



Global AIDS Response Progress Report

Egypt

2014

Table of Contents

Status at a glance	1
Overview of the AIDS epidemic	12
National AIDS Response to the AIDS Epidemic	19
Best Practices	30
Major Challenges and Remedial Actions	35
Support from the country's development partners	38
Monitoring and Evaluation Environment.....	39

Global AIDS Response and Progress Report 2014

Egypt

I. Status at a Glance:

The Government of Egypt (GOE) has demonstrated a continued commitment to combating the HIV and AIDS epidemic since the first case was detected in Egypt in 1986. Egypt's national response is guided by global priorities in the fight against HIV and AIDS and aligned with the Millennium Development Goals and the 2011 Political Declaration on AIDS High level meeting 2011 globally set targets.

The Ministry of Health and Population (MoHP) compiled the 2013 Global AIDS Response Progress Report (GARPR) with technical assistance and input from stakeholders, including relevant GOE agencies, civil society organizations (CSOs), UNAIDS and other UN agencies, and donor agencies. A detailed account of the reporting process and the NCPI documents can be found in the Annexes.

Since 1986, the GOE has demonstrated a strong commitment to combating the spread of the virus. In partnership with domestic and international organizations, the GOE has improved HIV and AIDS surveillance and detection and increased awareness of the virus among Egyptians. Today, we stand at a cross road where we recognize the need for enhancing and developing the national HIV response. The GOE recently demonstrated a renewed commitment to the fight against HIV/AIDS through the restructuring of the National AIDS Program toward a more inclusive National response to the epidemic.

While Egypt's general population has a low HIV prevalence rate of less than 0.02%¹, there are demographic groups with markedly higher prevalence rates. The prevalence of HIV among these groups represents a major development concern for Egypt. People living with HIV in Egypt were estimated to be 6,500 in 2013² which remains low, however 2013 witnessed a surge in number of confirmed cases, that were almost double the cases confirmed in previous year.

In 2010, the MoHP, FHI360, and Center for Development Services (CDS) conducted the most recent round of the Bio-Behavioral Surveillance Survey (Bio-BSS). The Bio-BSS 2010 indicated that there is a concentrated epidemic among men who have sex with men (MSM) and male people who inject drugs (PWID). The HIV prevalence is 5.4% among MSM in Cairo and 6.9% among MSM in Alexandria. Among male PWID the prevalence is 7.7% in Cairo and 6.7% in Alexandria.³ This Bio-BSS 2010 data confirmed the high concentration of HIV infection in these populations that was detected in the first round of the Bio-BSS in 2006.⁴ The 2010 data also identified HIV positive cases among street children.⁵

¹ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

² Estimation projection, World AIDS report 2013, UNAIDS

³ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

⁴ Biological & Behavioral Surveillance Survey 2006, MoHP/FHI/CDS

⁵ Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS,

There is a high risk of spreading the virus from these demographic groups to the general population. MSM and PWID are connected to the general population through marriage and both commercial and non-commercial sexual activity. These groups also demonstrate high-risk behaviors, such as low rates of condom use and use of contaminated injecting equipment.⁶

To combat the spread of HIV in Egypt, the GOE established The National AIDS Program (NAP) in 1987.⁷ The NAP leads the national response to the HIV and AIDS epidemic in Egypt. The NAP is currently implementing the five-year National Strategic Plan (NSP) for 2012-2016. The NSP has three primary goals: stabilize the growth of the AIDS epidemic in Egypt; prevent new infections in key populations (including MSM, FSWs, and PWID); and improve overall health outcomes for People Living with HIV (PLHIV).⁸

The NAP collaborates with several international organizations as well as CSOs on issues related to HIV. The majority of the collaboration related to HIV seeks to promote raising awareness about the disease and prevention among target populations. Other areas of collaboration focus on provision of Antiretroviral (ARV) treatment, care and support for PLHIV.⁹ As well as service provision, NAP ensures elimination of stigma and discrimination, strengthening strategic information and governance.

The World Bank estimates that Egypt receives approximately USD 4,150,000 in HIV - related assistance from external sources annually. The World Bank also reports that in 2008 a total of USD 7,593,000 from domestic and international sources was spent on HIV response in Egypt.¹⁰ According to Egypt's National AIDS Spending Assessment (NASA) 50% of AIDS resources in 2008 were from government sources. The other half of resources came from multilateral international agencies, 31%, international NGOs, 14%, and direct bilateral contributions, 4%.¹¹ The NASA report published in 2011 contains data on AIDS spending from 2007 and 2008. This represents the most recent data available on AIDS spending in Egypt and is a clear gap in the availability of strategic information for financing the HIV/AIDS response in Egypt.

The largest international donor for HIV in Egypt is the Global Fund on HIV, TB and Malaria (GFATM). GFATM transitional funding mechanism to finance Egypt's national response was secured in 2012 to span between 2013 and 2015, however GFATM has suspended grant implementation since July 2013, due to observed shortcomings in implementation. In response to this, Egypt's MoHP has conducted internal reviews and restructuring, with support from UNAIDS, to address these gaps and efforts continue to

⁶ HIV/AIDS Situation, Response and Gap Analysis, Ministry of Health, Arab Republic of Egypt

⁷ The NAP is located within the Preventative Affairs and Endemic Diseases Sector, in the Communicable Disease Control (CDC) Unit of MoHP.

⁸ Egypt- HIV/AIDS Strategic Framework 2012-2016, MoHP

⁹ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

¹⁰ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt ;National AIDS Spending Assessment in Egypt 2010

¹¹ National AIDS Spending Assessment In the Arab Republic of Egypt 2011,

enhance the programme quality and to prepare Egypt’s National AIDS Program to receive the GFATM new funding model grant. Other major international donors include UN agencies, bilateral organizations, such as USAID and the Italian cooperation, and private not-for-profit organizations, such as the Ford Foundation and Drosos.¹²

The following table summarizes GARPR updates and other national indicators. Further details can be found in the body of this report.

Targets	Indicators										
<p>Target 1. Reduce sexual transmission of HIV by 50% by 2015 <i>General population</i></p>	1.1	<p>Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission* (source of data DHS2008)</p> <table border="1" data-bbox="748 831 1351 1024"> <thead> <tr> <th data-bbox="748 831 948 894">Age Group</th> <th data-bbox="948 831 1148 894">Females</th> <th data-bbox="1148 831 1351 894">Males</th> </tr> </thead> <tbody> <tr> <td data-bbox="748 894 948 957">15-19</td> <td data-bbox="948 894 1148 957">3.1%</td> <td data-bbox="1148 894 1351 957">16.0%</td> </tr> <tr> <td data-bbox="748 957 948 1020">20-24</td> <td data-bbox="948 957 1148 1020">6.4%</td> <td data-bbox="1148 957 1351 1020">21.2%</td> </tr> </tbody> </table>	Age Group	Females	Males	15-19	3.1%	16.0%	20-24	6.4%	21.2%
	Age Group	Females	Males								
	15-19	3.1%	16.0%								
	20-24	6.4%	21.2%								
1.2	<p>Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15</p> <p>NOT IDENTIFIED</p>										
1.3	<p>Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months</p> <p>NOT IDENTIFIED</p>										
1.4	<p>Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*</p>										

¹² HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

		NOT IDENTIFIED
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results Number of 15-49 who know their results Number of 15-49 who were tested 5813/5870= 99% (VCT Data 2013 MoHP)
	1.6	Percentage of young people aged 15-24 who are living with HIV* Numerator: number of 15-24 positive Denominator: Number of 15-24 tested 507/3733=13.5% (VCT data 2013 MoHP)
<i>Sex workers</i>	1.7	Percentage of sex workers reached with HIV prevention programs 49.04% with condoms (Source of data El-Shehab CSO)
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client 10% (Source of Data Elshehab CSO) FSWs commercial sex 50/200 = 25% (BBSS 2010) FSWs non-commercial sex 8/73= 10.96% (BBSS 2010) MSM commercial anal sex 72/414=17.39% (BBSS 2010)
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results 100% all 137 FSW who received HIV test knew their results (Source of Data Elshehab CSO)

		2/178 = 1.12% (BBSS 2010)
	1.10	Percentage of sex workers who are living with HIV HIV positive cases among FSW Total number of FSW tested in 2013 VCT data 0/200 =0% (BBSS 2010) 0/137=0% (El-Shehab) 1/188= 0.53% (VCT data MoHP 2013)
<i>Men who have sex with men</i>	1.11	Percentage of men who have sex with men reached with HIV prevention programs Numerator: MSM reached with prevention Denominator: MSM reached by the survey 448/594 = 75.5% (BBSS 2010)
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner MSM non commercial anal sex 97/478= 20.29% (BBSS 2010) Geographical disaggregation 56/197= 28.42% (Cairo-BBSS 2010) 32/220= 14.54% (Alex-BBSS 2010) 9/61= 14.75% (Luxor-BBSS 2010) 319/541=59% (Denominator is the total number outreached) (Source of data MSM Project UNAIDS)
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

