High Level Meeting Targets 2011
Stocktaking Report in Egypt

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1. Background and Context

Egypt as one of the UN member states has conducted a national midterm review to track progress against the 2011 Political Declaration on HIV/AIDS referred to as the "HLM2011 Ten Targets". As part of this midterm review, stocktaking exercise assesses national targets, priority interventions and resource allocation, building on and contributing to country-level progress. The process also combined an appraisal of progress, constraints and gaps in the national response while proposing course of actions to achieve the set targets by 2015.

1.1. Overview of HIV Epidemic

Egypt has low HIV prevalence among the general population (below 0.02 %) with a concentrated epidemic among men having sex with men (MSM) and people who inject drugs (PWID) in Cairo and Alexandria[1]. Since 1990 and to date, there has been a steady increase in the number of HIV detected cases, as this number has increased from 1,040 (from 2001-2005) to 1,663 (from 2006-2009), and then to 3058 by March 2013[2]. This increase could be partially explained by the efforts of the National AIDS Program to improve HIV surveillance, testing, counselling, and reporting. National AIDS Programme (NAP), UNAIDS and WHO estimate the number of people living with HIV in Egypt is to be 9,500 in 2012[3].

The bio-behavioural surveillance study conducted in 2006 found out that the HIV prevalence among MSM in Alexandria is 6.2%, and the following study in 2010 demonstrated a concentrated epidemic among MSM in Cairo at 5.7% (2.6-10.1%) and in Alexandria at 5.9% (3.0-10.2%) respectively[14]. Additionally the HIV prevalence among PWID is at 6.8% (3.9-10.8%) in Cairo and at 6.5% (3.3-10.3%) in Alexandria[1].

The population group most affected by HIV is likely to be adults in the age group 25 – 40 years (54% of all diagnosed cases)[2]. There is an increase in the number of people living with HIV among 15-24 years old at 14.1% at the end of 2009. 14 (4.9%) were children of various ages denoting probable mother to child transmission. Gender disaggregated date show females to represent about 20% of all diagnosed cases while males represent about 80%. This could be

[1]MOH, FHI and CDS, *Biological Behavioral Surveillance Survey* (2010).
[2]NAP, *Global AIDS response Progress Report* (2012).
[3] UNAIDS, *Global epidemic update report* (2012).
[4]MOH, FHI and CDS, *Biological Behavioral Surveillance Survey* (2006).

partially attributed to accessibility to testing being higher among males, and compulsory pre-travel tests for male migrant workers. In 2010, most transmissions seemed to occur sexually (66.8%): 46.2% are heterosexual transmission and 20.6% are homosexual transmission. Transmission through injecting drugs represents around 28.3%.

A recent study suggests an estimated percentage of MSM is to be 0.2% of the total adult male population in Cairo[5]. Nevertheless, reported risk behaviours are likely to drive an epidemic among key populations and bridging groups in the population. Earlier studies show that 24% of MSM have had one or more sexually transmitted infections (STIs) within the 3 months preceding the study[1]. Low level of condom use among MSM is more likely to be associated with acquiring STIs. Additionally MSM reported to have ever had sex with females at 39.8%, 59.2% and 86.5% in Cairo, Alexandria and Luxor respectively[1]. This can point out the vulnerabilities of female sexual partners.

The estimated number of PWID in Egypt ranges from 57,000to 120,000[5]. Among studied groups of PWID (275 in Cairo, and 285 in Alexandria), 22.9% and 40.5% in Cairo and Alexandria respectively shared needles with one or more persons in the 30 days prior to the survey[1]. In addition, a study reported PWID who currently married are at 48.7% and 29.3% in Cairo and Alexandria respectively, with 4.3% and 18.7% in Cairo and Alexandria reporting using condoms in the last 12 months with regular non-commercial partners[1].

Despite the low prevalence among female sex workers[2], risk behaviour might suggest that the HIV prevalence is likely to increase. Out of 200 female sex workers in Cairo, 25% reported condom use in the last sex, and 41% reported condom use at least once 30 days prior to the study[1]. Additionally, 45.5% reported being currently married[1].

Street children, in general, are greatly marginalized and highly mobile in Egypt. A study on street children showed that 8.1% and 9.1% of boys and girls aged 15-17 in Cairo reported ever injecting drugs, with 8.2% and 10.5% of boys and girls reporting injecting drug use in Alexandria)[1]. While the biological behavioural surveillance survey in 2010 (200 street boys and 200 girls in Cairo), demonstrated HIV prevalence among this group at 0.5%. As for their sexual debut, 46.5% and 16% of the studied population of street boys and girls reported ever having sex[1]. Median age at first sex was reported to be 13 and 14 years old for boys and girls respectively[1].

[5]MSM pop size estimation , 2009, MOH and UNAIDS

1.2. Overall development and economic context

HIV is considered a development concern even though Egypt has a low HIV prevalence among the general population. This is due to the fact that social and other development indicators influence on HIV situation in Egypt and vice versa. Political conflict and unrest has recently developed into additional risk factors that potentially can affect the epidemic dynamic.

The annual GDP growth in Egypt has been steadily decreasing from about 7% to 5% since 2009, with a significant fall to 1.8% in 2011 followed by 2.2% in 2012[6]. Also investments dropped 13% in 2012[6]. This stagnant economy increased unemployment rate at 13%[6] with unemployment among university graduates being nearly 45% for females and 25% for males according to the 2006 Census. There has been an increase in the percentage of people who live below the poverty line (less than 2 USD per day) from 19.4% in 1996 to 25.2% in 2011[6]. The national illiteracy is up to 40%, with male and female being 12.1% and 18.2% respectively for young people aged 15-24 years old. The current political unrest seems to drive the economic decline and expand the gap between the rich and the poor in Egypt. GNI per capita, indicates equity in the society, has been increasing regularly since 2004 (USD 1,280) until 2012 (USD 3,000)[6]. Moreover, lack of security makes women more likely to be vulnerable to sexual assaults.

Funding for the UN agencies and programmes alone dropped by 20% compared 2010-2011 and 2013-2015 probably due to the decisions of the government and donors on altering their priorities[7]. Restrictions on civil society role may delay and hampers many programmatic interventions. This is also seen to affect donors' willingness to support Egypt's development agenda.

2. Methods

2.1. Methodology of assessment

[6]World Bank, 2013. Available on 11th August 2013 from http://data.worldbank.org/country/egypt-arab-republic
[7] UNAIDS, *UN Joint Programme of Support* (2013).

A nationally led process through an independent national consultant took place over the second quarter of 2013. The consultant has conducted a comprehensive review utilizing UNAIDS guidance and with close consultation with NAP as the representative of the Egyptian government;

The Comprehensive review of evidence had the following sources:

a. A desk review conducted prior to the focus group discussion and interviews with key informants
b. Focus group discussion among key players in HIV prevention and control in the country.
c. Interviews with key informants including officers from the national AIDS program, Ministry of Health and other key national institutions.

2.2. Key Informants and information sources

Key informants;

- National AIDS Program(NAP) Staff:
  - NAP Manager
  - VCT officer
  - M&E officer
- Civil society representatives ,
- Academia representative,
- PLHIV, and
- UN agencies and programmes.

Information sources;

- National strategic plan
- HIV/ AIDS Situation Response and Gap Analysis
- Global AIDS response and progress reports
- National AIDS spending assessment (NASA).

3. Stocktaking - Progress

3.1. Scope of stocktaking

This exercise comes at an essential time for the HIV response in Egypt. The exercise was utilized to assess progress made towards achieving the 10 HLM targets. Additionally, the

exercise is expected to inform the midterm review of the national strategic plan to best realign the country plans and resources to achieve results.

The exercise also served as an inclusive forum for government, civil society and donors to consult on the progress made and communicate towards mitigating gaps in the HIV response.

