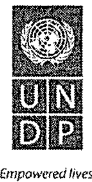
UNITED NATIONS DEVELOPMENT PROGRAMME



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PROJECT DOCUMENT
[Egypt – GFATM - UNDP]

Project Title: Strengthening the HIV and TB Response in Egypt
Project Number: 00119017, Output: **00115586**
Implementing Partner: United Nations Development Programme
Start Date: 1 April 2019 **End Date:** 30 March 2022

Brief Description
Recent data shows that the HIV epidemic in Egypt has grown but remains mostly concentrated and affecting key and vulnerable populations. The overall HIV prevalence among the general population remained largely unknown but estimated at below 0.02%. Evidence has shown that HIV is affecting specific key population groups. An Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2010 indicated an overall prevalence of 0.5% among SBG, 6.1% among MSM, and 7.2% among PWID. Programmatic data among FSW in 2010 indicated an average of 2.9% HIV prevalence. *Egypt's national response is guided by global priorities in addressing HIV/AIDS and aligned with the Sustainable Development Goals and the 2016 Political Declaration on AIDS High level meeting 2016 globally set targets. The National AIDS Program (NAP) leads the national response to the HIV/AIDS epidemic in Egypt. The NAP has, in July 2018, concluded a consultative and inclusive process of reviewing and revising the National HIV Strategic Plan (NSP). The NSP 2018 to 2022 has been built on the four pillars of the preceding National Strategic Framework 2015-2020: (1) prevention, (2) testing, care, support & treatment, (3) enabling environment, and (4) management, coordination & knowledge generation.* *There have been positive developments in the national HIV response in Egypt over the last years. Most notably, there are small-scale prevention programs implemented for the key populations of people who inject drugs (PWID), men who have sex with men and female sex workers. Prevention services for these populations have been made available outside the two largest cities of Cairo and Alexandria.* *This program is proposed in complementarity to the HIV services already provided by the Government of Egypt and other ongoing efforts. The program builds on the previous implementation experience, including lessons learned and best practices. The program is aligned to the concentrated-nature of the HIV epidemic in Egypt. The program being thus prevention-oriented, focusing on interventions targeting key affected populations (KAPs). In addition to improving the overall HIV service delivery in Egypt through other capacity development interventions that target the improvement of the overall HIV detection and treatment.* *WHO estimates indicate that between 1990 and 2017, Egypt's TB incidence declined from 35 (32-39) to 13 (11-14) per 100,000 population; and TB related mortality declined from 3.5 to 0.41 per 100,000 population (excluding HIV associated TB) (Annex 03: WHO Country TB Profile).* *MDR TB prevalence is estimated at 14% and 30% among new patients and retreatment patients, respectively. 83% of all TB patients were notified. This program comes in addition to other ongoing efforts by the Government of Egypt. The program is prioritizing addressing the DR-TB issue in addition to improving the Capacity building in Clinical Management of DR-TB, Improving the Monitoring and Evaluation and strategic information. Since TB notification remains a challenge, this program will also improve case detection and notification of Tuberculosis among priority groups.*

Contributing Outcome (UNDAF/CPD, RPD or GPD): Indicative Output(s) with gender marker[2]: GEN2	**Total resources required:**		$ 2,058,336
	Total resources allocated:		
		UNDP TRAC:	-
		Donor (the Global Fund):	2,058,336
		Government:	-
		In-Kind:	-
	Unfunded:		-

Agreed by (signatures)[1]:

UNDP
Randa Aboul Hosn Resident Representative a.i
Date:

[1] Note: Adjust signatures as needed

[2] The Gender Marker measures how much a project invests in gender equality and women's empowerment. Select one for each output: GEN3 (Gender equality as a principle objective); GEN2 (Gender equality as a significant objective); GEN1 (Limited contribution to gender equality); GEN0 (No contribution to gender quality)

I. DEVELOPMENT CHALLENGE (1/4 PAGE – 2 PAGES RECOMMENDED)

While there are significant gaps in the HIV epidemiological data for Egypt, it has been noted that the HIV epidemic has grown but remains mostly concentrated in specific geographic areas (Cairo/Giza, Alexandria) and among key and vulnerable populations. The overall HIV prevalence among the general population remains largely unknown but estimated at below 0.02%. There are no estimations available on HIV prevalence among pregnant women.

An Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2010 reached the following overall prevalence rates: 7.2% among people who inject drugs (PWID); and 6.1% among men who have sex with men (MSM); 0.5% in street boys and girls (SBG). Programmatic data also indicated an average of 2.9% HIV prevalence among female sex workers (FSW) in 2010. In the absence of more recent IBBSS data, and the limited scope of interventions targeting HIV prevention among key populations, it is probable that the prevalence has remained constant or, more likely, increased among these key populations. According to UNAIDS estimates, there has been a growing trend in the number of new HIV infections in Egypt, with the number of people living with HIV increasing by around 130% between 2010 and 2017. Modeled estimates (UNAIDS) suggest that the annual number of new HIV infections will rise from 2,342 in 2017 to 3,740 in 2022. There are approximately 16,000 people living with HIV in the country, with an estimated 51% of people living with HIV who knew their status in 2017, 47% of those who knew their status were on ART, and 43% of those on ART were virally suppressed.

Egypt has experienced a decreasing incidence, prevalence and mortality of TB in the last three decades, with incidence declining from 35 to 13 cases per 100,000 population and mortality declining from 3.5 to 0.41 per 100,000 population between 1990 and 2017. Egypt's TB burden is therefore low and similar to other countries in the Eastern Mediterranean Region. The country notified 83% of estimated cases, or 8,195 incident and 309 previously treated cases in 2017, with a higher proportion of smear-positive male than female cases. Given the low prevalence of HIV, only a small proportion of people with TB are co-infected with HIV.

TB treatment success rate for drug-sensitive TB cases was 87% in 2016 and the populations considered at risk of TB include slum dwellers, refugees and prisoners. Noticeably 14 and 30 percent of new and retreatment patients had Multi Drug Resistant-TB in 2017.

The Government of Egypt is committed to covering 88.6% (US$ 85.27 million) of the total projected financing needed for implementing the National HIV Strategic Plan for the period 2019-2022. Other main source of funding for HIV come from UN agencies and other international donors with an estimated US$ 1.1 million contribution over the same period. The above anticipated contributions leave a funding gap of approximately US$ 9.86 million. The Global Fund's allocation to the country during the period 2019-2022 is estimated to cover 8% of this funding gap.

The National TB Program and its National Strategic Plan has a projected financing need of US$ 9.96 million for 2019-2022. The Government of Egypt's anticipated funding allocation for this disease component is US$ 5.3 million, which corresponds to 53% of the funding need. However, and unlike the HIV response, there is currently no funding commitments from other donors for TB, which leaves a funding gap of US$ 4.65 million in TB health financing for the period 2019-2022. The Global Fund grant allocation to the country during the 3-year period commencing January 2019 would cover 16% of the funding gap for TB.

II. STRATEGY (1/2 PAGE - 3 PAGES RECOMMENDED)

Disease Component: HIV

The National HIV Strategic Plan (NSP) 2018-2022 has been developed through a multi-stakeholder consultative process that involved a mid-term program review and analysis. It is a revised document of an already existing HIV/AIDS Strategic Framework 2015 – 2020. It was essential that the NSP revision focuses on ensuring sustainability and supporting impact-oriented, cost-efficient interventions to scale up and fast-track Egypt's national response to HIV. This new strategic plan is extending the scope of the operations beyond 2020 to cover the period until 2022,

aligning itself with the Global Health Sector Strategy on HIV 2016-2021. It is has drawn from lessons learned through the implementation of the previous national strategies.

The new NSP contains four Strategic Impact Targets that have also guided the design and prioritization of modules and interventions included in this Funding Request.