		67/ 118 = 56.8% (BBSS 2010)
	1.14	<p>Percentage of men who have sex with men who are living with HIV</p> <p>From VCT</p> <p>Cairo = 5.4% (Pop. Estimate = 5.7%)</p> <p>Alex = 6.9% (Pop. Estimate= 5.9%)</p> <p>Luxor = 0.0% (Pop. Estimate= 0.0%)</p> <p>14/625=2.24% (VCT MoHP 2013)</p>
<p>Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015</p>	2.1	<p>Number of syringes distributed per person who injects drugs per year by needle and syringe programs</p> <p>Numerator: No. of syringes distributed by FHI organizations is 892/666= 1.34 per PWID</p>
	2.2	<p>Percentage of people who inject drugs who report the use of a condom at last sexual intercourse</p> <p>37/666 = 5.5% (FHI 360)</p> <p>Regular sexual partner</p> <p>17/357= 4.76% (BBSS 2010)</p> <p>Geographical disaggregation</p> <p>9/175= 5,14% (Cairo-BBSS 2010)</p> <p>Commercial sexual partner</p> <p>15/61= 24.59% (BBSS 2010)</p> <p>Geographical disaggregation</p> <p>7/29= 24,13% (Cairo-BBSS 2010)</p> <p>8/32= 25% (Alex-BBSS 2010)</p> <p>Non regular non commercial</p>

		<p>22/154= 14.28% (BBSS 2010)</p> <p>Geographical disaggregation</p> <p>7/61= 11,47% (Cairo-BBSS 2010)</p> <p>15/93= 16,13% (Alex-BBSS 2010)</p>
	2.3	<p>Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected</p> <p>303/666=45.5%</p>
	2.4	<p>Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results</p> <p>36/43= 83.7% (FHI 360)</p> <p>27/66= 40.9% (BBSS 2010- % of PWID who ever tested for HIV and know their result)</p>
	2.5	<p>Percentage of people who inject drugs who are living with HIV</p> <p>13/863=1.5% (VCT data MoHP 2013)</p> <p>Cairo = 7.7% (Pop. Estimate= 6.8%) BBSS 2010</p> <p>Alex = 6.7% (Pop. Estimate= 6.5%)</p> <p>BBSS 2010</p> <p>15/666= 2.25% (FHI 360)</p>
<p>Target 3. Eliminate new HIV infections among children by 2015 and</p>	3.1	<p>Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission</p>

substantially reduce AIDS-related maternal deaths**		15.15%
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding 0 % Rationale: National guidelines indicate strictly artificial feeding following delivery for women living with HIV.
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth 100%
	3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months $41/125 = 32.8\%$
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4.1	Percentage of adults and children currently receiving antiretroviral therapy* Number of PLHIV adults and children receiving ART $1171/6500 = 18.02\%$
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy Number on ART for 12 months= 490 Number receiving=670

		73.13%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV No available data
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources No available data
Target 7. Eliminating gender inequalities	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months <i>All indicators with sex-disaggregated data can be used to measure progress towards target 7</i>
Target 8. Eliminating stigma and discrimination	8.1	Discriminatory attitudes towards people living with HIV 86.8% of women aged 15-49 would not buy vegetables from a person who have HIV (DHS 2008) 80.7% of men aged 15-49 would not buy vegetables from a person who have HIV (DHS 2008)
Target 9. Eliminate travel restrictions		<i>Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed</i>
Target 10. Strengthening HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10–14*

	10.2	Proportion of the poorest households who received external economic support in the last 3 months
Policy questions (relevant for all 10 targets)		National Commitments and Policy Instruments (NCPI)
<p>* Millennium Development Goals indicator</p> <p>** The <i>Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive</i> defines this target as:</p> <ol style="list-style-type: none"> 1. Reduce the number of new HIV infections among children by 90% 2. Reduce the number of AIDS-related maternal deaths by 50% <p>For further information see:</p> <p>http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf</p>		

II. Overview of the AIDS Epidemic

The low prevalence of below 0.02% for HIV among Egypt's general population masks the relatively high prevalence among certain high-risk groups, such as MSM and PWID. The high prevalence among these represents a major development concern for Egypt.¹³

The Bio-BSS 2010 revealed a total of 6,228 cumulative cases of HIV in Egypt by end of December 2013, with 5,108 and 1,120 cases detected among Egyptian nationals and foreigners, respectively. Out of the cumulative cases by the end of 2013 3,733 Egyptians are currently known to be living with HIV/AIDS. Among that number, 1,171 PLHIV are receiving ARV treatment.¹⁴

The extensive information collected by the 2010 survey reinforced the findings of the 2006 Bio-BSS.¹⁵ The Bio-BSS 2010 indicated that there is a concentrated epidemic among specific groups including MSM and male PWID. The Bio-BSS 2010 also identified that there was increased risk among street children. The survey revealed that while street children currently had a low HIV prevalence rate of 0.5%, they exhibited high-risk activities that made them vulnerable to the spread of HIV. These behaviors include injecting drug use and relatively high rates of unsafe sexual activity. For example, 46.5% of male street children reported being sexually active. Of the female street children who responded, 16% admitted to being sexually active. These high-risk behaviors combined with relatively low levels of awareness about HIV suggest that street children are vulnerable to the spread of the HIV.

The first case of HIV in Egypt was detected 1986. The data show that the number of detected cases of the virus has increased regularly since then. Between 2001 and 2005, 1,040 HIV cases were detected. Between 2006 and 2009, there were 1,663¹⁶ cases were detected. The increase in detected cases could be explained, at least in part, by increased and improved surveillance, testing and reporting methods led by the NAP.

In 2010, the MoHP reported that 66.8% of HIV transmissions occurred through sexual activity. Among those whose transmission occurred through sexual activity, 46.2% of transmissions took place through heterosexual activity. Homosexual activity was responsible for 20.6% of transmissions. Transmission via injecting drug use represents approximately 28.3% of detected cases. Detected cases in children represented 4.9% of transmissions, possibly due to mother to child transmission.¹⁷

In 2009, the NAP chaired a monitoring and evaluation reference group (MERG). The group was comprised of members that represented civil society, academia, technical partners and UN agencies. The group worked to unify data collection tools and establish a national M&E system. Unfortunately, limited resources and increasing political

¹³ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

¹⁴ UN Best Practices: HIV/AIDS activities in Egypt, UNAIDS 2014 (under publication)

¹⁵ Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS

¹⁶ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

¹⁷ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

instability caused progress to come to a halt. The MERG was not active in 2013.¹⁸

Men who have Sex with Men (MSM)

The Bio-BSS 2010 suggests that MSM have an increased vulnerability to HIV. The Bio-BSS 2010 surveyed MSM in Cairo, Alexandria, and Luxor. The data show that the MSM who were surveyed have a higher prevalence than the general population. The data also show that surveyed MSM exhibit high-risk behaviors such as both commercial and non-commercial sexual activity and low rates of condom use.

Intake surveys, performed at the time of enrollment in to one of the UNAIDS MSM programs in Cairo or Alexandria, indicate that the baseline knowledge of HIV/AIDS transmission was relatively higher among MSM than the general population.¹⁹ However, the level of knowledge regarding the transmission and prevention of HIV/AIDS was still low. Of participants in the MSM projects surveyed at intake, only 8% knew that HIV/AIDS could be transmitted from mother to child. Higher proportions of respondents knew that it could be transmitted through unprotected sex, 66%, and infected blood, 52%. Respondents were less familiar with means of prevention. When asked about how to prevent HIV/AIDS transmission, only 45.2% cited condoms as a means of prevention and 35% did not know any means of preventing transmission.²⁰

Of MSM surveyed in the Bio-BSS 2010, 15.6% of respondents in Cairo reported using a condom during non-commercial sex in the 6 months preceding the survey compared with 6.7% of Alexandria respondents and 19.4% of Luxor respondents. However, 51%, 34.4% and 22.0% of the same groups respectively reported using condoms during commercial sex in the 6 months preceding the survey. The significance of these high-risk behaviors is demonstrated by data from a 2010 gap analysis of Egyptian MSM conducted by the MoHP. That study revealed that 24.0% of MSM studied had one or more sexually transmitted infections (STIs) within the 3 months prior to the survey.²¹

Moreover, MSM pose a risk of spreading the HIV virus to the general population through commercial and non-commercial sex. Of respondents from the MSM demographic in Cairo, 39.8% reported ever having sexual relations with women. The percentage of MSM in Alexandria who reported the same was 59.2%. In Luxor, 86.5% of MSM respondents reported ever having sexual relations with women. Of MSM in Cairo, 10.4% reported ever being married to a woman. In Alexandria, 16.2% of MSM surveyed reported ever being married to a woman. The percentage of MSM in Luxor who reported ever being married to a woman in Luxor was 16.5%. In addition to increasing the risk of HIV transmission to the general population, these activities increase women's vulnerability to contracting the virus through conjugal heterosexual relations.

¹⁸ National Commitments and Policy Instrument part B, 2014

¹⁹HIV Risk -Reduction among Vulnerable Men in Egypt, UNAIDS.

²⁰ HIV Risk -Reduction among Vulnerable Men in Egypt, UNAIDS.