3.2. Target-by-target review and analysis report matrix

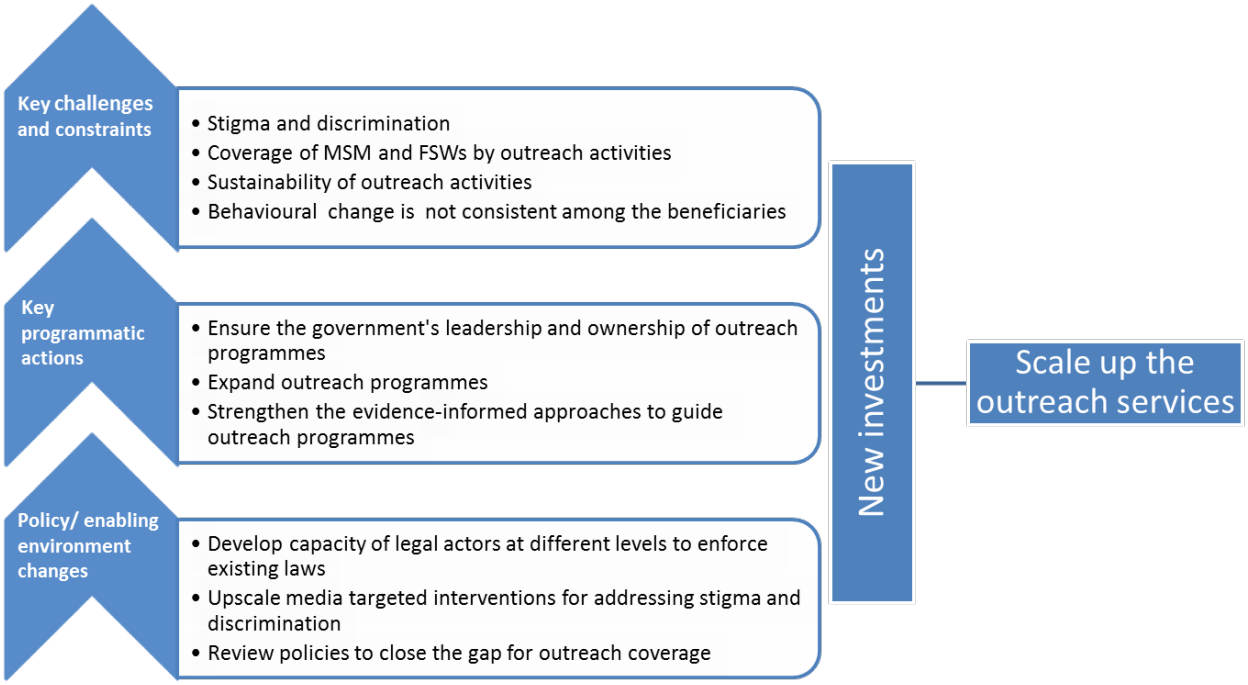
1. Reduce sexual transmission

The national strategic plan 2012-2016 includes prevention of sexual transmission as the first priority. Coverage of prevention programmes has been increased for the key populations at risk, to contain HIV prevalence among the key populations below 5 % by 2016.

Key Actions since 2011

The National Strategic plan for 2012-16 is directly linked to this target and has three of its priority areas focusing on prevention to key, vulnerable and general populations. Additionally the NSP highlights the importance of strategic information and availing evidence to guide prevention programming.

The NAP strategy included provision of messages on prevention, commodities and information and education communication (IEC) materials to key, vulnerable and general population. Voluntary testing and counselling (VCT) centres have been established by the government and civil society organizations to reach key populations with the support of UNFPA, Family Health International (FHI), UNAIDS and others. Several civil society led programmes targeting key populations have functioned to provide HIV services such as prevention commodities, medical, psycho-social, and legal services, and counselling and testing for HIV. Programmes varied in approach between drop-in center based projects and network based projects. Additionally, the NAP has worked to enhance 6 STI clinics in 3 governorates and operate VCT centres across the country. Programmes addressing vulnerable populations include an on-going project led by Refuge Egypt which offers VCT and prevention services including provision of post-exposure prophylaxis (PEP), emergency contraceptives and STI management for victims of sexual assault among refugees. Drop-in centres have been established particularly in Cairo and Alexandria that offer free access to condoms, counselling and testing, IEC materials and referral upon need.



Key challenges or constraints

Stigma and discrimination constitute a key challenge facing prevention programme coverage for key and vulnerable population. A notable gap exists between the number of FSWs and MSM reached and their population size estimation. Moreover, another constraint is the lacking sustainability of outreach services due to financial constraints. A gap still remains between services provided and targeted populations, further evidence is needed to best position prevention programmes and facilitate service provision.

Key programmatic actions to address challenges and constraints

In order to stay on track for reducing sexual transmission of HIV by 50% by 2015, it is essential to ensure government leadership and ownership of outreach programs to key populations and to scale up these programmes. This scale up should be evidence based and guided by the inherit experience from previous pilots and from good practices of similar contexts.

Policy /enabling environment changes

To tackle stigma and discrimination, the stakeholders should build capacity among legal actors to enforce existing laws, and upscale media targeted interventions. In addition, policy changes on scaling up the prevention programme should close the existing gap of outreach coverage.

Recommendations for implementing suggested changes

In order to implement the suggested changes, this paper suggests three recommendations;

1. Capacity development of civil society actors related to HIV programming for key and vulnerable populations
2. Mobilize resources to scale up the evidence-informed programming; and
3. Strengthen coordination mechanisms to optimise resource allocation.

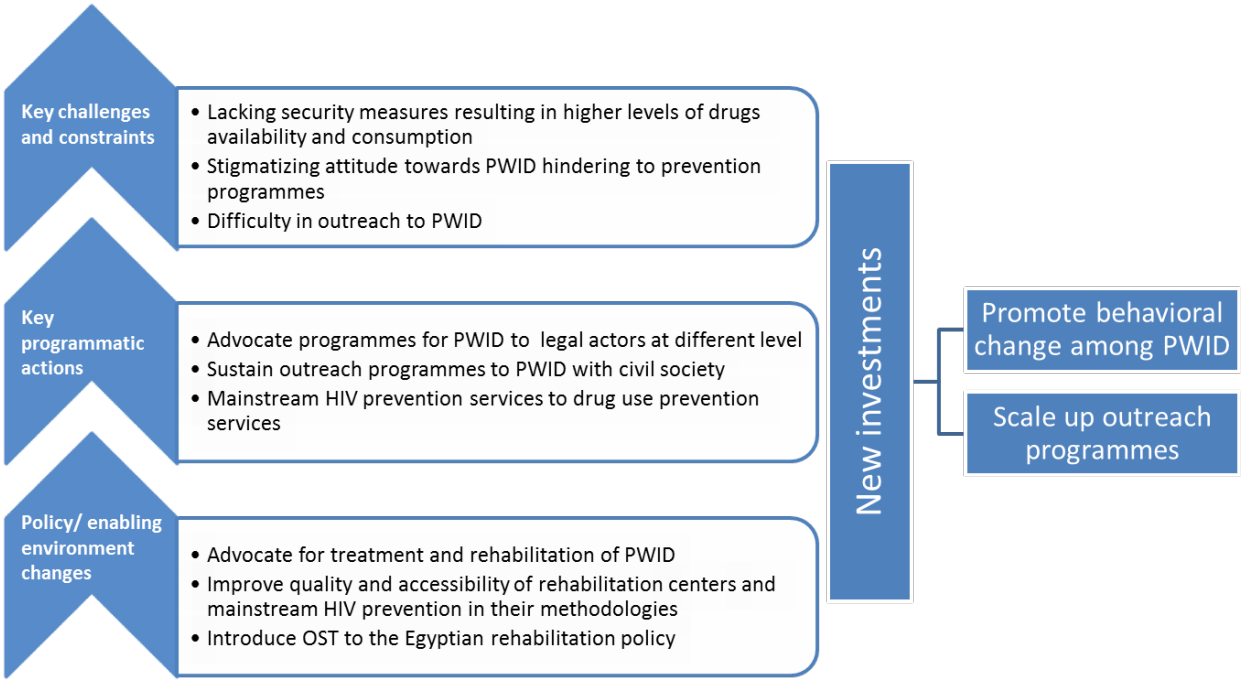
2. Reduce transmission of HIV among people who inject drugs

The most recent BBSS (2010) showed a concentrated epidemic among PWID in Cairo and Alexandria at 5.7% (2.6-10.1%) and at 5.9% (3.0-10.2%) respectively. Significant risk factors also exist indicating a wider epidemic among this population and potentially inflicting their spouses and thus necessitating immediate interventions. Population size estimation has not been carried out for this population though regional UNAIDS estimates suggest this figure could be around 100,000. One of the main strategies of the NSP is to increase coverage of prevention programs to 60% of PWID in four governorates (Cairo, Alexandria, Luxor and Gharbia) by 2016.

Key Actions since 2011

In light of the concentrated epidemic among PWID; prevention interventions for PWID has become a priority for the HIV response in Egypt. VCT outreach has reported 2700PWID as beneficiaries of service with the majority based in Cairo, Alexandria and Menoufiya. Additionally, NAP, FHI and UNODC support several outreach projects in high priority governorates. These projects rely on a drop in center model which offers referrals to medical, psychological and legal aid services and have approximately reached 5,300 by the end of 2012.

