in terms of numbers, utilization, risk factors, etc...and such data is not linked to or used to evaluate or inform on going projects.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 3

Comments and examples:: Civil society representation is diverse in terms of the populations being served such as sex workers, MSM, PWID and PLHIV and refugees. This is very positive despite the challenging environment within which some of them are forced to operate. The Egyptian NGOs Network Against AIDS (ENNAA) represents a coalition of NGOs who mainstream HIV into their work. But most of these organizations provide awareness rather than services for PLHIV or KPs. There are some Human Rights organizations providing legal services but there is still lack of strong human rights groups promoting and protecting the rights of PLHIV and KPs. This is also true of faith-based organizations and media advocacy groups. Despite the establishment of more than one organization of PLHIV, the representation of people living with HIV and key populations is still lacking mainly due to stigma, discrimination and criminalization and more efforts need to be done to ensure their safe and effective participation. Diversity is also weak geographically as most services are concentrated in Cairo and Alexandria and very few CSOs provide services over a wider geographical area.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?: 2

b. Adequate technical support to implement its HIV activities?: 3

Comments and examples:: Funding for CSOs has improved in 2013 through existing and new donors, namely Ford Foundation, Drosos Foundation and the USAID. These funds are administered to CSOs directly or through UN agencies. Two organizations received funds as SR of the Global Fund grant, however it was discontinued. Funding to HIV related projects are still limited, the impact of the interventions is low compared to the funding and sustainability remains a challenge. CSOs were concerned that the donor interest imposes the area of intervention relying mostly on the findings of the 2010 BBSS, which covered only Cairo and Alexandria. Hence, projects in these two governorates are more likely to get funded than in Upper Egypt. Funds to conduct studies and situation analysis in areas, where the extent of the epidemic is not known are limited. More established organizations are more likely to receive funds and technical assistance compared to newly established ones. Technical support is available through UN agencies which are committed to providing support to CSOs through training workshops and conferences and issuing guidelines and manuals, in addition to the close contact with CSO partners. The establishment of the Network of Associations for Harm Reduction (NAHR) by FHI 360 in 2013 presented an opportunity for exchange of experience and supporting members of the network technically. Regionally, The Middle East and North Africa Harm Reduction Association (MENAHRA), also provides some technical assistance to CSOs in Egypt through trainings and capacity development activities. Technical support is conducted through trainings lacking mentoring and hands on training with little evidence on its impact on CSO's institutional and technical capacities. CSOs need capacity building in areas of grant proposal writing, fundraising and project management. Also CSOs, who are keener on seeking financial support, need to be motivated to make use of available technical assistance opportunities.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations:

People living with HIV: >75%

Men who have sex with men: >75%

People who inject drugs: >75%

Sex workers: >75%

Transgender people: <25%

Palliative care : <25%

Testing and Counselling: 25-50%

Know your Rights/ Legal services: >75%

Reduction of Stigma and Discrimination: >75%

Clinical services (ART/OI): <25%

Home-based care: <25%

Programmes for OVC: <25%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?: 4

Since 2011, what have been key achievements in this area:: There has been an apparent increase in the number of CSOs providing HIV-related services. The most significant achievement has been the establishment of more than one group of PLHIV in addition to "Friends of Life" the first organization of PLHIV and more organizations working with key populations. A civil society forum was fostered by UNAIDS in October 2012, in collaboration with the National AIDS Program. The workshop aimed at sharing experiences, specifically in areas of prevention, and empowering civil society to engage with different donors and government counterparts. The establishment of NAHR is a key achievement in bringing together CSOs and strengthening harm reduction efforts . Networking opportunities were also supported by the International Development Law Organization (IDLO) and UNAIDS by brining together human rights groups and CSOs working on HIV-related legal services and rights in 2013. A country stocktaking exercise led by the National AIDS Program in May 2013, supported by UNAIDS has mobilized civil society, academia, PLHIV and UN organizations to assess the country's progress towards achieving the high level meeting 2011 targets. Civil society was successful in making their efforts visible to the government. For example a meeting organized by EANNA in September 2013 showcased the activities of members of the network in cooperation with the NAP. Since the restructuring of the NAP in late 2013, there has been an improved communication between the program and CSOs.