²¹ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt; Abdel Sattar et al. 2002

People Who Inject Drugs (PWID)

The Bio-BSS 2010 reported several important risk factors for male PWID. First, a high percentage of male PWID respondents reported being away from home for an extended period of time in the 12 months prior to the survey. Specifically, 22.1% of male PWID in Cairo and 46.0% of the same in Alexandria,²² reported having spent at least one month away from home in the year before the survey. Second, respondents from the same group reported low condom use. Only 3% of respondents reported condom use with non-regular, non-commercial sex partners. Third, respondents in Cairo and Alexandria reported frequent commercial sexual activity. Specifically, 13.1% of PWID respondents in Cairo and 10.8% in Alexandria reported exchanging sex for money.

PWID respondents also indicated high rates of risky drug use behaviors. Of those surveyed in Cairo, 30.7% reported injecting drug use with needles and 22.9% reported using contaminated injecting equipment with at least one person within the 30 days prior to the survey. In Alexandria, 79.8% of PWID respondents reported injecting drug use and 40.5% reported using contaminated injecting equipment with at least one person within the 30 days prior to the survey.

The high rate of mobility of PWID when coupled with their high rates of risky sex and drug use behaviors increases the risk of transmission to the general population, including the spouses of PWID. Among PWID surveyed in Cairo, 56.4% reported ever being married and 48.7% reported being married at the time of the survey. In Alexandria, 34% reported ever being married and 29.3% reported being married at the time of the survey.

Street Children

The Bio-BSS 2010 surveyed 200 male and 200 female street children in Cairo. Data from the survey indicate a low prevalence rate of 0.5% among street children.²³ However, several factors make them a high-risk group for HIV.

First, while most street children questioned in a behavioral survey of street children in greater Cairo and Alexandria²⁴ had heard of HIV/AIDS, a much lower percentage could correctly identify means of transmission. When asked about the transmission of HIV/AIDS 59% of respondents mentioned heterosexual relations, 21% mentioned homosexual relations and 21% cited contaminated blood as a source of transmission. Additionally, only 41% of respondents knew that a healthy looking person could have HIV/AIDS.²⁵ Such a low level of knowledge regarding the transmission of HIV/AIDS increases street children's vulnerability to contracting the disease.

²² Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS

²³ Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS

²⁴ Behavioral Survey among Street Children in Greater Cairo and Alexandria, Population Council, 2008

²⁵ Behavioral Survey among Street Children in Greater Cairo and Alexandria, Population Council, 2008

Second, high rates of sexual activity were reported. Of the boys surveyed, 46.5% reported as being sexually active. Of the girls surveyed, 16.0% of girls reported ever having sex. While 7.7% of sexually active boys reported selling sex for money, 50.0%, of sexually active girls reported having sold sex for money. Condom use during both commercial and non-commercial sex was almost nonexistent.

Third, street children are targets for sexual abuse. Of those surveyed, 30.0% of sexually active girls and 11.5% of sexually active boys reported being forced to have sex with a partner in the past 12 months.²⁶

Fourth, street children also demonstrated other non-sexual, high-risk behaviors, such as injecting drug use and low rates of HIV testing and counseling. Among street children, 7.0% of boys and 2.0% of girls reported injecting drugs within the preceding 12 months. Very few respondents were aware of confidential testing and counseling services and of those who were aware only 5.8% of boys and 5.3 percent of girls were ever tested. Only 1 boy reported being tested for HIV within the 12 months preceding the survey.

Female Sex Workers (FSWs)

The Bio-BSS 2010 indicates that FSWs exhibit risk behaviors that make them a high-risk group for the transmission of HIV. Of the total number of FSW respondents, only 25.0% reported condom use at last commercial sex and 41.0% reported condom use at least once in 30 days prior to the survey. FSWs also reported a low rate of condom use with non-commercial sex partners. Of those surveyed, 27.4% of respondents reported using a condom with a non-commercial sex partner in the 12 months preceding the survey. Only 3.4% reported ever being tested for the virus. Low rates of condom use combined with low utilization of testing and counseling, put FSWs at high exposure to HIV.

FSWs are connected to the general population through both non-commercial and commercial sex activity and marriage. Of respondents, 89.0% reported ever being married and 45.5% reported that they are currently married. High-risk behaviors such as low condom use put FSWs and their partners, both commercial and non-commercial at an increased risk of HIV transmission.

Awareness of HIV among FSWs is relatively high. Many respondents, 89.0%, had heard of HIV and more than 50.0% stated at least one correct mode of transmission and means of prevention. However, important misconceptions were also common. When asked if a healthy person could be infected with HIV, 56.2% replied “no”. Many also stated that HIV can be spread by sharing a meal with a person who is living with HIV or by being bitten by the same mosquito as a person who is HIV positive.²⁷

²⁶ Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS

²⁷ Biological & Behavioral Surveillance Survey 2010, MoHP/FHI360/CDS

In 2012, UNAIDS commissioned a cost benefit study of four prevention programs.²⁸ The report indicated that FSWs are unique in the way that they behave as beneficiaries when compared to those of the other beneficiary groups, in this case MSM and PWID. The factor that most attracted FSWs to a program was the availability of legal services while other groups were more attracted to free products, such as condoms. They also utilized professional services at a much higher rate, about 20 times that of MSM, than the other groups. The cost benefit study concluded that, among the groups studied, FSWs were the least cost effective, as compared to MSM and PWID groups.²⁹ These results provide an important resource for future planning of HIV/AIDS prevention programming for FSWs.

Youth

Young people have often been drivers for change. This was evident during the waves of uprising hitting Egypt early in 2011. Young people have played a key role in putting in motion drastic changes over the past three years. Egypt is considered a relatively “young” nation with young people estimated to comprise almost 39% of Egypt’s population.

The Survey of Young People in Egypt (SYPE) 2010 builds upon the Adolescence and Social Change in Egypt (ASCE) survey conducted in 1997 and covers a nationally representative sample of 15,029 young people aged 10-29.³⁰

The Egyptian population has a large proportion of young people relative to other age groups. Based on data collected in the SYPE 2010, 62% of the Egyptian population is 29 or younger and 39.4% of the population is aged 10-29.³¹ Youth are considered to be more vulnerable to HIV than other age categories due to the fact that youth are more exposed to a combination of risk factors and risky behaviors, while comprehensive knowledge among this age group remains low (DHS2008)

The SYPE 2010 revealed that a high percentage of respondents aged 15-29 had some knowledge of HIV and sexually transmitted infections (STIs). Among respondents 71.5% had heard of HIV. Respondents also demonstrated some understanding of means of transmission, 82.4% knew that HIV can be transmitted sexually and 62.9% knew that HIV can be transmitted through contaminated blood. However, only 20.3% knew that HIV can be transmitted through using contaminated injecting equipment and 10.3% knew that it can be transmitted from mother to child. Though knowledge of one or more correct mode of transmission was high it is important to note that only 3.0% of respondents correctly identified all four possible modes of transmission, which suggests that overall knowledge of HIV transmission is still low.

Data from the SYPE 2010 indicates that stigma against PLHIV is high among youth. Of respondents aged 15-29, only 21.9% responded that they would be willing to interact

²⁸ The Costs and Benefits of HIV and AIDS Prevention Programs in Egypt, Gary L. Gaumer, Ph.D 2012

²⁹ The Costs and Benefits of HIV and AIDS Prevention Programs in Egypt, Gary L. Gaumer, Ph.D

³⁰ Survey of Young People in Egypt, Population Council, 2011

³¹ Survey of Young People in Egypt, Population Council, 2011

with someone who is HIV positive. The percentage was higher among those with a university degree, although only 33.0% of degree holders responded that they would shake hands or ride in a car with someone who is HIV positive.³²

Stigma and HIV/AIDS

In 2011, The Egyptian Society for Population Studies and Reproductive Health (ESPSRH) published a report on stigma against HIV and PLHIV in Egypt.³³ ESPSRH studied the understanding of and attitudes toward HIV and PLHIV of three groups: local community members; informal and formal community leaders; and healthcare providers. The report found that stigma against HIV, PLHIV, and members of at-risk populations presents a high barrier to preventing HIV and caring for PLHIV in Egypt. This finding affirmed the theory that long-term success in combating the HIV epidemic in Egypt must include programming in the area of stigma against the disease and those who are living with it, in addition to targeting the immediate medical needs of PLHIV.

The data revealed three common characteristics across the community members and the community leaders groups. First, respondents did not support quarantining PLHIV or denying social rights. Second, respondents expressed fear of casual contact with PLHIV and distance themselves socially from PLHIV, such as demonstrating hesitance to interact with PLHIV at home, neighborhoods and workplaces. Third, religious beliefs reinforced stigma against HIV and PLHIV, such as the belief that HIV is a punishment from God or that HIV was associated with deviant and immoral behaviors and promiscuous sexual relations.