In addition, a joint initiative of the NAP, Ministry of Interior (MOI) and UNODC brought prevention services to 4 prisons in Egypt. At the onset of the revolution in 2011, this project was put on hold as several VCTs at the prisons were destroyed. Efforts are underway to resume this project and reinstall VCTfacilities and prevention services in the prison settings. Furthermore, HIV awareness campaigns among MOI personnel have been conducted to eliminate stigma and discrimination related to HIV and AIDS.



Key challenges or constraints

The lower level of legal enforcement has resulted in higher levels of drug availability in Egypt which increase accessibility and consumption among PWID. Moreover, stigmatizing attitude in public towards PWID hinders outreach.

Key programmatic actions to address challenges and constraints

One of the mitigations is to advocate legal entities in relation to PWID at different levels for regulating and reinforcing the existing laws governing narcotic drugs. Moreover, it is recommended to mainstream HIV prevention services with drug use prevention services to ensure sustainability of service and increase coverage. Furthermore, there is a need to mobilize resources for sustaining outreach programmes to PWID and institutionalizing its services.

Policy /enabling environment changes

One of the priorities of policy issues is advocating for treatment and rehabilitation of PWID in Egypt. In addition, improving quality and accessibility of rehabilitation centres and mainstreaming HIV prevention in their strategies. Furthermore, introducing OST to the Egyptian rehabilitation policy may be a beneficial option for PWID to address both HIV and drug use.

Recommendations for implementing suggested changes

Fostering media interventions and mainstreaming HIV messages in public forums is key. Additionally, outreach programmes should be up-scaled to increase coverage of programming for PWID. Furthermore, The National AIDS response should capitalize on the political momentum towards addressing addiction to mainstream HIV prevention among PWID.

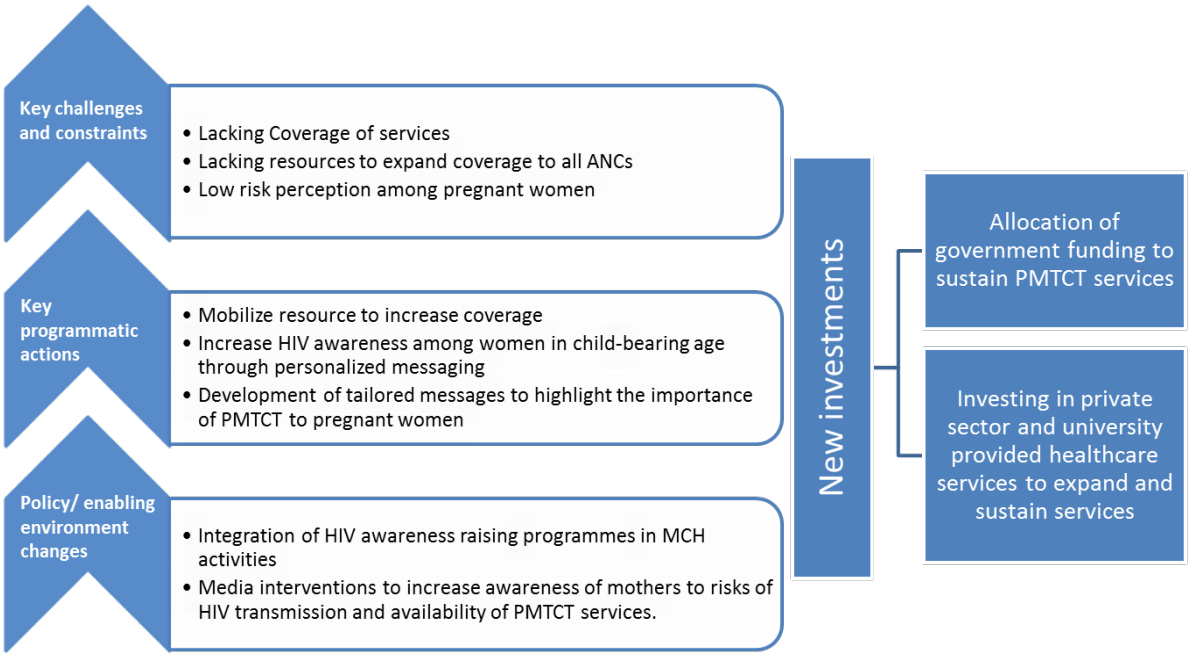
3. Eliminate new HIV infections among children and reduce AIDS related maternal deaths

Ministry of Health has established services for preventing mother to child transmission (PMTCT) in Egypt based on the estimates of women needing PMTCT services generated. This estimate has been obtained based the number of pregnant women receiving PMTCT out of the total known HIV positive women. In 2012 a total number of nine HIV positive pregnant women, representing all known HIV positive pregnant women, were covered by this PMTCT programme. They gave birth to 9 healthy babies.

Key Actions since 2011

Integration in antenatal care services has resulted an increase in access of pregnant women and their infants to the PMTCT services, coverage 60% of pregnant women in 50 clinics. Provider Initiated Counselling and Testing has been implemented in 20 ANC, and it is to be increased to 50 by the end of2016.

In order to eliminate new infections among children, counselling and testing services coverage has been scaled up, additionally, NAP supervises HIV surveillance in over 36 ANC clinics across Egypt and hundreds of physicians have been trained on PMTCT. Four NGOs and youth-led organizations reached out approximately 600street children to provide knowledge and skills to protect themselves from HIV in 2012.



Key challenges or constraints

The major constraints are lack of coverage of services and lack of resources to expand coverage to all ANCs. However, coverage is not the only challenge, as even within ANCs providing VCT services a low utilization rate for PMTCT service is observed. This could be attributed to the low risk perception among pregnant women and prevailing stigma towards HIV. However, these are potential hypothesis for further studies on service utilisation before scaling up the PMTCT services for increasing availability.

Key programmatic actions to address challenges and constraints

First of all, the programme needs to take into consideration acceptability of PMTCT services among pregnant women and service providers. Provided that under utilisation of PMTCT is confirmed, the research may assist improving service utilisation. Then, tailored messages are to be conveyed for childbearing or pregnant women about HIV and sexually transmitted diseases and the importance of PMTCT. Lastly, efforts in resource mobilisation should be encouraged for increase coverage of national PMTCT services.

Policy /enabling environment changes

Maternal and child health (MHC) care services have wide service delivery coverage in Egypt. Therefore, integration of the HIV awareness programme in the MHC services is more likely to sustain the HIV prevention programme. In addition, it is recommended to increase public service announcements on risk of HIV transmission and availability of PMTCT services in each governorate.

Recommendations for implementing suggested changes

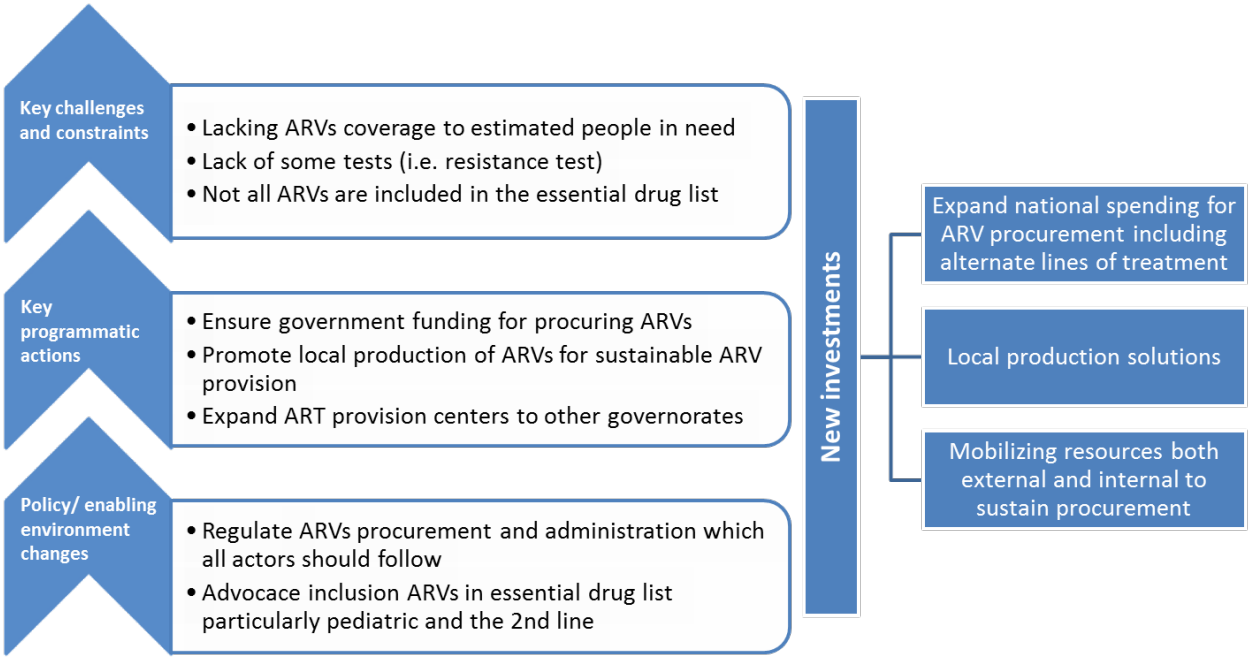
Overall, scaling up PMTCT service requires an increase in government allocation for its services for availability and enhancing services quality. As well as the government's efforts, PMTCT service provision at private and university hospitals will increase the service availability, coverage and sustain the PMTCT service in Egypt.