Strategic impact target 1: *Achieve the global targets on HIV testing and diagnosis.* HIV testing remains the entry point for HIV prevention, treatment, and care services. It is a strategic pillar for achieving the global targets of 90-90-90. The Government of Egypt, through its national AIDS program, is committed to meeting the global commitments and ensure that 90% of all people living with HIV know their status by the end of 2022.

Strategic impact target 2: *Achieve the global targets on HIV/AIDS treatment and quality of care.* Globally, countries have committed to ensuring that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020. Egypt had committed to fast track the response during in the period 2016-2020. Given the progress and its challenges in recent years, the country is aiming to catch-up on some of its key targets has now reset its goal of achieving these targets by 2022.

Strategic impact target 3: *Achieve the global targets on Zero new HIV infection.* Egypt is committed to achieving zero new infections as a global target of the Fast Track strategy to end AIDS as a public health threat by 2030. The growing trend of the new infections in Egypt calls for urgent actions to reverse this trend, and to focus on high impact interventions and strategies to achieve this goal. The country aims at reducing the estimated number of new HIV infections by 50% of its 2017 baseline by the year 2022.

Strategic impact target 4: *Build strong and sustainable systems for delivery of HIV services.* The global architecture of global health financing calls for more focus on strengthening systems to deliver ambitious programs like HIV epidemic control. Effective, efficient and comprehensive health and community systems are vital for ensuring accessible, affordable and sustainable HIV services. At the same time, HIV innovation and investment are helping to transform health systems and empower communities in ways that benefit other public health and social areas. Enhanced capacity of data, finance, HR, supplies and service delivery systems, are all essential to deliver a successful response, together with collaborative contributions from community and civil society players.

HIV Priority Modules 1 to 3 that are being proposed for this funding allocation are focused on reaching key populations with HIV prevention services. Key populations continue to be the primary drivers of a concentrated HIV epidemic in the country. Egypt aims, by 2022, to reduce the annual number of new HIV infections from 2,100 to under 1,000 and eliminate new HIV infections among children. Achieving this reduction in the number of new HIV infections will only be possible through a combination of interventions that aim at breaking the trajectory of transmission. This includes a combination of biomedical interventions, in addition to a robust strategy for addressing social and structural determinants, social behaviour change communication, and customized interventions for key and vulnerable populations.

According to recent population size estimates in priority governorates, there are around 23,000 female sex workers (FSW), 64,000 men who have sex with men (MSM) and 93,000 people who inject drugs (PWID) who need to be reached with the services. A minimum package of prevention services, following technical guidelines from WHO and collaborates, will be adapted to the local context and delivered. This core prevention package includes behavioural interventions, condoms distribution, and provision of voluntary counselling and testing services.

Greater Cairo or Cairo/Giza, Alexandria, and Gharbya have been chosen for prevention activities as they have the largest populations and the most HIV case detections so they are assumed to

have the largest numbers of members of key populations. The smaller centre of Menia was also added.

HIV Priority Module 1: Focused prevention programs with people who inject drugs and their partners

Intervention: Peer education & outreach program and drop-in centres.

Efforts are in place to reduce risks among people who inject drugs. However, these efforts remain limited in geographical coverage and capacity. Furthermore, a challenge exists in sustaining these efforts given the program funding interruption that had happeed since 2013 (Global Fund). Currently, CSOs have ongoing programmes in Cairo, Alexandria and to a lesser extent, in Menia. Most programmes utilize the comprehensive care center model in the provision of services and conduct outreach work through peer field workers.

Voluntary counselling and testing is offered to all people reached and those who test positive for HIV are encouraged to join support groups. They are referred for care but thus far, no systematic tracking of care is being done. About three thousand people who inject drugs have been served in the past several years. Ninety per cent of them are male, ten percent are men who have sex with men and about eighty per cent of them have undergone HIV testing. Women who inject drugs are not systematically reached by programmes. There is also a programme implemented by Caritas in Alexandria which has reached two hundred and seventy people in the last year and a half, mostly people who inject drugs and some men who have sex with men. Only two to three in a hundred are women. Beneficiaries are offered needles and syringes, referral for treatment of substance use disorder, targeted education, condom promotion, & voluntary counselling and testing. There are small-scale prevention programmes for people who inject drugs in and Menia but these programmes have not yet been systematically assessed. The sexual partners of people who inject drugs, including spouses, are not systematically reached with prevention activities.