On this third characteristic, the data from the community members and community leaders was particularly informative. Of the community members interviewed, 53.82% of men and 46.92% of women said that HIV is a sexually transmitted disease that is spread through improper sexual relations and by MSM. The responses from local community members did not vary according to marital status or educational level and reinforced the first common characteristic. The community leaders group was comprised of professionals such as school principals, religious leaders, village heads, and NGO directors. Despite their education, familiarity with the disease in Egypt and, in some cases experience with providing services to PLHIV under the NAP, many from the community leaders group identified immoral sexual relations and lack of religious commitment and to low moral standards as a cause for the spread of HIV.³⁴

Data collected from trained and untrained healthcare providers revealed that there is a strong need for education targeted at trained and untrained healthcare providers about

³² Survey of Young People in Egypt, Population Council 2011

³³ The Impact of AIDS-Related Stigma on Attitudes, Behavior, and Practices towards People Living with HIV and AIDS in Egypt; The Egyptian Society for Populations Studies and Reproductive Health, Professor Hind AbdouSeoud Khattab 2011.

³⁴ The Impact of AIDS-Related Stigma on Attitudes, Behavior, and Practices towards People Living with HIV and AIDS in Egypt; The Egyptian Society for Populations Studies and Reproductive Health, Professor Hind AbdouSeoud Khattab 2011.

HIV. While untrained medical providers did not recognize HIV as a disease present in Egypt, only a minority of trained doctors and nurses recognized HIV as a disease present in Egypt.³⁵ However, both trained and untrained healthcare providers expressed a general willingness to provide treatment, care and support to PLHIV. The study results highlighted the effectiveness of training and the importance of repeating training to avoid forgetting the information due to lack of practice. Discussions revealed desire among healthcare providers to learn more about HIV transmission, symptoms, diagnosis, lab tests, ART availability and VCT services. An increased interest was also noted among healthcare providers to comment on all contexts of AIDS-related discrimination, the religious rules concerning treatment of PLHIV, and the duties of the family members and spouses of an HIV-positive individual from the religious perspective.

In 2013, the ESPSRH published another study on stigma titled “Stigma experienced by people living with HIV in Egypt”.³⁶ The study focused on the experience of PLHIV in Egypt. The results of the study results showed that a high rate of PLHIV surveyed had not disclosed their HIV status and had, therefore, experienced relatively low rates of external discrimination such as being excluded from social gatherings or negative treatment from healthcare providers. Despite that many respondents had not experienced external stigma and discrimination directly, many expressed hesitation to visit health clinics or disclose their HIV status to friends and family out of fear of being treated poorly or denied health services.

Respondents indicated much higher rates of internal discrimination such as feelings of shame or guilt. The results of the study indicated a marked difference in the internal stigma feelings reported according to gender. For example, male respondents reported high rates of feeling shame, 50.4%, and guilt, 63.4%. Female respondents reported high rates of blaming others 51.5%, and low rates of feeling that they deserved punishment, 12.5%, for their HIV status.

Finally, respondents who had disclosed their HIV status reported having to change their place of residence, approximately 20% of men and 21% of women. Additionally, of those who had lost their employment in the 12 months preceding the survey a majority believed that it was due to their HIV status. When they were asked about the best ways to address stigma and discrimination most respondents believed that the most important areas of support were emotional, physical and referral support to PLHIV; as well as increased awareness among the general population.³⁷

³⁵ The Impact of AIDS-Related Stigma on Attitudes, Behavior, and Practices towards People Living with HIV and AIDS in Egypt; The Egyptian Society for Populations Studies and Reproductive Health, Professor Hind AbdouSeoud Khattab 2011.

³⁶ “Stigma experienced by people living with HIV in Egypt”, The Egyptian Society for Population Studies and Reproductive Health (ESPSRH), Professor Hind AbdouSeoud Khattab.

³⁷ “Stigma experienced by people living with HIV in Egypt”, The Egyptian Society for Population Studies and Reproductive Health (ESPSRH), Professor Hind AbdouSeoud Khattab.

III. National response to the AIDS epidemic

Prevention, care, treatment and support

Key Populations

The National AIDS Program led a series of capacity development activities targeting most at risk populations, aiming at increasing their awareness on HIV/AIDS and providing them with proper knowledge and tools for prevention. This activity had a wide geographical distribution across Egypt, and was hosted by VCTs.

MSM

UNAIDS Egypt supports one project for MSM in Alexandria which remains functional and another in Cairo that ended in 2012. The projects provide street-level outreach and a comprehensive package of harm reduction services to MSM. In 2013, UNAIDS Egypt expanded the scope of the project in Alexandria to include legal services to MSM.³⁸ In 2014, the project will expand again to include activities in a third governorate. Efforts to expand this programming are due to additional funding UNAIDS Egypt received from Drosos for the period of 2013-2014. This expansion builds upon the additional support UNAIDS Egypt provided to its NGO implementing partners in 2012. The additional support provided in 2012 covered new activities in two areas: the development of M&E systems for Alexandria and Cairo projects and support groups for MSM living with HIV/AIDS and their partners.

Furthermore, FHI360 is technically supporting CSOs implemented projects in Cairo and Alexandria addressing MSM initiated in 2013, through donor's support coming from Drosos and Ford Foundation.

PWID

FHI360 has been supporting projects addressing PWID in Cairo and Alexandria continued in 2013, through a network of NGOs (NAHR) supported by Drosos foundation and Ford Foundation. Project NAHR is foreseen to span over the coming four years, and seeks to establish a platform for harm reduction NGOs to share experiences, jointly address bottlenecks and mobilize resources. The network mobilized technical support from the National AIDS programme, UNAIDS, UNHCR and UNODC.

UNODC plans to support a project for PWID and MSM in Alexandria and another in Luxor. The projects provide street-level outreach and harm reduction services for PWID and MSM. Additionally, UNODC also led several activities to provide drug dependence treatment services called for by the NSP and the comprehensive care package for PWID.

³⁸ UN Joint Programme Monitoring report: Egypt, 2012-2013

Furthermore, in a significant programmatic advance, UNODC convened the National Opioid Substitution Therapy (OST) Taskforce and commissioned a feasibility study to select, approve and procure the most appropriate controlled substances for piloting OST in Egypt. OST is seen by national stakeholders as a key programmatic intervention towards achieving HLM targets.³⁹

In 2012 and 2013, UNODC worked with the Youth Association for Population and Development (YAPD), an Egyptian NGO, to implement a civil society outreach project called 'Promoting Good Practices and Networking for Reducing the Demand For and Harm From Drugs' in Alexandria and Luxor. The program provides street-level outreach to PWID and MSM. Outreach under this project comes in the form of a comprehensive harm reduction package that includes educational information and referrals to services available through the YAPD's network of NGOs.

To date the YAPD outreach project has reached more than 535 PWID in Alexandria. The outreach has already shown some impact. In follow-up surveys 50% of beneficiaries report a reduction risk behavior. For instance, 30% of respondents report that they started using condoms and more than 20% had stopped using contaminated injecting equipment. To date, the program has distributed 900 condoms and 2,335 clean syringes.

FSWs

The UN Joint Team on AIDS (UNJT) supported an outreach program for FSWs in Cairo through its local NGO implementing partner Al Shehab. The project provides outreach, prevention and alternate career services to outreached female sex workers. By Mid-2012, the program's 22 outreach workers had made contact with over 4,000 sex workers and more than 9,200 condoms had been distributed since 2010. The programme has received UNFPA, UNICEF and UNAIDS support to continue into 2014, while efforts are made to integrate its interventions in more sustainable programmes beyond that date.

Vulnerable Populations

In 2012 and 2013, UNHCR continued its support for local medical NGO partner Refugee Egypt. Refugee Egypt is a local NGO that provides age and gender sensitive primary health care services and HIV/AIDS awareness raising activities to refugees and other persons of concern to UNHCR in Alexandria and Cairo. During this period, 45,000 refugees and other persons of concern to UNHCR received assistance from Refugee Egypt, including Syrian refugees and youth asylum seekers. UNHCR also supported 520 health awareness sessions attended by 10,400 beneficiaries through its partnership with Refugee Egypt. Furthermore, Egyptian National AIDS Program provides ARVs as necessary to refugees free of charge, as part of the national treatment coverage.

³⁹ Country stocktaking exercise, Egypt, Prof. Mervat El Genedy, 2013

In 2012 and 2013, UNHCR also continued its HIV VCT services for refugees and persons of concern. UNHCR work in this area reached 1,518 beneficiaries. During this period, UNHCR in cooperation with UNFPA distributed over 22,000 condoms through medical NGO partners Caritas and Refugee Egypt. UNHCR partnered with UNFPA to distribute 3,200 condoms to the refugee camp in Salloum during 2012 and 2013.

Together, the primary care services in Cairo and Alexandria and condom distribution at the Salloum have increased awareness of HIV/AIDS and access to prevention, care, support and treatment of the disease. Persons of concern to UNHCR are increasingly taking advantage of these services.

Children and young people:

UNICEF's 'Interactive Games' project is funded by Starwood Hotels. The project provides educational programs for children aged 10-18 and youth ages 18-24 run out of DICs in 3 governorates of greater Cairo. The project uses interactive games, dramas, songs and dance to teach children about basic life skills and first aid training. Modules teach specific skills with overarching messages regarding HIV awareness.