4. Reach 15 million people living with HIV with antiretroviral treatment

Key Actions since 2011

Timely enrolment of PLHIV into treatment and care, and saving their lives are important implementation principles in the national strategic plan. This was further highlighted through a priority area that focuses on increasing the coverage to quality comprehensive and integrated treatment, care and support to PLHIV. Registered PLHIV receive antiretroviral treatment (ARVs) from Ministry of Health and Population free of charge. Currently the coverage of PLHIV who are eligible for treatment is 40%, which is the highest in the MENA. Additionally, Egypt provides free treatment for refugees living with HIV with a close collaboration between NAP and refugee Egypt. The NAP has ensured the quality of treatment at different dispensary sites by establishing HIV treatment monitoring for HIV viral load and CD4 counts.

The NAP decentralized distribution of ARVs for greater accessibility for PLHIV who live outside Cairo, with the extended ARVs dispensary sites being selected based on the geographical distribution of PLHIV. To ensure treatment adherence among PLHIV, a support group has provided health education and peer counselling for adherence.



Key challenges or constraints

One of the major challenges is that ARVs are not on the essential drug list; accordingly they cannot be freely imported or produced locally. Moreover, high production cost for ART and supply in excess for ART (due to the small number of PLHIV in Egypt) prevent local producers to enter the market which results in purchasing ART overseas. As well as ART costs, procurement management seems to hinder adherence of ART for PLHIV which is likely to increase self-procurement of ART overseas. This self-administration of ART without professional supervision is more probable to cause drug resistance to the first or second line of ART from those provided by misunderstanding in adherence. Additionally, there is limited access for treatment and care for PLHIV at tertiary hospitals.

Key programmatic actions to address challenges and constraints

Provided that PLHIV relies on the government supply for ART, ensuring the allocation for ART by the government is essential which sustains adherence of ART among PLHIV. Furthermore, expanding ART provision centres to other governorates will increase accessibility for PLHIV. Lastly, advocacy efforts may open a window of opportunity for local pharmaceutical producers for producing ART by seeking potential ART markets in the Middle East, North Africa and Sub-Saharan Africa.

Policy /enabling environment changes

The NAP will advocate for including ARVs in the essential drug list particularly paediatric and the 2nd line of ART.ART procurement and administration are regulated by the existing policy in Egypt and this regulation, therefore, should be enforced and adhered by all the actors.

Recommendations for implementing suggested changes

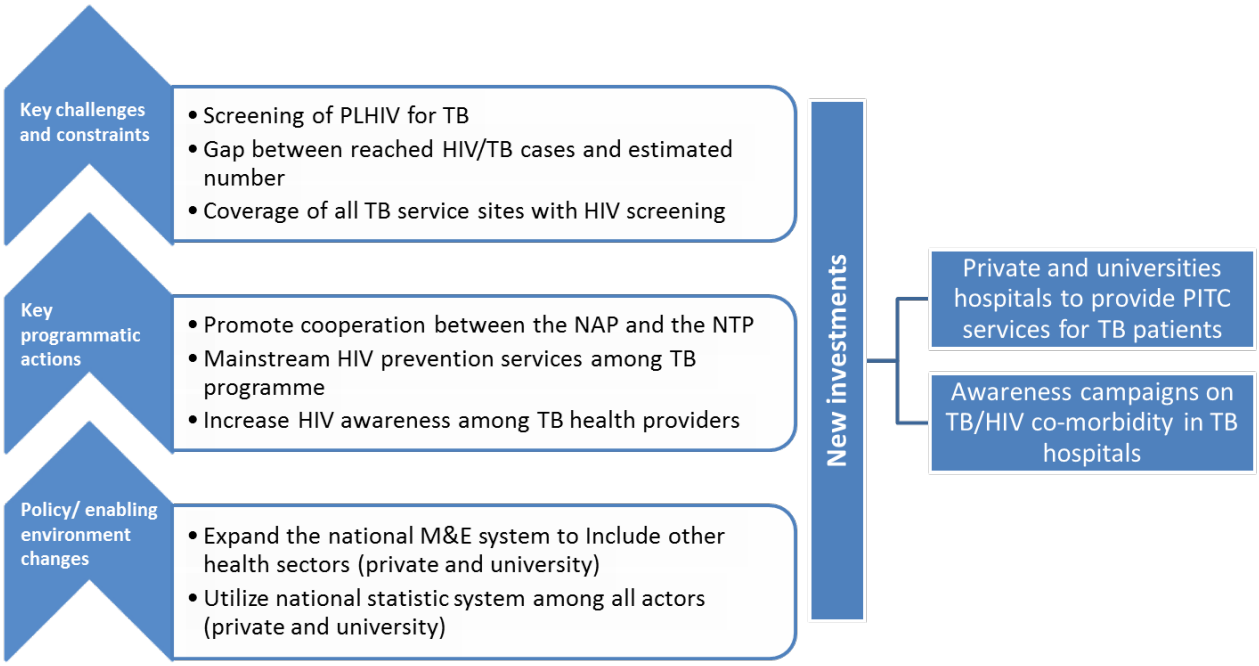
Expanding different ART monitoring tools in main governorates will improve patient monitoring for ART adherence and procurement. As well as treatment efforts should be made for the training of physicians on comprehensive care guidelines.

5. Reduce Tuberculosis deaths in people living with HIV

Coordination between the NAP and NTP appears to occur mainly in surveillance and healthcare services at selected sites. Across the country, there are 41 TB clinics as sentinel sites. In each clinic, at least 5 persons have been trained on surveillance by the NAP, and all TB patients attending these sites are tested for HIV. Additionally, TB/HIV integrated services are offered in selected settings (i.e. prison projects). PLHIV are not routinely screened for TB. Currently 87 PLHIV reported TB co-infection and received treatment in 2012. Lacking data on comorbidity pose as a challenge to address this area in the response.

Key Actions since 2011

The main achievements are; the increased number of established HIV surveillance sentinel sites in TB hospitals, and implementation of HIV testing and counselling for all TB patients in these sites. In this respect, approximately 1500 newly diagnosed TB patients were tested for HIV in 2012, with all PLHIV with TB receiving ARVs as well as DOTS therapy according to WHO recommendations. Moreover, the NAP conducted several HIV/ TB co-morbidity trainings for health care providers. TB/ HIV guidelines have been formulated.



Key challenges or constraints

A big gap still exists between the TB/HIV cases reached and the estimated number of TB/HIV cases. Moreover, there is a gap knowledge on comorbidities between healthcare providers who were trained and other healthcare facilities. There is no screening policy for PLHIV with TB yet, not all PLHIV are screened for TB. TB/HIV services are also provided through a project in some selected prisons; this project is currently pending after the 2011 revolution.

Key programmatic actions to address challenges and constraints

For TB/HIV management, the NAP will promote continuous cooperation with the NTP for mainstreaming HIV programme in TB programmes and increasing HIV awareness and management among health care providers mainly working for TB programmes. With HIV programme, TB screening should be offered to PLHIV as a part of care service.

Policy /enabling environment changes

In addition to the government efforts, the inclusion of private and university hospitals is crucial for expanding the TB/HIV co-infection management. First of all, the NAP will include private and university hospitals in the national M&E system. Second, the information in the national M&E system will be available to all the stakeholders for improving TB/ HIV management.