Based on the "Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, treatment and Care for Injecting Drug Users" issued jointly by WHO, UNODC and UNAIDS, the package of services for people who inject drugs being proposed in this funding request includes: needle and syringe distribution, HIV testing and counselling, antiretroviral treatment, condom program, targeted information, education and communication, prevention, vaccination and diagnosis of Viral Hepatitis and Tuberculosis. These services will be provided through peer education outreach programs, drop-in centres and fever hospitals.

Funding will be used for two drop in centres for people who inject drugs, one in Cairo and one in Alexandria, as well as two peer education outreach model programmes: in Greater Cairo one serving both people who inject drugs and men who have sex with men, and the second in Menia. Given the limited allocation for this proposal, two comprehensive care centers are being proposed within allocation to cover Cairo and Alexandria, while one outreach model in Cairo proposed within allocation and another in Menia above allocation. This is based on estimates of number of PWID in Egypt.

Finally, funding is requested to conduct large group education sessions for a total of eighteen hundred people who inject drugs over three years who are in governmental, nongovernmental, and private sector drug rehabilitation facilities. These sessions will offer information on HIV prevention and refer people with substance abuse disorders who have had risk behaviour for voluntary counselling and testing. Many PWID cannot be reached through peer education outreach program and cannot access the drop in centres, so these on-site sessions target PWID seeking rehabilitation services from governmental centres to provide them with prevention awareness and to link them with NGOs.

HIV Priority Module 2: Focused prevention programs men who have sex with men

Intervention: Peer education & outreach program and drop-in centres.

As with PWIDs, a package of prevention activities is also being implemented for men who have sex with men: targeted education and comprehensive condom promotion in addition to STI treatment, psychosocial counseling, legal support and medical services. Voluntary counselling and

testing is also offered and people who test positive for HIV may join support groups and be referred for care. But as with other current HIV care programs, no systematic tracking is being done. Prevention activities for men who have sex with men currently take place in Greater Cairo, Alexandria, Luxor and Gharbya. There are new initiatives to reach the female partners of men who have sex with men in Alexandria through provision of attractive services for women such as subsidized high quality healthcare or couples interventions including premarital testing, health education and antenatal care.

The proposed package of services for men who have sex with men includes behavioural change interventions and condom and lubricant distribution. Teams of peer educators will conduct outreach with men who have sex with men to deliver information, education and communication messages regarding HIV prevention and care. These outreach programs are to be implemented by civil society organizations. Individuals are referred to either a voluntary counselling/testing service provider or a drop-in center for testing, counselling, and access to condoms and lubricants.

Drop-in centers are supported to provide a package of services that include information, education and communication messages, voluntary counselling and testing, condoms, medical care, and psychological counselling.

Referral to Tuberculosis and Viral Hepatitis services are also integrated into service packages of outreach programs and drop-in-centers.

Funding will be used for three sites based on the peer education outreach model: one in Greater Cairo , one in Alexandria and one in Gharbya. Given the limited allocation for this proposal, only two interventions were proposed within allocation to cover Cairo and Alexandria, while one outreach model in Gharbya proposed above allocation.

HIV Priority Module 3: Focused prevention programs for sex workers and their clients

Intervention: Peer educators outreach program and drop-in centres.