Since the project began in 2010, more than 2,500 children have been reached. Through a partnership with YAPD, around 14,000 youth, 68% male and 32% female, aged 10-24 were reached through peer-to-peer education. Egyptian NGOs Caritas, Hope Village Society (HVS), the Al Mawa Institution, and the Egyptian Association for Societal Consolidation (EASC) implement this project.

ARV Procurement

In 2012 and 2013, UNICEF continued its efforts to improve the logistics and supply chain management for the acquisition of ARVs and other medical supplies. Additionally, UNICEF procured ARVs and related supplies through the NAP and GFATM to support Post-exposure Prophylaxis (PEP) services coordinated by the NAP. With procurement support from UNICEF, the MOH distributed ARVs through a network of 11 public hospitals in 2012 and 2013.⁴⁰

Laboratory Capacity

In 2012 and 2013, the UNAIDS Secretariat, alongside UNICEF and WHO advocated for the enhancement of MoHP laboratories to include drug resistance testing. UNAIDS provided funding estimates and an implementation plan for 2014. Funding gap remains a challenge to overcome to finalize implementation in 2014.

⁴⁰ UN Joint Programme Monitoring report: Egypt, 2012-2013

HIV/TB co-infection

In 2012 and 2013, the NAP prioritized support for HIV/AIDS testing and counseling for TB patients. To support the NAP, UNHCR facilitated coordination between and UNHCR medical NGO partner Refugee Egypt, the NAP and the National TB Program (NTP) to deliver increased TB/HIV co-infection services – such as HIV VCT services – as a part of humanitarian assistance efforts in Egypt. For instance, the MOH National TB Program provides anti-TB treatment with the support of UNHCR and Refugee Egypt. The anti-TB treatment includes referrals to MOH chest hospitals and clinics and TB screening for PLHIV. Also, TB patients receive VCT services. As a result of this programming, two patients were diagnosed with TB/HIV co-infections.

Knowledge and Behavior Change

World AIDS Campaign

The World AIDS Campaign (WAC) promotes HIV/AIDS awareness and interventions among the general population. WAC awareness raising activities include seminars, workshops and other public events. During 2012 and 2013, WAC focused its activities in the areas of media and youth. In 2013, a Joint national taskforce co-chaired by UNAIDS and National AIDS Program (NAP) convening CSOs, UN, PLHIV and youth-led organizations worked together to plan and implement the advocacy campaign. Resulting from this inclusive, multistakeholder collaboration in 2013, WAC activities spanned eight governorates and involved 55 Egyptian youth organizations, activities reached an estimated 60,000 people despite significant unrest, showcasing a truly national advocacy campaign.

WAC media outreach and engagement efforts in 2012 and 2013 included establishing the Media Academy. At the Media Academy, members of the media participated in peer-to-peer trainings aimed at correcting misconceptions and converting negative attitudes about HIV/AIDS. During this time, media activities also mobilized increased media coverage of advocacy activities. WAC also supported public awareness messages through an internet-based social media campaign.

WAC youth engagement activities included the establishment a youth advisory board in 2012-13. The board provides youth the opportunity to plan public awareness campaigns aimed at their peers. Also in 2012-13, the UNAIDS Secretariat led efforts to build the capacity of youth-led organizations to perform outreach to their peers through the World AIDS Advocacy Campaign.

Young people

Putting young people at the center of the national HIV response has been a key national priority, especially with leading role young people have taken in the Egyptian scene in recent years. NAP is keen on having youth led organizations represented in all national forums and events.

UNAIDS continued its support to youth-led organizations to lead peer to peer education programmes through the World AIDS Campaign activities. Furthermore, through supporting a local youth-led organization (EYAH), UNAIDS red ribbon award implemented in 2013 developed the NGO's advocacy capacity and pushed the starting NGO to become engaged in the response. Additionally, UNFPA's supported Y PEER network continued to advocate among youth led organization for HIV awareness through peer education methodologies.

Stigma Index Study

The Egyptian Society for Population Studies and Reproductive Health (ESPSRH) conducted a study of People Living with HIV Stigma Index during the period October 2011-November 2012. Commonly referred to as the Stigma Index, the study collected information about the experiences of PLHIV related to stigma and discrimination. ESPSRH finalized the Stigma Index in 2013 and will publish it in 2014. The data collected for the Stigma Index reveal that members of key populations and vulnerable groups experienced negative feelings and internal stigma related to HIV/AIDS. This indicates that HIV/AIDS-related stigma and stigma attached to behaviors of key populations are linked and mutually reinforcing. The Stigma Index study will recommend that further efforts be made to increase the awareness of the general population about HIV/AIDS. Increased awareness will lead to better understanding that, in turn, may reduce stigma and irrational fears regarding PLHIV.

Cairo Medical school project

In 2012, the UNAIDS Secretariat initiated a one year pilot program with the Cairo Medical School. This project aims to engage academics by developing the capacity of medical and nursing staff to provide stigma free healthcare services to PLHIV. The project also provided the opportunity to increase the capacity of health researchers to participate in HIV/AIDS research and benefit the HIV response.

Impact Alleviation

Empowering PLHIV

The National AIDS Program currently ensures an open communication channel with PLHIV groups and individuals to empower them through getting their voices heard. This

new level of openness and transparency is welcomed by international organizations, CSOs and PLHIV.

Friends of life (association of PLHIV) has had few interventions throughout 2013, namely through the Network of women living with HIV (MENAROSA), they were successful in holding some support groups for WLHIV. Furthermore, they worked on developing their capacity through a joint capacity development initiative with support from UNDP, UNICEF and UNAIDS; this was further capitalized on through UNAIDS support to develop the NGOs capacity in resource mobilization in 2013.

International Development Law Organisation (IDLO) fostered a national project enlisting eight civil society organizations to work on programming in the areas of awareness raising ,legal services for PLHIV, empowering PLHIV and removing legal barriers to access essential medicines. This was done in close partnership with UNAIDS and with support from the National AIDS Program. First, IDLO and UNAIDS worked together to translate and disseminate a legal services toolkit to educate policy makers and key populations about the legal rights of PLHIV. Second, IDLO funded eight local NGOs to provide HIV/AIDS-related legal services to PLHIV and educate PLHIV about their rights, through a grant by Ford Foundation. Furthermore, a joint report on sustainability options for HIV related legal services was jointly developed.

Additionally, to address PLHIV empowerment to realize their own rights, UNAIDS held a joint regional workshop with IDLO in Sudan, where Egypt's CSOs Al Shehab and EIPR were represented to develop their capacities in programming for PLHIV empowerment.

Furthermore, the population council, have initiated a project addressing the reproductive health needs of women living with HIV. A manual for provision of service is currently being developed through multisectoral consultations. This project is supported by Ford Foundation.

Psycho-social support groups remain an integral part of programmes addressing key populations , projects led by civil society organizations addressing MSM, PWID and FSWs through technical support sought from UN and FHI360.

Strategic Information

COUNTRY STOCKTAKING EXERCISE

With support from the UNAIDS Secretariat, the GOE led a country stocktaking exercise in 2013. The exercise included civil society, academia, PLHIV, and UN agencies. The exercise resulted in the development of 10X10 matrix adopted by the GOE. The matrix includes key priorities and programmatic actions, in addition to a narrative report that identifies key challenges and gaps in HIV/AIDS programming. The exercise also identified programmatic and policy actions that must be taken to achieve HLM2011 targets by the end of 2015.

COST EFFECTIVENESS STUDY FOR PREVENTION PROGRAMS

The UNAIDS Secretariat commissioned a cost effectiveness study in 2012⁴¹. The study identified strategic issues related expanding HIV/AIDS prevention programs for key populations in Egypt. The study compared the costs and benefits of UN- supported outreach programs implemented through 2011. The results of this study will be used to inform future program planning for key populations in Egypt.

The exercise offers a valuable resource for future planning in the national HIV/AIDS response. For instance, the exercise illustrated the importance of providing ARV for PLHIV. Also, the exercise led to a GOE commitment on reducing the cost of ARVs through local production of ARVs in Egypt and the inclusion of ARVs in a national health insurance scheme.

Management and Leadership

THE NATIONAL STRATEGIC PLAN 2012-2016

The NSP guides the NAP HIV/AIDS response in Egypt. The current NSP covers the period of 2012-2016 and builds upon the work of previous NSPs. NSP 2012-2016 re-ordered the priority areas for HIV/AIDS response. The NSP 2012-2016 programmatic priority areas include:

- 1) Increase coverage of prevention interventions for most at risk populations;
- 2) Increase coverage of prevention interventions for vulnerable populations;
- 3) Increase coverage of prevention interventions for general populations;
- 4) Increase coverage of comprehensive and integrated treatment, care and support for PLHIV;
- 5) Ensure availability and use of strategic information for decision-making;
- 6) Ensure supportive and enabling environment for the national response to HIV and AIDS; and
- 7) Ensure effective leadership, coordination and management by government, civil society and other actors at national and governorate levels.⁴²

Moreover, NSP 2012-2016 established a clearer focus on PLHIV and prioritized treatment and care of HIV/AIDS. Finally, the current NSP emphasizes the need for capacity development of implementing partners for efficient project development and implementation, and inclusive participation for program development, implementation, M&E and governance.