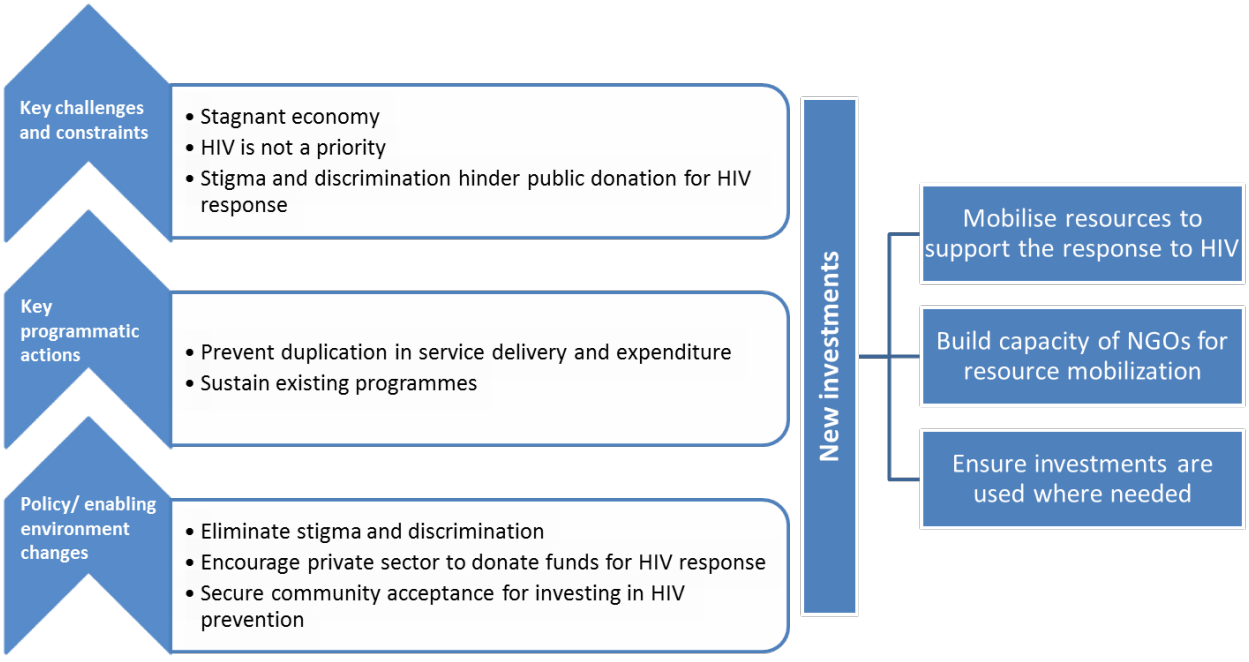
Recommendations for implementing suggested changes

As an initial start, the NAP will set initial target to reduce TB/HIV deaths, such that multisectorial co-operation will be ensured for TB/HIV management.

6. Close the global AIDS resources gap and reach annual global investment

Key Actions since 2011

Domestic coverage of HIV expenses is exceeding 75% the government of Egypt is financing all HIV testing expenses, procurement of HIV first and second line and treatment of opportunistic infection. Currently, the bulk of financing for the HIV response in Egypt comes from a Global Fund Round 6 in the amount of over US$10 million for 5 years. With the cancellation of Round 11 and the grant set to expire soon, Egypt has applied for and been selected for transitional funding (TFM) from the Global Fund. Minimal contribution in HIV expenses is provided by the United Nation and other national and international donors. The exact estimates of expenditures are outdated as the last NASA was completed in 2008. The NSP has also addressed these issues by calling for cost effective and accountable allocation and use of financial resources across the NSP according to priorities.



Key challenges or constraints

The key challenges encountered in addressing this target include; the national economic burden coupled with the fact that HIV has a low national priority. Provided that stigma and discrimination towards HIV is ubiquitous in Egypt, calling for donation for HIV programmes may

not have positive results. Also stigma and discrimination can hinder investments in HIV prevention.

Key programmatic actions to address challenges and constraints

The NAP will prevent duplication of efforts and expenditure by coordinating programmes among stakeholders in Egypt. Furthermore, the NAP will secure sustainability of existing programmes.

Policy /enabling environment changes

All stakeholders should address stigma and discrimination towards HIV at all levels so that public and private donations are acceptable and encouraged in the Egyptian society.

Recommendations for implementing suggested changes

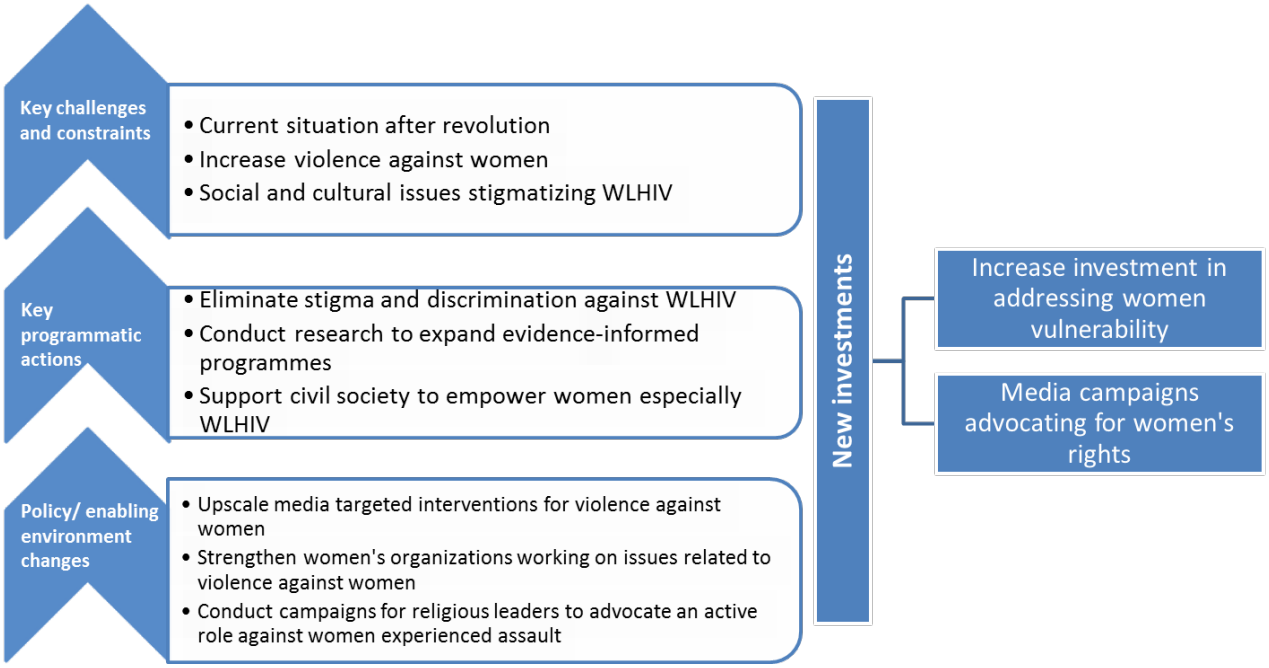
For understanding and improving resource allocation for HIV programme, it is recommended to conduct the National AIDS Spending Assessment (NASA) as a part of midterm review. In addition, identified duplicated programmes should be incorporated or minimised as soon as possible.

7. Eliminate gender inequalities and gender-based abuse and violence

Gender equality is one of the NSP's implementation principles, such that all activities for HIV response will promote, protect and respect equality and equity and assure gender equality. The NSP does specifically address the issue of gender by increasing women awareness and capacity to protect themselves from HIV and promoting PMTCT.

Key Actions since 2011

A few projects and studies have been initiated to address gender inequalities in the HIV response in Egypt. Microfinance projects provide women living with and affected by HIV capacity development to enable them to sustain their livelihoods, including vocational trainings, capacity building workshops and micro-credit loans. The NAP launched awareness campaigns to address stigma towards WLHIV in recent years to reduce the social burdens faced by WLHIV.



Key challenges or constraints

Research has shown that social and economic vulnerabilities exist for women in Egypt which may put them at higher risk of HIV transmission. Generally, women in Egypt already face

greater socioeconomic and educational barriers in comparison to men. In terms of HIV, these vulnerabilities are compounded. Women are much less likely to present for HIV testing and counselling than men and only accounted for around 18% of visitors to the VCCT in 2011. In addition, women are much less likely to have comprehensive information about HIV than men, with only 7.1% of women and 18.1% of men aged between 15 and59 having comprehensive knowledge on HIV in the 2008 Demographic Health Survey (DHS). Additionally, some studies have indicated that women living with HIV (WLHIV) in MENAoften get HIV transmission passively and unknowingly through their husbands. Many WLHIV know their HIV status when their husband falls ill in late-stage of AIDS. Thus many WLHIV in Egypt face a triple burden of having to be a caretaker, a mother and a breadwinner for their families in addition to living with. Some case studies also have shown that Egyptian society tends to be more stigmatizing and critical towards WLHIV than men living with HIV.

Key programmatic actions to address challenges and constraints

First of all, stigma and discrimination against WLHIV should be addressed. Secondly, NAP, bilateral agencies and the UN should support civil society to empower women especially WLHIV. Lastly, the emphasis should be on research for promoting evidence-informed programmes.

Policy /enabling environment changes

Up-scaling media interventions are one of the major mitigations to address violence against women by promoting messages and notions about the issue. Also, strengthening women's organizations are essential for working on issues related to violence against women. Not only women's organisation, but also involvement of men is important for addressing the issue. The stakeholders agreed that religious leaders have great influence in Egyptian society. Therefore, the NAP will advocate and implement campaigns for religious leaders to assume an active role against assault towards women.