What challenges remain in this area:: It is still unclear whether improved communication between the NAP and CSOs will lead to meaningful civil society involvement and what impact it will have on the national strategy and policies. Funding to CSOs is still limited and not sustainable. The active participation of civil society is linked to on going projects only. Stigma and discrimination still constitute barriers to CSOs providing HIV related services especially those doing outreach work with key populations. Political instability and high turnover of policy makers has greatly affected the HIV response in the past three years. Restrictions on civil society in Egypt can create obstacles despite the availability of funding. For example, Friends of Life organization were only able to get the Ministry of Solidarity approval for a grant one year after they were to receive a grant from UNICEF for a project to support women and children and lost the grant as a result.

B.II Political support and leadership

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?: No

IF YES, describe some examples of when and how this has happened:: There was some representation of PLHIV in the CCM but their role in decision-making was not meaningful. There has been no effort on part of the government to support groups of PLHIV or KPs politically or financially or to engage them in decision-making PLHIV and key populations and other vulnerable groups are still seen as beneficiaries rather than actual decision makers. There are now more civil society groups representing PLHIV and key populations that act as pressure or advocacy groups to improve the AIDS response and political commitment of the government. There are also more organizations providing services targeting key populations. Despite some limited engagement of PLHIV and key populations in civil society projects, there is a lack capacity building and personal development opportunities to allow them to participate meaningfully in the national dialogue.

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: No

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]::

: No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:: The new Egyptian Constitution of 2014 (as well as previous constitutions) prohibits discrimination but there is no specific anti-discrimination law in place to protect that constitutional right. The same is true for the right to health care. Egypt is signatory to all relevant international human rights treaties that prohibit discrimination in general or based on health status specifically and that protect the right to health care and medical treatment and other rights of most of the groups mentioned in Question 1.1. Right to confidentiality and informed consent are mentioned in the Medical Ethical Regulations by the ministerial degree No. (238) of the year 2003. The regulations also include provisions that prohibit doctors from denying medical care to anyone. But these regulations are not legally binding. The Prisons Law No. (396) of the year 1956 specifically guarantees the right of prisoners to receive health care, including HIV treatment. The Egyptian Anti-Narcotics Law No. (122) of the year 1989 has provisions that allow courts to refer drug users to treatment in rehabilitation facilities as an alternative to imprisonment. Also , Egypt has a 2014 Constitution provision beholding the right to seek asylum.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: There are no domestic legal provisions, or mechanisms, that support Egypt's constitutional or international commitment to non-discrimination or the right to health care. However some legal and human rights groups were successful in using litigation before domestic courts to enforce the right to access medicines. For example, the Court of Administrative Justice in Alexandria has issued two verdicts in favour of the plaintiffs' right to HIV-medicine based on the 2012 constitution. There are no mechanisms in place to ensure doctors commit to their responsibilities set forth in the Medical Ethical Regulations, as these regulations were never translated in to laws.

Briefly comment on the degree to which they are currently implemented:: Stigma and discrimination against PLHIV and KPs present major obstacles to the implementation of laws or policies that protect their rights. Additionally there are no mechanisms in place to ensure these laws are implemented and as a result protection of the rights of PLHIV and KPs remains very weak. In many instances, without the intervention of human Rights groups and CSOs providing legal services for PLHIV and KPs, the laws are not implemented. There is limited evidence on the degree to which courts refer PWID to medical treatment rather than imprisonment (Prisoners in need of medical treatment?) Some of the existing laws need to be reformed to ensure their practical implementation. For example, while the prison law guarantees the right to medical care to sentenced prisoners, that does not include people in long or short-term detention.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?: Yes

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: Laws, regulations and policies that present obstacles to some of the above groups exceed those that protect their rights. There are laws criminalizing commercial sex work and drug use in Egypt. Same sex practice is not criminalized, but the law against debauchery is often used to prosecute MSM. For example, in 2013 there were a number of raids by the police on MSM gatherings in private property. Sex workers and MSM are sometimes subject to arbitrary arrests due to previous offenses, or to suspicion based on their dress or the places they frequent or for possessing condoms. There is no criminalization based on HIV status, but HIV/AIDS is listed as one of the infectious diseases subject to quarantine according to the Minister of Health decree No. (335) for the year 86 Foreigners wishing to obtain a residency permit in Egypt must present a certificate that they are free from HIV according to decree number 700 of the year 2006 on the Rules and Implementing Measures Surrounding Work Permits for Foreigners, issued by the Ministry of Manpower and Immigration.