⁴¹ The Costs and Benefits of HIV and AIDS Prevention Programs in Egypt, Gary L. Gaumer, Ph.D 2012

⁴² Egypt- HIV/AIDS Strategic Framework 2012-2016, MoHP

For NSP management and progress review, two mechanisms were established in 2012, through 2013, to convene different stakeholders, namely: Strategic Theme group, and Operational Theme group. The strategic theme group convenes strategy level actors such as UN system, donors and International organizations, while the Operational theme group convened civil society and implementers. Both were convened and chaired by NAP.

COUNTRY COORDINATION MECHANISM

GFATM grant application procedures require that grantees form a Country Coordination Mechanism. CCM membership is comprised of Government, UN agencies, CSOs, Private sector, Academia and people living with the disease (TB and HIV). The members collaborate to write an oversight plan for HIV/AIDS and TB program development and implementation.⁴³

The CCM, however, faced multiple challenges. For instance, CCM member represented only a small cross-section of sectors. Also, there was inconsistent participation by those organizations that were represented. Moreover, the CCM had limited mechanisms to resolve conflict of interests between its members. Finally, the body lacked a secretariat.

In 2013, with support from UNAIDS Egypt, the GOE initiated a restructuring and strengthening process for the CCM. Efforts to improve the CCM included the selection of CCM coordinator, assistant coordinator, and re-electing members to serve as CCM members. This is sought to increase the efficiency and independence of the body while reducing conflict of interests among its members. GFATM will provide technical assistance to the CCM restructuring process which is foreseen to be completed by October 2014.

UN JOINT TEAM ON AIDS (UNJT)

The UN joint team is comprised of HIV focal points among UN agencies. The Joint team functions as a coordination mechanism for all UN activities related to HIV in Egypt, and is chaired and convened by UNAIDS. The joint team functions through a single strategic framework with clear deliverables, timeline, and a monitoring and evaluation framework (UN Joint programme of support - UNJPS). Through the Joint programme of support, the UN system has contributed significantly to the national HIV response in 2013, especially in areas of prevention to key populations, care, support and Treatment and the enabling environment. The new UNJPS (2013-15) has been endorsed by Egypt's government, and is linked to the NSP, UN Development assistance framework and HLM2011 targets. The joint programming initiative has been inclusive to civil society and PLHIV.

⁴³ GFATM (2014). *Resource Book for Applicants – The Global Fund's new funding model*.

CIVIL SOCIETY INVOLVEMENT

The role of civil society in the fight against HIV/AIDS in Egypt has steadily increased in recent years. The NAP involved CSOs in the development of the NSP 2012-2016, particularly in the establishment of the NSP priority areas. CSOs are also an important part of the Country Coordinating Mechanism (CCM), which oversees program development and implementation related to HIV and TB. Participating organizations monitor and report on CSO participation through the GARPR reporting process. Finally, CSOs are a priority for the NAP, which assists CSOs by mobilizing resources and providing political support for activities.

THE NETWORK OF ASSOCIATIONS WORKING ON HARM REDUCTION (NAHR)

With support from Ford Foundation, Drosos, and FHI360, a group of Egyptian CSOs established the NAHR in December 2013. NAHR aims to advance harm reduction for key populations such as MSM, PWID, and FSWs. NAHR focuses its efforts on strengthening CSOs service provision through experience sharing and the coordination of prevention efforts. Egypt's MoHP and donors UNAIDS, UNODC, UNFPA and other UN agencies provide technical support to NAHR.

Trends Observed through the NCPI since 2010

The National Commitments Policy Instrument (NCPI) reports on the HIV/AIDS response in Egypt. Data from the NCPI can be used to track changes and trends in the National HIV/AIDS response. In recent years the NCPI reports have indicated several positive trends in the national response to the HIV/AIDS epidemic.

Positive Trends

CONTINUED POLITICAL SUPPORT

In recent years, the GOE has demonstrated its continued support for the fight against HIV/AIDS. For instance, the GOE improved the policy framework for coordinating the national response. The NAP developed the NSP 2012-2016. The NSP re-ordered the priority areas for intervention, identified key populations as priority groups and established a more clear focus on PLHIV. The increased emphasis on treatment and care for PLHIV in the NSP underwrote GOE improvements to Egypt's health infrastructure for service provision for PLHIV and key populations. The GOE also continues to make strong public statements in support of HIV/AIDS programming as a part of its public awareness raising efforts.

SCALING UP OF PREVENTION EFFORTS

HIV/AIDS prevention programming has continued to grow each year. Regular increases in geographical coverage, services offered, and beneficiaries reached indicate that the response remains strong and is gaining momentum.

HIV/AIDS interventions have been integrated into other areas of health, such as TB and MCH services. Other new areas of prevention include focusing on risk reduction for the partners of PLHIV and school based HIV/AIDS education for young people.

SERVICE PROVISION

Treatment and care guidelines for PLHIV and key populations have been integrated into other areas of health. For example, provider initiated counseling (PIC) has been integrated into TB and MCH services. A rapid assessment for the integration of HIV services into health facilities was carried-out in 2012. The results of this work are being used to plan for future implementation. The comprehensive package of health services for PLHIV has also continued to grow. The comprehensive package of health services includes increased access to ARVs, ARVs for TB patients, early infant diagnosis, HIV testing and counseling for TB patients, pediatric AIDS treatment, PMTCT, psychosocial support for PLHIV, TB preventive therapy for PLHIV and TB control in HIV treatment and care facilities, and treatment of common HIV-related infections. New areas of prevention include a focus-on risk reduction for the partners of PLHIV and school based HIV/AIDS education for young people.

The GOE has prioritized the strengthening of the HIV/AIDS infrastructure and related components of the health system. HIV/AIDS services have been integrated into the general healthcare setting. The number of ARV distribution sites has increased significantly. UNICEF has worked and continues to improve the logistics and supply chain management for the acquisition of ARVs and other medical supplies.

INCREASED INVOLVEMENT OF CIVIL SOCIETY

The role of civil society in the fight against HIV/AIDS has steadily increased in recent years. The NAP involved CSOs in the development of the NSP 2012-2016, particularly in the establishment of the NSP priority areas. CSOs are also an important part of the Country Coordinating Mechanism (CCM), which oversees program development and implementation related to HIV and TB. The participation of CSOs is monitored and reported through the GARPR reporting process. Finally, CSOs are a priority for the NAP, which assists CSOs by mobilizing resources and providing political support for activities.

Continuing Challenges

M&E SITUATION

While some M&E efforts for HIV/AIDS interventions occur in Egypt, there is no functional national M&E protocol system. The absence of such a system affects the quality and availability of information for situation assessments and future planning of HIV/AIDS interventions.

STIGMA

Stigma against HIV/AIDS, PLHIV and key populations remains a barrier to HIV/AIDS awareness in the general population. Religious beliefs regarding HIV/AIDS and the behaviors of key populations combined with a general lack of knowledge propagate fear behaviors among the general population. The majority of HIV/AIDS programming is currently aimed at key populations and PLHIV, which leaves little opportunity for the general population to gain awareness.

HUMAN RIGHTS

NGOs and CSOs have continued to advocate for the human rights of PLHIV in two main areas. First, NGOs and CSOs focus on the rights of PLHIV to receive adequate medical care and treatment, such as access to ARVs. Second, NGOs and CSOs advocate for removing legal barriers hindering outreach to key populations. These legal barriers hinder outreach workers efforts to distribute prevention tools such as condoms and clean needles, which could be wrongfully used as evidence of illegal behavior.

HEALTH SYSTEM INTEGRATION:

Integrating HIV services in the health system remains a key challenge for the national response. While there is consensus both on government and non-government sectors that this remains a key gap that requires programmatic interventions, further advocacy efforts are needed.

GEOGRAPHICAL DISPARITY

Disparity in coverage of prevention, care and support programmes remains a challenge. While PLHIV face different challenges and marginalization especially in upper Egypt, this remains a gap that needs to be addressed in future plans.

IV. Best Practices

The GOE and partners working to fight the HIV epidemic in Egypt have implemented many successful projects over the past year. The following describes the impact several projects have had for PLHIV and other key populations in various focus areas.

Country Stocktaking Exercise

In 2013, National AIDS Program led a country stock taking exercise to assess Egypt's progress toward achieving the HLM2011 targets for 2015, utilizing UNAIDS support. The process included civil society, academia, PLHIV and UN agencies. The exercise resulted in the development of a matrix of key priorities and suggested programmatic and policy actions for achieving the 2015 goals. This document was the first of its kind in Egypt and offers a valuable resource for future planning of HIV/AIDS programming.

World AIDS Campaign

World AIDS Campaign 2013 was coordinated through a national taskforce convened jointly by NAP and UNAIDS. The co-chaired taskforce included members of civil society, UN agencies, academia, youth led organizations and PLHIV. In 2013, WAC Egypt combated HIV stigma and discrimination by engaging media, civil society and youth-led organisations to targeting young people. WAC activities took place in 8 governorates and involved 55 youth organizations. These activities reached 60,000 participants.⁴⁴ In 2013, WAC EGYPT also worked to improve healthcare providers' attitudes and practice aiming at provision of stigma free services to PLHIV.