One local nongovernmental organization has activities for female sex workers in parts of Greater Cairo and Alexandria. Peer education outreach workers currently reach about fifty women per month due to underfunding. Half of beneficiaries are newly reached and half have been reached before. The key peer education outreach activities are targeted education and condom promotion. A wide range of other services are offered through a drop in centre, including legal services, psychosocial support, referral for health services, and voluntary counselling and testing. It is remarkable that NGO staff accompany women who test positive on their first visits to ART provision centres and continue contact with them in their first year of treatment. Current reach of prevention will have almost no impact in the geographic areas in which activities take place. Higher reach and coverage would be necessary among the female sex workers who have the most sexual partners in places where the highest number of female sex workers work to prevent an epidemic. There is value in having female sex worker-specific services programmes as women peer education outreach staff will be more effective than men peer education outreach staff and a full-fledged programme could include interventions for clients and gate keepers. WHO guidelines recommend targeted education and comprehensive condom and lubricant promotion as well as structural interventions.

The package of services for female sex workers is composed of behavioural interventions and condom distribution. HIV testing is also included in this package as it is largely delivered by the same organizations that deliver prevention interventions. During outreach activities of the NGOs/CBOs in FSW "gathering spots", the outreach teams provide prevention and awareness messages, but most importantly they also provide referrals to drop-in centres and associated services.

As with the other key population groups, outreach work and drop in centres are being proposed in this funding request. An attempt will be made to reach the halfway point to universal access to

prevention services (40%) for the population of female sex workers over the three year grant period. By the third year of the grant, annual service coverage in Cairo will reach 2,597 representing all of the targeted population, and in Alexandria 775 representing 46% of the targeted population. Annual HIV testing coverage in Cairo/Giza will be 70% of those reached and in Alexandria 70%. Given the limited allocation for this proposal, one comprehensive care center is proposed within allocation to cover Cairo, while one outreach model in Alexandria proposed above allocation. This is based on estimates of number of FSW in Egypt.

This funding request is for one drop in centre model programme in Cairo, and one peer education outreach model programme in Alexandria. Funding to implement the national operational plan will be mobilized from other donors due to the current limits of Global Fund's allocation for Egypt's country response to HIV and TB.

HIV Priority Module 4: Treatment, care and support

Intervention 4.1: *Training for counselling and testing workers from governmental and nongovernmental units to improve their counselling skills.*

A testing quality assurance tool will be developed and implemented. Training will be delivered for one hundred and twenty counseling and testing workers in eleven fever hospitals over the three year period. This training is aimed improving their counselling skills. It is envisioned that this will result in increased adherence to treatment through the building of better relationships between providers and beneficiaries of service. This will be antiretroviral expert training through 5 training sessions in three years, This training course on HIV was designed to assist health care providers to assess, classify, treat and follow up HIV/AIDS and also to enhance their skills in counselling around HIV/AIDS. The course is designed to build upon and complement the existing capacity of health care providers.

The course has been developed for clinicians and pharmacists in centres providing care and treatment to people living with HIV, mainly at fever hospitals. Gaps in service delivery, partly due to centralized prescription services, have led to drop outs, and this activity being proposed under this funding request, aims to bridge those gaps. Focal persons responsible for coordinating the implementation of the HIV/AIDS services from each corresponding governorate will also be enrolled to ensure proper follow up and decrease number of loss to follow ups

The course adopts a participatory and interactive approach, built around the information contained in national guidelines for HIV/AIDS care and ARVs.

All activities will include a component on community partnerships. The expert training on ARVs aims will also include specialists from treatment sites and NGOs with medical services background to help increase PLHIV access to services.

While capacity development activities for providers all seen as essential, given the limited funding for this proposal, training for VCT personnel was divided between allocation and above allocation.

Intervention 4.2: Treatment adherence support

Educational session on adherence and antiretroviral treatment, support groups for people living with HIV, and training for health care providers

Treatment literacy and support groups will be organized and supported, in close collaboration with CSOs. The care and support forum - which is responsible for discussing issues related to care, treatment, ARVs and psycho social support - includes representatives from various governmental, academic and nongovernmental entities. This will create a common missing link to establish referral systems and prevent loss to follow ups, especially those testing positive at university hospitals and NGOs sites.