Recommendations for implementing suggested changes

Mobilising resources is a priority to provide evidence-informed actions to address women's vulnerability. Followed by the resource mobilisation, civil society strengthening is a key in addressing the issue. The NAP will emphasize the role of religious leaders and capacity building

for civil society in reducing women's vulnerability.

8. Eliminate stigma and discrimination against people living with and affected by HIV

Eliminating stigma and discrimination is a priority in the NSP in Egypt. Stigma remains the biggest barrier hampering efforts to achieve universal access to HIV prevention,treatment, care and support.

Key Actions since 2011

Media advocacy campaigns have been carried out to increase general HIV awareness and eliminate stigma and discrimination. Campaigns take place annually around World AIDS Day and aim to disseminate key custom tailored messages every year. The campaign is organized by a joint taskforce convening representatives of civil society, government, the UN, youth lead organizations and people living with HIV. While the message varies every year, the general theme of tackling stigma and discrimination remains as a main goal. Key messages are driven from the human rights approach to HIV prevention, treatment, care and support.

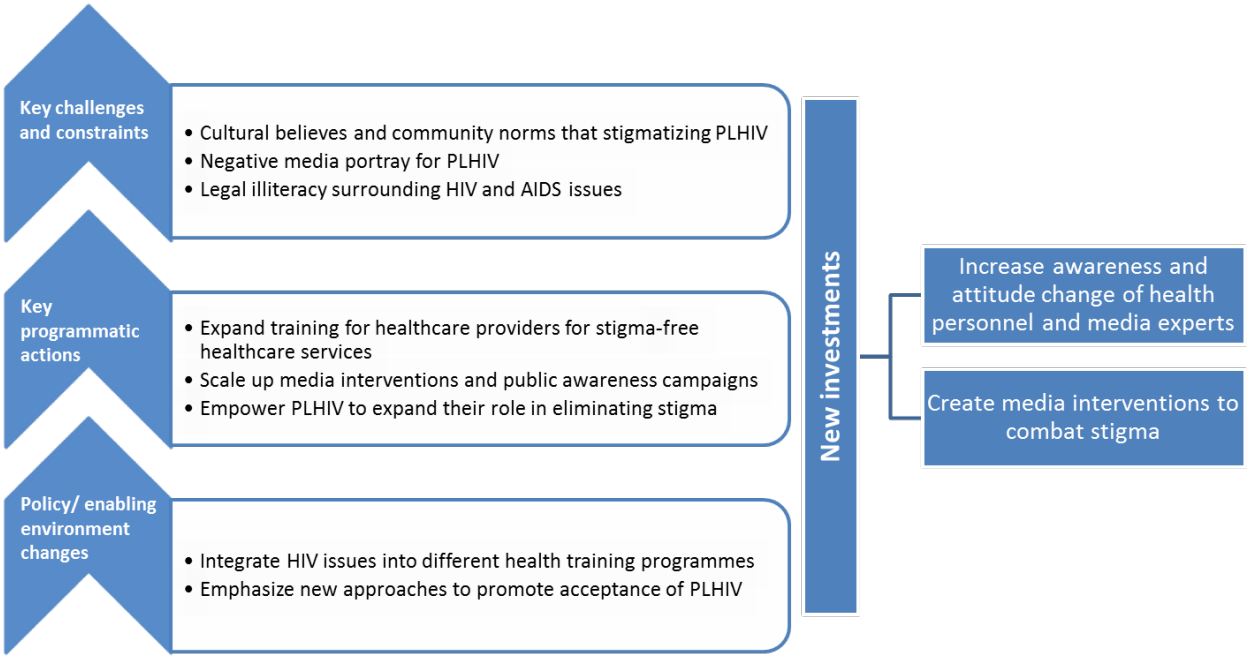
The NSP works on eliminating stigma and discrimination in several ways; primarily targeting stigma in the healthcare setting, increasing knowledge among community and religious leaders and the general public, and providing support to PLHIV.

Several initiatives have been carried out to address stigma towards PLHIV. Recently, a stigma index study was conducted to assess the magnitude and effect of stigma towards PLHIV which shall inform strategic interventions. Other initiatives include creation of stigma free hospitals, trainings for healthcare providers and large-scale awareness campaigns all year around including the World AIDS Day.

Furthermore, A feature film, Asmaa, was a prime example of a national effort that reached millions of viewers in the Arab world with positive messages coming from a WLHIV in Egypt.

Key challenges or constraints

In spite of all of these achievements, cultural beliefs at all levels in the society are major hindrances to eliminate stigma and discrimination for PLHIV. Moreover, limited understanding of legal issues among some stakeholders on HIV and AIDS is another constraint.



Key programmatic actions to address challenges and constraints

The NAP will focus on expansion of training of health personnel to reach stigma free health care services. Additionally scaling up media interventions and public awareness campaigns will target the general public. Last, but not least, empowering PLHIV will assist them to expand their role in eliminating stigma and discrimination in Egyptian society.

Policy /enabling environment changes

Addressing stigma among healthcare providers is key towards eliminating stigma.HIV stigma should be an integral part of the different health training programmes. Emphasis should be made on new and innovative approaches to promote acceptance of PLHIV and integration into the community.

Recommendations for implementing suggested changes

The healthcare providers at all levels must provide stigma and discrimination free health care to PLHIV. The NAP will empower and engage PLHIV fully for stigma and discrimination free society.

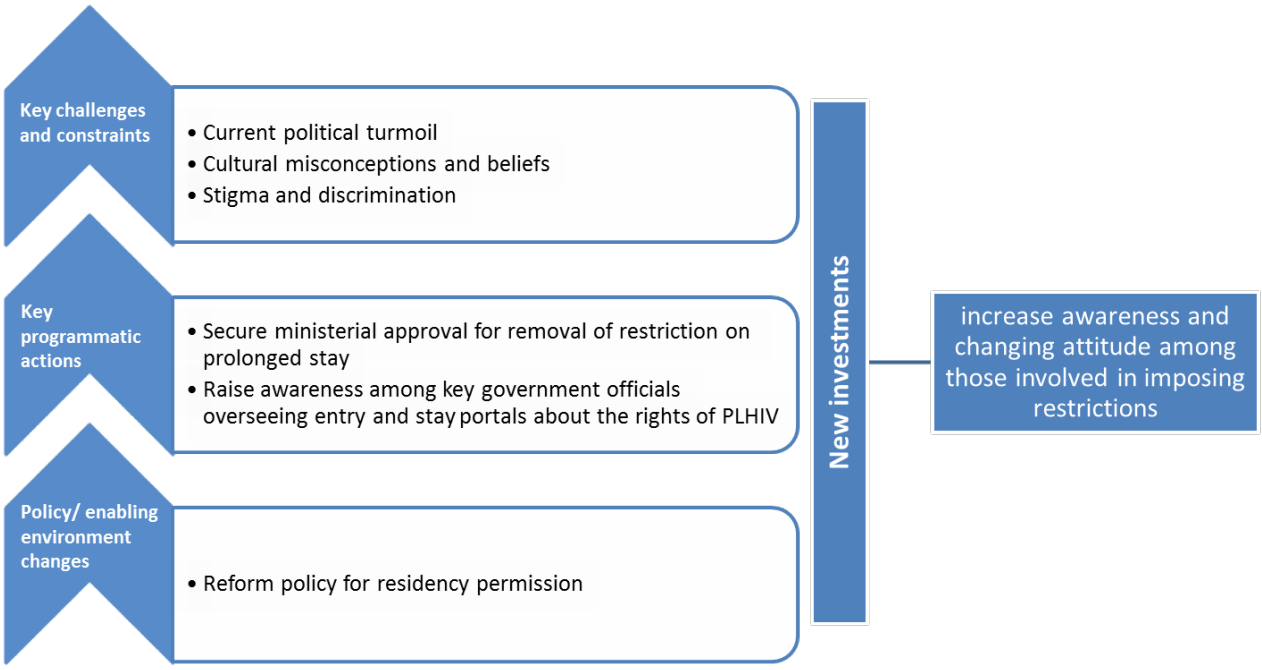
9. Eliminate HIV- related restrictions on entry, stay and residence

Key Actions since 2011

Egypt is one of the countries worldwide that imposes restrictions on residence for PLHIV from other countries. Non-Egyptians are required to prove a negative HIV status in order to obtain a student or work residency with a very few exceptions. Egypt is also one of the countries that deny residency based on their HIV status. The NSP does not directly advocate for the removal of HIV related restrictions, the national AIDS program has voiced the importance of the issue and requested support to mitigate with ministry of manpower to address the restrictions.