Feature Film: Asmaa

In 2007, UNAIDS Egypt began work on a project to develop a feature film that would give HIV/AIDS a human face. UNAIDS Egypt enlisted the assistance of Egyptian writers and producers to create a feature film titled "Asmaa". The film was produced by New Century and is the true story of a woman living with HIV. The film challenges the misconceptions about PLHIV and brings the fight for the rights of PLHIV to the forefront of public debate. PLHIV participated in the script writing process, acted in the film and were involved in many areas of the film production. "Asmaa" was released in 2011 and appeared at several international film festivals in 2011 and 2012 including London, Abu Dhabi, Ankara, Rome, Tallin, Palm Spring, Berlin, Swiss, Kerala and Goteborg. The film won several international awards.

⁴⁴ UN Joint Programme Monitoring report: Egypt, 2012-2013

The Network of Associations working on Harm Reduction (NAHR)

With support from Ford Foundation, Drosos, and FHI360, a group of Egyptian CSOs established the NAHR in December 2013. NAHR aims to advance harm reduction for key populations such as MSM, PWID, and FSWs. NAHR focuses its efforts on strengthening CSOs service provision through experience sharing and the coordination of prevention efforts. Egypt's MoHP and donors UNAIDS, UNODC, UNFPA and other UN agencies provide technical support to NAHR.

People Who Inject Drugs (PWID)

UNODC led a feasibility study of piloting and launching an Opioid Substitution Therapy (OST) program for PWID in Egypt, under the guidance of the National Opioid Substitution Therapy Taskforce and the General Secretariat for Mental Health. The UNODC feasibility study and its operational model synthesize the global evidence to support OST and adapt OST to the Egyptian context. The deliverables called for under the feasibility study are currently being drafted. Once complete, they will be used to inform national decision-making about appropriate mechanisms and service delivery for OST. In preparation for piloting OST across six governorates, Egyptian NGO El Shehab trained 18 service providers on evidence-based drug dependence treatment. This training was provided as a part of basic TreatNet trainings and upon the request of the General Secretariat for Mental Health.⁴⁵

Female Sex Workers

UNFPA, UNAIDS, and UNICEF jointly support a nationally led project entitled Comprehensive Prevention to Vulnerable Women in Cairo, implemented by Al Shehab institution. The project provides HIV awareness training to outreach workers. These outreach workers then deliver educational information about HIV and other health issues to female sex workers (FSWs) and other vulnerable women. Additionally, the outreach workers invite FSW and other vulnerable women to visit drop-in centers (DICs) where they can receive a wide range of stigma-free services including condom distribution, VCT services, STI management and other medical services. The DIC model allows beneficiaries to easily access multiple services in the same place. Teams of specialists include lawyers, gynecologists, primary care doctors, psychologists, psychiatrists, and social workers. These personnel are highly trained in the provision of stigma-free services.

In addition to health-related services, Al Shehab offers psychosocial and legal services to beneficiaries at the DICs. The project also offers FSWs and vulnerable women training to prepare them for new job opportunities. The Egyptian NGOs Al Shehab and the Association for Health and Environmental Development (AHED) implement the project.

⁴⁵UN Joint Programme Monitoring Report: Egypt, 2012-2013

By mid-2012, 22 outreach workers supported by the project had contacted over 4,000 female sex workers. Drop-in-centers supported by the project had received more than 700 visits from women and 550 women engaged in activities at the centers. By mid-2012, the program also had distributed approximately 9,200 condoms. Efforts are currently under way to scale up project activities geographically and in capacity.⁴⁶

HIV Legal Services Project

IDLO supported projects with eight civil society organizations to address HIV related legal services and access to essential medicines were completed over the year 2013 and up till march 2014. Project activities varied, however key achievements included training more than fifty lawyers to sensitize them to HIV specific issues, and more than 250 legal consultations were provided as part of this pilot. Furthermore, CSOs mobilized private sector, legal actors, government to initiate discussions surrounding local manufacturing of ARVs to find a sustainable solution for this chronic gap. Several experience sharing meetings took place in collaboration and partnership with NAP and UNAIDS.

Vulnerable Women

UNDP and UNAIDS support the project called Leadership Development Program for Women Living with HIV in Egypt. The project is a country specific and culturally sensitive leadership development initiative that targets women living with HIV (WLHIV). The project's activities provide technical and financial support for WLHIV through a micro credit loans, train WLHIV in leadership and project management skills, and help WLHIV establish their own viable business ventures. Since the program began in 2010, 154 WLHIV have attended training sessions, 50 loans totaling USD 9,000 have been dispersed.⁴⁷ The project is implemented by the Egyptian NGOs Women's Health Improvement Association, Friends of Life, Think and Do, and the international NGO FHI360.

MSM

UNAIDS supports the project entitled 'for Vulnerable Youth' HIV risk reduction among vulnerable men in Egypt' The project targets MSM in Alexandria and Cairo through field workers who reach out to MSM directly by distributing free prevention packages with condoms and lubricant. They also provide MSM with information about HIV and encourage them to enroll in the MSM project. Once enrolled in the project, beneficiaries have access to counseling services, medical and legal services, workshops on HIV and human rights training. The project is implemented by Al-Mofid, the National Foundation for Social Development, Al Reyada, and Ahaly el Dahrya.

⁴⁶ UN Best Practices: HIV/AIDS activities in Egypt, UNAIDS 2014 (Under publication)

⁴⁷ UN Best Practices: HIV/AIDS activities in Egypt, UNAIDS 2014 (Under publication)

While many of the MSM approached by field workers were willing to enroll in the project, utilization of medical and legal services has remained low. A customer satisfaction survey conducted in 2013 revealed that the fear of stigmatization or discrimination related to their sexual identity could explain the low levels of service utilization by beneficiaries. UNAIDS has secured funding to scale up the MSM project that will expand the project during 2014 to additional governorates, including Tanta.

Migrants and Refugees

UNHCR, NAP, UNAIDS and GFATM support the project called ‘HIV Prevention and Impact Mitigation Among Migrants and Refugees in Greater Cairo.’ The project raises awareness of HIV among the refugee and migrant population and enables access to prevention, care, support and treatment. Since it began in 2008, the project has provided treatment for approximately 40 PLHIV. The project also has offered VCT services to more than 6,000 refugees and other people of concern.⁴⁸ The project is implemented by Refugee Egypt, a stigma free NGO operating in Alexandria and Greater Cairo.

Street Children and Youth

UNICEF has worked to enhance partnerships with NGOs and Child Protection Committees. Together, they have held a number of coordinated meetings and established child protection protocols, which were signed with the Ministry of Education and the MoHP.

UNFPA’s supported Y Peer network continued to outreach young people with custom tailored advocacy message and specific Y Peer methodology for peer education.

Stigma Reduction

In 2013, The Egyptian Society for Populations Studies and Reproductive Health (ESPSRH) finalized the “Stigma experienced by people living with HIV in Egypt” study. The study was based on Stigma Index methodology and was administered between October 2011 and November 2012.⁴⁹ Assessment of the perceptions and attitudes of the partners, family members, neighborhoods and workplaces of PLHIV indicated a wide range of reactions toward PLHIV. The reactions varied from acceptance and support to complete rejection. Many PLHIV reported that they did not disclose their HIV status in order to protect themselves from stigma and discrimination.

The study focused on three types of stigma. The first type was external stigma. Although the fear of external stigma and discrimination is common among PLHIV, relatively few respondents reported being excluded from social gatherings or activities within the last 12 months, 11.7% of men and 5.6% of women surveyed. Even fewer

⁴⁸ UN Best Practices: HIV/AIDS activities in Egypt, UNAIDS 2014 (under publication)

⁴⁹ Stigma experienced by people living with HIV in Egypt, Summary Report; The Egyptian Society for Population Studies and Reproductive Health, Professor Hind AbdouSeoud Khattab 2013

reported being victims of direct verbal assault. It is important to note that these low numbers may, in part, be due to the large number of respondents who do not disclose their HIV status.

The second type of stigma discussed in the study was perceived stigma. When asked about why PLHIV are stigmatized, 23.8% of men and 29.4% of women believed that it was because people are afraid of getting HIV through casual contact or that people do not understand modes of transmission. More than 20% of male and female respondents reported being forced to change their place of residence or were unable to rent housing due to their HIV status. Additionally, 40% of working men and 80% of working women surveyed reported losing their employment due to their HIV status.

The Third type of stigma was internal stigma. Respondents reported high levels of internal stigma. Female respondents demonstrated a higher rate, 51.3%, of blaming others due to the assumptions about men's sexual behavior causing heterosexual transmission. Male respondents reported high rates of self-blame, 70.5%, guilt, 63.4%, and shame, 50.4% about their HIV status.

The results of the study highlighted a gap in the role played by CSOs and NGOs that work with PLHIV. Only 28% of male respondents and 19% of female respondents reported knowing of an organization that they could go to for help while fewer reported seeking help from a CSO or NGO.