HIV Priority Module 5: Program to reduce human-rights related barriers to HIV services

Intervention:

This intervention involves the creation of a supportive and/or tolerant environment, helping reduce barriers to access, facilitating the scaling up and improving the quality of services for key populations. This can be achieved through joint activities of government and civil society groups, and the judiciary and legal sector. An example of this is the Training-Of-Judges that covers criminal cases concerning illegal "behaviour", labour-related cases and rights violations on persons living with HIV.

Another fundamental requirement for scaling up and improving coverage – is to safeguard outreach teams, peer workers and marginalized (sometimes 'hidden') key population groups as they access HIV prevention, care and treatment services. C

Coordination and partnership between the relevant NGOs and the governmental bodies is key to achieving this supportive environment. Key government ministries that need to be engaged in this collaborative effort include: MOSS (Ministry of Social Solidarity), MOI (Ministry of Interior) and MOH (Ministry of Health).

The funding request is for legal education of judges, prosecutors and leaders from key governmental institutions on special topics related to people who inject drugs, men who have sex with men, female sex workers and people living with HIV. These activities are to be implemented with direct collaboration from NAP-MOH. This training is aimed at reducing HIV stigma & discrimination reduction. This will be conducted by UNDP in collaboration with legal service providers who had previously undergone similar training.

This intervention will be complemented by parallel work with health workers and doctors on stigma and discrimination, which is being planned for implementation by the CSO Al Shebab Foundation with funding from the 5% French Initiative.

HIV Priority Module 6: Programme management

An organizational capacity assessment of the National AIDS Programme office will be undertaken and action taken to improve capacity based on this assessment. While this is a critical activity, we are envisioning getting support for this from other sources if above allocation resources are not granted. Hence, only 50% of assessment and capacity development activities are requested from within allocation. Three national forums with multi-ministerial governmental and civil society participation will be established and will meet quarterly: one for prevention, one for care, support, and treatment, and one for the enabling environment.[xvi] The enabling environment forum will address key issues as gender issues, the legal environment, human rights, and stigma & discrimination. A review of the current monitoring and evaluation system will be undertaken, software will be developed, and management meetings will be held with HIV focal points in key governorates.[xvii] The new system is envisioned to also build a link with the national TB program. Support for these forums is proposed to be covered 50% from within allocation and 50% from above allocation. Through this system, a coding system for outreached key populations will be developed and standardized to avoid double counting, in addition to a case management system to ensure proper follow up of people living with HIV on treatment.

Disease Component: Tuberculosis

TB Priority Module 1: TB Care and Prevention

Intervention 1.1. Case detection and diagnosis

Sub-intervention 1.1.1. Increasing case detection through revising access to diagnosis pathway and implementing access to new and more sensitive diagnostic technology; revision of program guidelines; revision of diagnostic algorithm

Sub-intervention 1.1.2. Countrywide roll out of XpertMTB/Rif in alignment with WHO recommendations and linked to ongoing operational research to ensure efficiency ad

effectiveness; backed up with confirmation with culture as appropriate and linked to full first and second line treatment programs for all patients diagnosed; identified at risk populations and children prioritised

Sub- intervention 1.1.3. Increase access to TB diagnosis in priority work places - prioritise factory workers already under social support umbrella of the HIO

Sub-intervention 1.1.4. Increasing notification from university hospitals

Sub-intervention 1.1.5. Increasing notification from the private sector

Sub-intervention 1.1.6. Contact management program

Intervention 1.2. Treatment

Sub-intervention 1.2.1. Decentralising treatment closer to the patient and improving treatment observation and support, reducing treatment default and improving cure rates for patients on first line treatment

Sub-intervention 1.2.2. Ensuring continuous supply of anti-TB drugs at all TBMUs and treatment centres

Intervention 1.3. Prevention

Sub-intervention 1.3.1. Isoniazid chemoprophylaxis for all eligible children who are household contacts of infectious TB

Sub-intervention 1.3.2. Isoniazid preventive therapy for all PLHIV without active TB disease

Sub-intervention 1.3.3. BCG for all infants per national immunisation policy and booster dose as recommended