Key challenges or constraints

Several cases of deportation of foreigners and refugees living with HIV in Egypt have helped to focus on this restriction issue prior to the revolution in 2011. At that time, policy reform on travel restrictions was on the agenda with strong political commitments. Changes in the government after the revolution halted all efforts, and current political turmoil might mean even further setbacks.



Key programmatic actions to address challenges and constraints

The NAP will advocate for securing ministerial approval for removal of restriction on prolonged stay for non-Egyptian workers and residents. Raising awareness, therefore, will be implemented for key government officials overseeing entry and stay portals about the regulatory laws and decrees preserving the rights of PLHIV.

Policy /enabling environment changes

The NAP will advocate for policy reform regarding residency.

Recommendations for implementing suggested changes

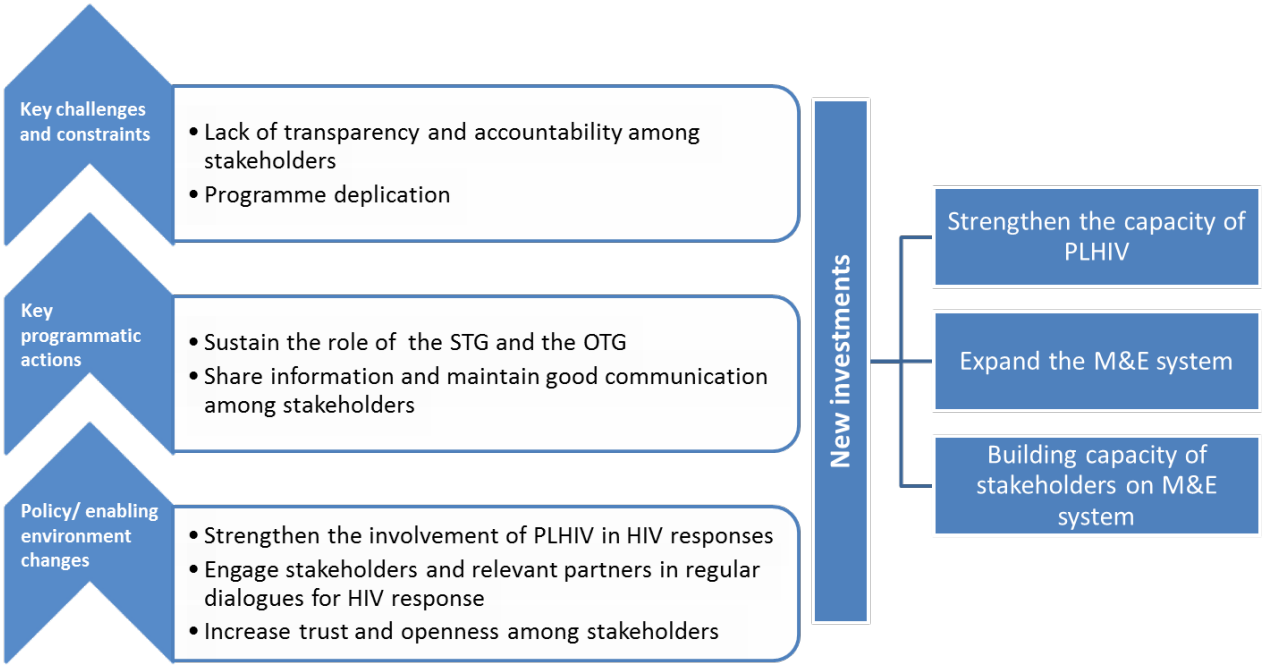
The NAP and stakeholders will engage media to discuss issues relating to human rights and HIV and their impact on the rights of travel and residence. Additionally, NAP and stakeholders should cooperate in multilevel advocacy efforts.

10. Strengthen integration of the AIDS response in global health and development efforts

Key Actions since 2011

Provided the limited global resources for HIV response, integration is important for sustaining the HIV programmes. In Egypt, the NAP functions under the auspices of the Ministry of Health and works as a vertical programme structurally and financially under the Division of Communicable Diseases. The NAP, however, continues to have linkages to other programmes rather than full-scale integration. The NAP collaborates with other sectors including the Central Lab, the NTB, ANCs, Blood Safety as well as other relevant ministries and non-governmental partners. The NSP does not directly advocate for integration of programmes but calls for increased coordination and efficiency for a sustainable HIV response in Egypt.

The national strategic plan stated that the necessity of ensuring effective leadership, coordination and management by the government, civil society and other actors at national and governmental levels. Moreover, it will be based on close and fruitful cooperation among the government, non-governmental organizations and private sectors based on transparency, partnerships and mutual accountability that are key principles for implementing the NSP. The different programmes offer HIV testing and counselling services to TB patients, pregnant women attending ANC clinics and in selected settings and projects. The NAP engages other stakeholders and relevant partners in dialogues to enhance an enabling environment for HIV response. Establishment of the Strategic Theme Group (STG) and the Operational Theme Group (OTG) has harnessed communication and coordination as well as limit the parallel programming. Yet, the roles of these groups have to be reinforced.



Key programmatic actions to address challenges and constraints

The NAP will sustain the role of STG and OTG for coordinating the stakeholders. Through STG and OTG, sharing information and good communication will be enhanced among the stakeholders.

Policy /enabling environment changes

Through STG and OTG, the NAP will engage stakeholders and relevant partners in regular dialogue regarding HIV activities in order to avoid programme duplication. Increase trust and openness among the stakeholders are keys to enhance transparency and accountability of the stakeholders in HIV response in Egypt. Strengthen the involvement of PLHIV in different HIV interventions is also a part of the roles of STG and OTG.

Recommendations for implementing suggested changes

Most important of all, we foster transparency and accountability among all the actors. The NAP will improve communication through STG and OTG among different stakeholders. Therefore, the NAP as a coordinator is an important role for HIV response in Egypt.

4. Conclusion and Recommendations

4.1. Conclusion

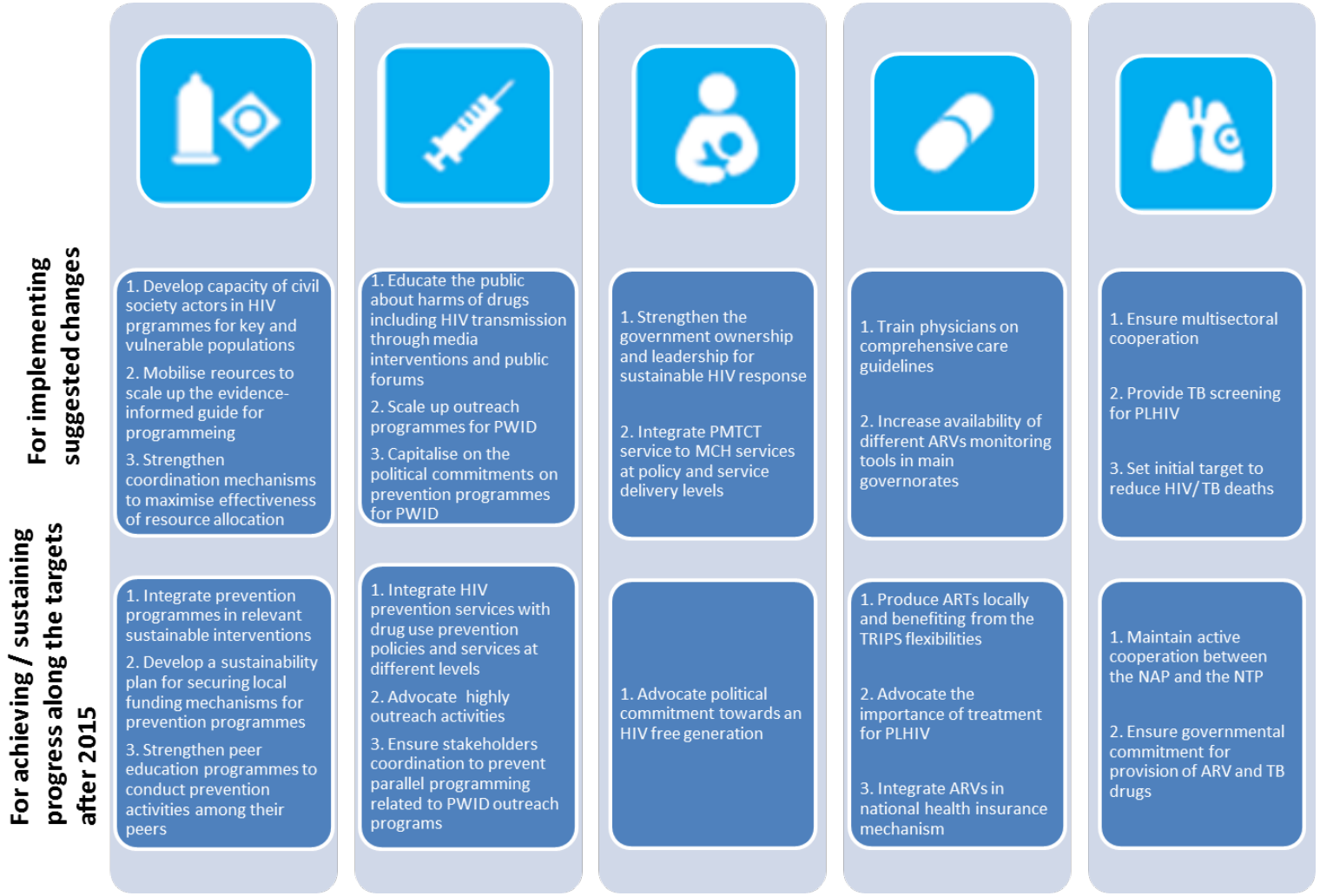
The country stocktaking exercise comes at a crucial time for the HIV response in Egypt. While the country is witnessing a political turmoil; shifting the focus away from HIV is an inevitable risk. This augmented with challenging economic environment the country is witnessing, pose as a major threat to the progress made in the HIV response thus far.