Briefly comment on how they pose barriers:: Criminalization of sex work and drug use and arbitrary practices and harassment by law enforcers against them as well as against MSM, further push these groups underground preventing them from seeking or accessing testing, prevention or care. Criminalization of risk behaviour also hampers harm reduction efforts, as outreach workers are themselves subject to harassment. This situation is compounded by high stigma against people living with HIV especially within the health care setting. Asylum seekers and refugees are often very reluctant to seek HIV services and support due to the risk of deportation. While the law imposes HIV mandatory testing for work purposes for non-nationals, However, refugees and persons of concern to UNHCR are exempted from this mandatory testing for their residency needs in Egypt. Coordinated efforts between UNHCR and the government have resulted in a reduction of deportation of refugees who are HIV-positive, however fear of deportation remains an obstacle to access to testing and treatment. Quarantine or isolation of PLHIV is not typically practiced in Egypt but the listing of HIV as one of the infectious diseases subject to quarantine is sometimes used in health care settings to detain people whose status was just found positive. This is also sometimes used to isolate prisoners who are HIV positive.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?: Yes

Briefly describe the content of the policy, law or regulation and the populations included.: Violence against women, including sexual assault is criminalized under the Egyptian penal code (articles 268 and 306). Law 242 of the Penal Code also criminalizes female genital mutilation. But these laws are not effectively implemented. Egypt is also signatory to the Convention to Eliminate all Forms of Discrimination against Women. However much of Egypt's commitment to the protection of women and girls under international law have not been effectively translated into domestic laws and policies.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?: No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy::

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?: No

IF YES, briefly describe this mechanism:: There is no formal national mechanism in place to document or address discrimination. However there were some CSO-driven efforts to document violations against PLHIV through reports.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: The National Strategic Framework has identified programmatic priorities including an integrated package of treatment, care and support for PLHIV and prevention interventions for KPs and vulnerable groups. ARTs are provided free of charge to all those who need it, and HIV clinical services are given for free in 11 fever hospitals nationwide. Treatment for refugees is also identified as a priority area but is implemented mainly through civil society Post-exposure prophylaxis is provided for free by the Ministry of Health but only for accidental needle stick injury. Prevention services are provided free of charge in HIV centres but most prevention services are provided through CSOs with better access to the target populations. However while prevention and treatment are meant to be provided free to all, non-financial obstacles to access mean that not all those who need the services are receiving it. Also the unavailability of some lines of treatment means that some PLHIV have to pay for their treatment mainly purchased from neighbouring countries. The government also takes no proactive measures to ensure access and to promote for VCT, prevention and treatment services available, and there is no follow-up for people who drop out of treatment. Refugees and persons of concern to UNHCR are part of the NSP priorities for access to prevention and treatment services including awareness raising and VCT/PMTCT.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?: No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?: No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?: Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:: The work of CSOs targeting KPs with prevention, treatment and support services is included in the NSP and aims to ensure access to these populations. However coverage is still low.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?: No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations::

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?: No

IF YES, briefly describe the content of the policy or law::

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work: Yes

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: No

IF YES on any of the above questions, describe some examples:: The only institution monitoring human rights on the national level is the National Human Rights Council, but the council does not consider HIV in its work.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?: Yes

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work?: Yes

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework: Yes

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?: Yes

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: No

Other [write in]:: Universities: for example protocol of cooperation between UNAIDS and Kasr El-Ainy School of Medicine

: Yes

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 3

Since 2011, what have been key achievements in this area:: There has been no change in the laws or policies to protect human rights in relation to HIV since 2011, but the role of CSOs and human rights groups in providing HIV-related legal services and advocating for better implementation of existing laws has been strengthened

What challenges remain in this area:: There needs to be an explicit mention and bigger focus on human rights in the HIV National Strategic Framework. CSOs and human rights groups who are in a position to advocate for HIV-related rights are still lacking sufficient financial support and technical capacity to produce any significant change. There needs to be better communication between such groups and the NAP to be able to identify areas for policy and legal reform across the various relevant governmental sectors. For example, stronger policies or laws protecting medical confidentiality, informed consent, and right to treatment within the medical sector, policies prohibiting the media from publishing confidential medical information, and integrating human rights into medical and general curricula, etc...