Stigma Reduction Project with Cairo Medical School

UNAIDS initiated a joint pilot project with the Cairo Medical School to reduce stigma in the healthcare setting in Egypt. With this project, UNAIDS works with the Cairo Medical School to meet the needs of PLHIV with regards to treatment and medical care. The project also works to increase the number of people who access VCT services. Concurrently, UNAIDS mobilized WHO, UNICEF, UNHCR and IOM to advocate for stigma-free healthcare at Cairo University hospitals.⁵⁰

Through the project, UNAIDS trained 73 staff members of Cairo Medical School to be peer trainers. Peer trainers then held 18 trainings during a period of five months that trained 511 staff and students. The project is scheduled to continue in 2014.

⁵⁰ UN Joint Programme Monitoring report : Egypt, 2012-2013

V. Major Challenges and Remedial Actions

Progress from GARPR 2012

The GOE has demonstrated continued support for the efforts to combat the HIV epidemic in Egypt. In the last year projects targeting HIV awareness and prevention have been scaled up to include more beneficiaries and cover greater geographical areas. Training in M&E for staff at peripheral data collection sites ensured quality data collection and reporting. HIV infrastructure and institutional capacity were also strengthened in the areas of supply chain management, and integration of HIV interventions into other areas of health care services.

Despite these efforts, significant policy and practical challenges still exist. For instance, the GOE has made progress integrating HIV related services into its national clinical care guidelines and into TB and MCH services. Geographic coverage remains low for this integration, and requires further support. Furthermore, progress toward integrating HIV programming into other sectors of development remains as an area for improvement.

Key and vulnerable populations

Key populations such as MSM, FSWs, and PWID and vulnerable population such as street children, migrants and refugees remain difficult to reach with information and services. Many among these populations are hesitant to come forward or to seek services for fear of discrimination and stigma society places on the disease and those who are infected by it. Female sex workers in particular are difficult to reach with prevention and health care services. Efforts have to be done to reduce stigma against key at-risk populations in order to increase demand from them for education about the disease and healthcare services.

Political Challenges

Egypt has witnessed significant political unrest and deteriorating security since the 2011 revolution. This unrest has caused the frequent change in senior government leadership. For instance, Egypt's MoHP has had seven different Ministers since 2011. This high rate of turnover in leadership has complicated the task of advancing HIV programming in Egypt. The deteriorating security situation has also interfered with the implementation of many outreach activities to, and service provision for, key populations.

Egypt's ongoing political transition has impeded progress on amending existing or developing new anti-discrimination laws that would benefit beneficiaries of HIV programming. The People's Assembly that will be elected in late-2014 will be responsible for amending existing laws or developing new ones to promote accepted prevention methods and protect PLHIV and outreach workers.

It is hoped that the current political unrest and security concerns that face Egypt today will subside as a new government is seated. The donor community and Egyptian civil society must continue to encourage the GOE to create a political context that is favorable to HIV interventions in Egypt. The new government can then include in its agenda efforts to champion HIV programming ensure the rights of PLHIV, including increasing domestic investments in the national HIV response.

Challenges in Health System

GOE's logistics for and supply chain management of ARVs and other medical supplies are in need of strengthening. Fixed dose combination drugs and the drugs necessary for PMTCT are not consistently available. This is significant because the GOE plans to update the eligibility criteria for HIV treatment from CD4 count of 350 cells/mm³ to 500 cells/mm³ will increase the number of PLHIV who are eligible for treatment.

Geographical coverage of HIV-related services is also an area in need of improvement. Improvement can come in the form of increased coverage of HIV prevention, care and treatment services for both key and vulnerable populations.

Currently the National AIDS Program with support from UNICEF and UNAIDS is leading a comprehensive assessment to its supply chain management systems and efforts are in place to enhance the system in the coming phase.

Monitoring and Evaluation Challenges

The GOE faces myriad challenges to conducting high-quality M&E activities. The GOE does not have an automated system for data collection. Moreover, recent political unrest and worsening security has impeded quality control monitoring visits by the MoHP to rural data collection points. In some cases government employees trained in M&E have left their posts. Finally, the GOE does not have a specific mechanism for the dissemination of M&E data. These challenges jeopardize the ability of the GOE to provide high-quality reporting on its efforts in the area of combating HIV/AIDS. The GOE must develop a standard national M&E mechanism and protocol and make progress against these other challenges in order to combat HIV/AIDS in Egypt.

Human Rights Challenges

STIGMA

Stigma and discrimination against PLHIV and key populations remain barriers to the implementation of laws and policies that protect the rights of PLHIV.

TRAVEL RESTRICTIONS

Egypt imposes restrictions on travel and residence based on HIV status. Non-Egyptians are required to provide proof that they are HIV-negative in order to obtain student or work residency. Prior to the Egyptian Revolution in 2011, this issue had gained significant attention and there were strong political commitments to changing the policies. Following the revolution the new government halted all efforts toward a change and current political uncertainty has delayed it even further. The NAP has expressed the importance of the issue and requested support to mitigate with the ministry of manpower to address the restrictions.⁵¹ In 2012, UNAIDS prepared a policy paper for decision makers, addressing the issue of HIV related travel restrictions. However, no further action was taken due to political instability, frequent changes in government and the dissolution of parliament.⁵²

⁵¹ High Level Meeting Targets 2011 Stocktaking Report in Egypt, Professor Marvat El Genidy.

⁵² UN Joint Programme Monitoring System: Egypt, 2012-2013

VI. Support from the country's development partners

To achieve its program objectives, the NAP actively partners with Egyptian CSOs and NGOs on the response to HIV in Egypt to include programming. Cooperation with NGOs and CSOs occurs in the areas of prevention, outreach to key populations, HIV related legal services and empowering PLHIV. In addition to service provision, CSOs are part of the CCM, which oversees the implementation of programming under the GFATM grant. The NAP also collaborates with the UN Joint Team, IDLO. Other international donor partners include the Ford Foundation, and DROSOS.⁵³

More specifically, UNAIDS works closely with the NAP in order to address challenges in programme implementation raised by the GFATM and to address programmatic shortcomings in 2013. UNAIDS also assisted the NAP in securing Transitional funding from the Global fund fin 2012 to span between 2013 and 2015. Other agencies also provided support to the NAP in 2012 and 2013; for example, UNICEF assisted in the assessment of PSM and the GFATM provided technical assistance and capacity building.

Additionally, FHI360 provided support to the NAP in the areas of VCT and HIV surveillance.

The support of UN agencies for the NAP is coordinated through the Joint Program of Support (UNJPS). The UN Joint Team on AIDS (UNJT) finalized the UNJPS for 2013-2015 and leads its work in three priority areas including prevention, care, support and treatment for PLHIV; advocacy for human rights; and secretariat-level work in coordination, advocacy, leadership and accountability.

⁵³ HIV/AIDS Situation, Response and Gap Analysis 2010, Ministry of Health, Arab Republic of Egypt

VII. Monitoring and evaluation environment

Current Status

Monitoring and evaluation (M&E) is a valuable part of the national response to HIV/AIDS in Egypt. Access to up-to-date accurate information about and analysis of project performance allows stakeholders to plan and implement effective programming in a timely manner. While the GOE has taken steps toward improving M&E in Egypt, a standard national-level system does not exist.

The Central Office of the MoHP maintains a database for HIV/AIDS-related data. An M&E Officer collects data from peripheral data collection centers and compiles it into the database. The M&E officer also coordinates the reporting activities of implementing partners to ensure timely and accurate reporting of data. Moreover, implementing partners hold periodic meetings for the purpose of information sharing.

In 2013, M&E was conducted at the sub-national and service delivery levels. The data is used by the GOE and implementing partners for various purposes, including the planning and selection of priority areas for the NSP, resource allocation, planning and scaling up of prevention and clinical care activities, and identifying training needs.

Key achievements in M&E since 2011 include the continued provision of M&E training of staff at data collection sites in order to match high turnover rates. Additionally, the GARPR reporting process for 2013 ensured greater involvement of implementing partners in order to ensure a more comprehensive reporting process.

Challenges and Remedial Actions

While the GOE stands committed to strengthening M&E for HIV/AIDS programming, it must overcome several challenges. First, both the M&E plan and system require further updating and automation.

The absence of a standard national mechanism or protocol for data collection, dissemination and analysis interferes with the availability of data for thorough analysis.

This deficiency, in turn, affects the ability to assess the situation and effectively plan HIV/AIDS programming and future M&E services. The development and implementation of a national M&E plan is the first step toward improving the M&E situation in Egypt.

Second, the current political situation and the resulting unrest and poor security have created problems for data collection and dissemination in certain parts of the country. Security issues have also interfered with the MoHP's ability to perform supervisory visits to peripheral data collection points. These challenges present barriers to the GOE from providing supervisory support and ensuring continuous feedback.

Third, there has been a high turnover rate of staff trained in M&E within GOE entities. This has especially affected the peripheral data collection points. This affects the continuity of the data collection and reporting process. Continued M&E trainings, particularly for staff at the peripheral data collection centers experiencing the greatest turnover is essential in order to ensure consistent high quality reporting.