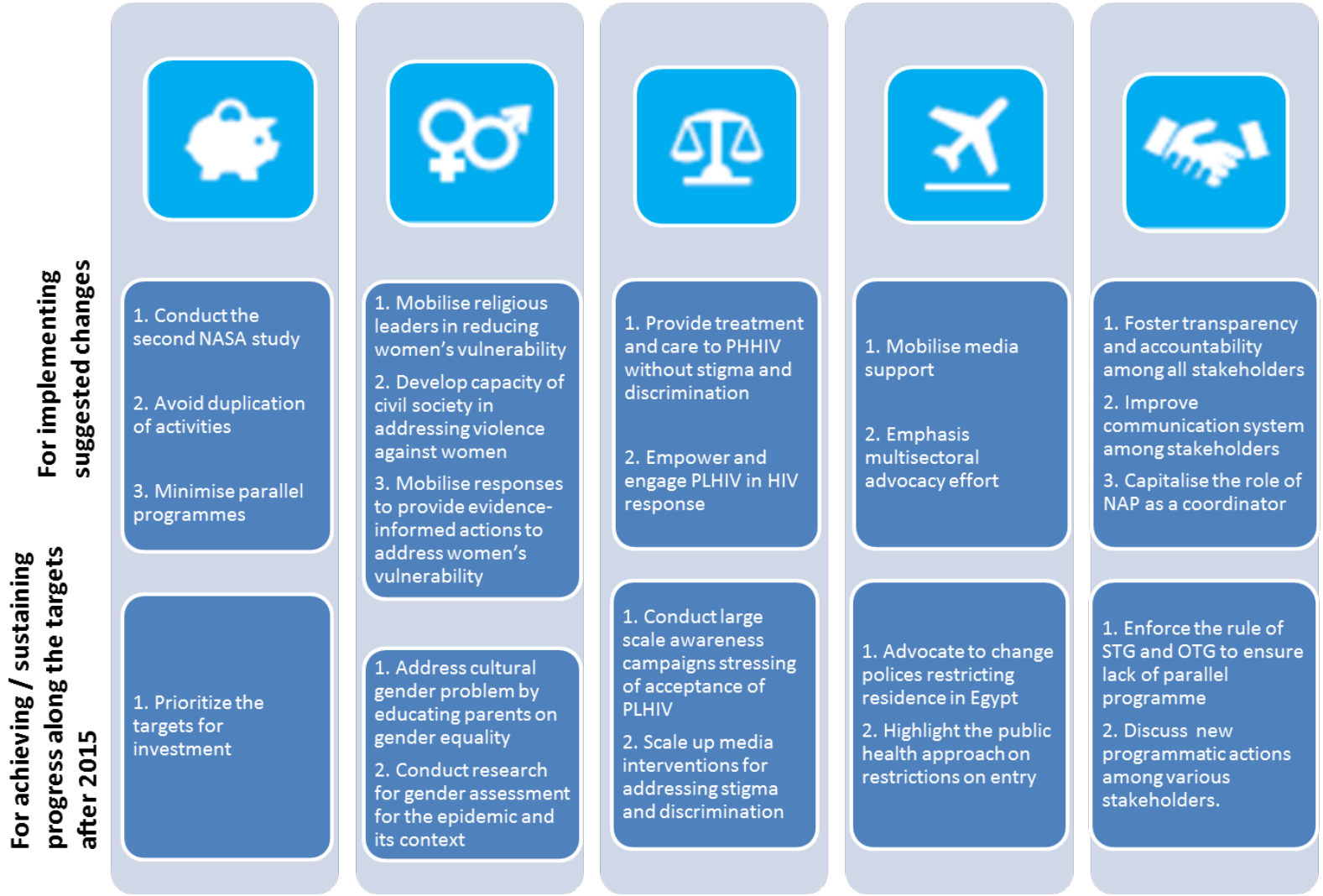
Nevertheless, revising the national strategic plan and assessing progress to realign and refocus its priorities is a must. This exercise comes to start this process and paves the way towards a more comprehensive alignment and review exercise, informed by strategic evidence.

The process itself has brought together different stakeholders and elicited difficult discussions around the table, which increased the level of transparency in communication between the different actors and showed the need for keeping this forum abreast of future development.

4.2. Recommendations and new investments

The stocktaking exercise composed the following recommendations for implementing suggested changes in the strategies and achieving and sustaining progress along the 10 targets after 2015.




For implementing suggested changes
For achieving / sustaining progress along the targets after 2015
1. Conduct the second NASA study
2. Avoid duplication of activities
3. Minimise parallel programmes
1. Prioritize the targets for investment
1. Mobilise religious leaders in reducing women's vulnerability
2. Develop capacity of civil society in addressing violence against women
3. Mobilise responses to provide evidence-informed actions to address women's vulnerability
1. Address cultural gender problem by educating parents on gender equality
2. Conduct research for gender assessment for the epidemic and its context
1. Provide treatment and care to PHHIV without stigma and discrimination
2. Empower and engage PLHIV in HIV response
1. Conduct large scale awareness campaigns stressing of acceptance of PLHIV
2. Scale up media interventions for addressing stigma and discrimination
1. Mobilise media support
2. Emphasis multisectoral advocacy effort
1. Advocate to change polices restricting residence in Egypt
2. Highlight the public health approach on restrictions on entry
1. Foster transparency and accountability among all stakeholders
2. Improve communication system among stakeholders
3. Capitalise the role of NAP as a coordinator
1. Enforce the rule of STG and OTG to ensure lack of parallel programme
2. Discuss new programmatic actions among various stakeholders.

4.3. The role of key stakeholders

This paper recommends the following roles for the stakeholders for achieving the 10 targets of the 2011 Political Declaration of AIDS by 2015.

The government

Policy level advocacy is a key role. Advocacy efforts should focus on closing the programme coverage gap for prevention programmes, and elimination of stigma and discrimination at all levels. Resource mobilisation, furthermore, falls within the government role in securing a sustainable national HIV response.

Civil Society

Civil society has been a driving force for implementing prevention programmes for key and vulnerable populations as well as care and support for PLHIV. This report urges to conduct needs assessment for increasing coverage and improve quality of services for delivering cost-effective interventions. In addition, provision of legal services is emerging needs for protecting the rights for PLHIV and those affected by HIV. Additionally, coordination among the civil society organisations will reduce duplication of the programmes for better resource allocation.

The UN agencies

As a mandate from the UN, technical and financial support play a pivotal role for the UN Joint Programme of Support. Furthermore, UN agencies and programmes should conduct or commission research for enhancing evidence-informed interventions. Additionally, technical support to strengthen the capacity of the government and civil society to improve existing interventions and expand programme coverage in Egypt. Lastly, the UNJPS will assist the government and civil society to mobilise financial and technical assistance from different national and international stakeholders.

People living with HIV

PLHIV are central to the HIV response. PLHIV should play an important role in implementing evidence-informed programming. Empowering PLHIV, therefore, enhances the programme especially in terms of eliminating stigma and discrimination, and promoting right-based

approach in health care provision. This includes prevention, treatment, care and support for PLHIV and those affected by HIV.

Media

Media intervention has had great impact in conveying information about HIV and AIDS. This report recommends that advocacy effort should be strengthened by 2015 especially for eliminating stigma and discrimination. Awareness efforts for media representatives, therefore, will improve producing correct messages about HIV and AIDS.