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 3

Since 2011, what have been key achievements in this area:: The key achievement since 2011 has been an increase in the number of CSOs providing legal services/aid to PLHIV and KP and advocating for the implementation and reform of existing laws. This was made possible through the support of the International Development Law Organization (IDLO) to HIV-related legal projects in Egypt. CSO-led projects to fight stigma and discrimination are also becoming stronger. A project led by Caritas in Upper Egypt has started in 2013 to fight stigma and discrimination and includes 2 PLHIV on each team. This is an improvement since 2011 when the NAP was more reluctant to support civil society work on these issues. More light is being shed on human rights issues relevant to HIV/AIDS and to the stigma surrounding it. The release of the movie "Asmaa" addressing the societal stigma and discrimination against a woman living with HIV has brought the matter to public attention. That, along with an increased general interest and debate on human rights could be seen as opportunity to intensify efforts to strengthen rights of PLHIV. A stigma research based on the stigma index methodology was commissioned by UNAIDS and UNICEF and implemented by ESPSRH and have developed a comprehensive evidence base for PLHIV perceived stigma in Egypt. Sustaining the waiving of HIV mandatory testing for refugees and persons of concern while supporting VCCT services and access to prevention and treatment services including life saving ARVs for refugees, remain a key achievement not least being sustained through a period of political transition and instability since 2011

What challenges remain in this area:: Since 2011 Egypt has been going through a transitional period that saw the changing of the constitution twice, 6 successive governments and no parliament. The environment is not enabling for the protection and promotion of human rights in general and HIV related issues specifically. The media is highly engaged in covering social uprisings and the political turmoil and there is little focus on HIV/AIDS or raising awareness to fight stigma and discrimination. More effort is needed to ensure that prevention and care services are not themselves stigmatizing. (For example, condoms provided at the government treatment centres are characterized by the AIDS ribbon. PLHIV have to enter HIV-specific treatment wards at the fever hospitals) In the absence of strong national human rights mechanism, the role of CSOs and human rights groups advocating for HIV-related rights needs to be further strengthened.

B.IV Prevention

1. Has the country identified the specific needs for HIV prevention programmes?: Yes

IF YES, how were these specific needs determined?: Priority areas and specific needs for prevention were identified in the 2012-2016 National Strategic Framework, which was guided by the HIV/AIDS Situation, Response and Gap Analysis (2010) and by the 2010 Biological and Behavioural Surveillance Survey (BBSS) which was done in partnership with FHI360 and the Center for Development Services (CDS).

IF YES, what are these specific needs? : Increased coverage of prevention interventions for KPs (SWs, PWID, and MSM). This includes expanding geographical coverage. In addition to increased coverage of prevention interventions for vulnerable populations and for the general population.

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Strongly agree

Condom promotion: Disagree

Harm reduction for people who inject drugs: Disagree

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Disagree

HIV testing and counseling: Agree

IEC on risk reduction: Disagree

IEC on stigma and discrimination reduction: Disagree

Prevention of mother-to-child transmission of HIV: Agree

Prevention for people living with HIV: Disagree

Reproductive health services including sexually transmitted infections prevention and treatment: Disagree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Disagree

School-based HIV education for young people: Strongly disagree

Universal precautions in health care settings: Disagree

Other [write in]::

:

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 5

Since 2011, what have been key achievements in this area:: Increased participation of civil society in HIV prevention activities and care of PLWA has been the most significant achievement in this area. There is a strengthened role of civil society in the provision of outreach prevention and harm reduction services to KPs and to raising awareness around HIV/AIDS, which has been further strengthened and supported by the establishment of NAHR. Furthermore, a UNAIDS project targeting MSM, funded by drosos foundation has been initiated in 2013, with a large upscale of services, and geographical expansion to cover an additional governorate (Gharbya). The Ministry of Health is now following the revised WHO guidelines to prevent mother to

child transmission (PMTCT) and all pregnant mothers living with HIV now receive ART at the onset of pregnancy. The NAP has continued to engage in awareness raising programs in cooperation with CSOs. For example, in 2013 an awareness raising program was implemented in all high schools in Al-Menia city The NAP has also shown a greater commitment to targeted prevention programs implemented by civil society.

What challenges remain in this area:: Coverage of harm reduction and prevention among most at risk populations is still low. Only a small number of CSOs have the capacity to reach out to KPs compared to the actual need. There is no systematic evaluation of the effectiveness and efficiency of the various existing models to reach KPs. Some vulnerable groups are not receiving enough attention such as prisoners and street children. This is further compounded by the current political context. For example, the project initiated by UNODC in collaboration with the Egyptian government to provide HIV testing, prevention, treatment and care inside a number of Egyptian prisons was discontinued shortly after it started in 2010 due to the political unrest that came with the 2011 revolution. Stigma and discrimination are still the greatest barriers to the implementation of effective prevention services and need to be addressed and integrated in the national strategy. A result of stigma and discrimination is that prevention services that are offered by the Ministry of Health are under-utilized. This is also due to the weakened focus on raising public awareness or promoting for VCT. The number of calls received by the HIV hotline and the number of people seeking VCT at government centres has declined dramatically since 2011. HIV prevention, treatment and care is not integrated into the health system and coordination between the NAP and other departments within the Ministry of Health is weak. For example, with the exception of PMTCT for women living with HIV, there has been much less attention given to provider initiated counselling and testing (PICT) in ante-natal clinics under the Maternal and Child Health (MCH) program. HIV testing is provided to some TB patients but no TB prevention or testing for PLHIV. Better coordination is needed between CSOs and the NAP as well as developing a mechanism to document best-practices and review national strategies

B.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

IF YES, Briefly identify the elements and what has been prioritized:: The elements identified in the NSP include an increase in the current access to ART to all patients in need based on new guidelines (people with CD4 below 500) and improving treatment adherence, strengthening medical care at the local level through several dispensing sites, strengthening ART management capacity and drug resistance monitoring, strengthening integrated services for including management of OI, and strengthening psychosocial support services and home based care services for PLHIV

Briefly identify how HIV treatment, care and support services are being scaled-up?: The NAP has worked with technical partners to develop the new National Clinical Care Guidelines which will be available in 2014. There has been an improvement in the availability of CD4 and viral load testing as well as ensuring there are no treatment delays. A comprehensive package for PWID with 9 key interventions of which 7 are currently being implemented on the ground (except for TB and OST) these are provided by CSOs but however the scale is still small.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…:

Antiretroviral therapy: Agree

ART for TB patients: Disagree

Cotrimoxazole prophylaxis in people living with HIV: Disagree

Early infant diagnosis: Agree

HIV care and support in the workplace (including alternative working arrangements): Strongly disagree

HIV testing and counselling for people with TB: Agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Disagree

Nutritional care: Disagree

Paediatric AIDS treatment: Disagree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly disagree

Post-exposure prophylaxis for occupational exposures to HIV: Disagree

Psychosocial support for people living with HIV and their families: Disagree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Disagree

TB preventive therapy for people living with HIV: Disagree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Disagree

Other [write in]::

:

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 4

Since 2011, what have been key achievements in this area:: New National Clinical Care guidelines have been developed but are yet to be implemented. The availability of viral load and CD4 testing as well as the availability of ARTs. More CSOs engaged in the provision of care and support to PLHIV. An increased effort by civil society, supported by the IDLO to address legal issues relevant to access to medicine.

What challenges remain in this area:: Despite improvements in availability of testing and treatment to PLHIV, the achievement of a comprehensive package of treatment and care is still lacking (for example home based care and psychological care) PLHIV receiving treatment do not receive literacy on dosage and coping with the treatment, which results in non-adherence and there is no follow-up on people who drop out of treatment. Doctors need to be better trained to provide those receiving treatment with proper instructions and care, including instructions on new medication. Resistance testing is still not offered to people receiving treatment. The Central Labs within the Ministry of Health have requested training of their personnel to perform the resistance testing. Treatment and care is still relatively centralized. More effort is needed to integrate HIV treatment and care within the health system and to involve CSOs as well as mainstreaming refugees in the national response. Sustainability of treatment and care is a challenge in the event the Global Fund support may not be available Political instability and the rapid change of governments compromises the political commitment to HIV.

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 4

Since 2011, what have been key achievements in this area:: New National Clinical Care guidelines have been developed but are yet to be implemented. The availability of viral load and CD4 testing as well as the availability of ARTs. More CSOs engaged in the provision of care and support to PLHIV. An increased effort by civil society, supported by the IDLO to address legal issues relevant to access to medicine.

What challenges remain in this area:: Despite improvements in availability of testing and treatment to PLHIV, the achievement of a comprehensive package of treatment and care is still lacking (for example home based care and psychological care) PLHIV receiving treatment do not receive literacy on dosage and coping with the treatment, which results in non-adherence and there is no follow-up on people who drop out of treatment. Doctors need to be better trained to provide those receiving treatment with proper instructions and care, including instructions on new medication. Resistance testing is still not offered to people receiving treatment. The Central Labs within the Ministry of Health have requested training of their personnel to perform the resistance testing. Treatment and care is still relatively centralized. More effort is needed to integrate HIV treatment and care within the health system and to involve CSOs as well as mainstreaming refugees in the national response. Sustainability of treatment and care is a challenge in the event the Global Fund support may not be available Political instability and the rapid change of governments compromises the political commitment to HIV.