Intervention 1.4. Engaging all providers

Sub-intervention: Engage with all providers for accountability, recording and reporting at national, sub-national and district level integration of reporting into the NTP M & E framework, supervision and technical support

Intervention 1.5. Key affected populations

Sub-intervention 1.5.1. Target urban slums for screening

Sub-intervention 1.5.2. Migrants and refugee populations in Egypt prioritising the governorates of Cairo, Giza , Kalyoubeya, Alexandria

Sub-intervention 1.5.3. Prison populations (on entry and resident inmates) in all 44 prisons in the country

Sub-intervention 1.5.4. School children and old age widows and pensioners covered through HIO for social support

Intervention 1.6. Collaborative activities with other programs and sectors

Sub-intervention 1.6.1. Expanding operational research in the country for TB

Sub-intervention 1.6.2. Framing guidelines for the management of complicated TB managed in tertiary hospitals

TB Priority Module 2: MDR TB

Intervention 2.1. Case detection and diagnosis MDR-TB

Activities to ensure access to DST for all TB patients; Per the guidelines, priority population is all retreatment patients, new patients on treatment who do not convert at the end of IP, contacts of MDR patients, any TB patient diagnosed in prison settings, TB patients with HIV co-infection. From year 1 onward, access to DST will be expanded for new TB patients beyond late convertors in a phased manner, through revision of the diagnostic algorithm prioritising key populations such as HIV infected, refugees and urban slums.

Intervention 2.2. Treatment - MDR-TB

Ensure that all patients detected with MDR-TB are enrolled onto treatment; focus on in-hospital treatment in identified treatment centres for intensive phase and adverse events and later community based care. Expand number of referral centres from 3 - 4

Intervention 2.3: Community TB care delivery

Pilots for community-based care; expansion of community based model across the country

Intervention 2.4. Prevention for MDR-TB

Implement TB infection control practices in all health care facilities

Intervention 2.5. Engaging all providers – MDR-TB

Engage with care providers working with MDR-TB - university hospitals, general hospitals, HIO, prisons, NGOs working with refugee populations, private chest physicians

Intervention 2.6. Key affected populations

Sub-intervention 2.6.1. Prisoners; Provide access to DST for all prisoners diagnosed with any form of TB

Sub-intervention 2.6.2. PLHIV; provide all TB patients with co-infection with access to DST (in collaboration with NAP and care providers in HIV care settings and linked to specimen transport system)

Sub-intervention 2.6.3. Migrant and refugee populations; all migrants and refugees diagnosed with TB will access DST (collaboration with UNHCR and Refuge Egypt)

Intervention 2.7. Collaborative activities with other programs and sectors

Sub-intervention 2.7.1. Introduce new and shorter regimens through operational research in the country (such as the introduction of bedaquiline)\

Intervention 2.8. TB/HIV Collaborative interventions

Sub-intervention 2.8.1. Set up a national coordinating committee within the MoPH for TB-HIV with representation from the curative and preventive health sectors

Sub-intervention 2.8.2. Support the implementation of intensified case finding and Isoniazid preventive therapy in HIV care settings

III. RESULTS AND PARTNERSHIPS (1.5 - 5 PAGES RECOMMENDED)

Expected Results

(see appendix one, performance framework of the project)

Resources Required to Achieve the Expected Results

In order to achieve the expected results, the following resources will be necessary:

- Medicines and medical products, especially laboratory equipment and consumables, for TB detection and treatment

- Medical products for HIV detection

- Upgrade of the information system to improve TB case notification

- Trainings for health personnel on the management of multi-drug resistant TB

- Incentives to multi-drug resistant (MDR) TB patients, to support adherence to treatment, and to health workers working with MDR TB patients

- Outreach missions for TB detection among target groups

- Operational research on MDR TB and drug resistance

- Visits and monitoring missions

- Support to outreach programmes in Cairo, Alexandria and Menia for key populations

- Training for health care providers (HIV)

- Advocacy training for key religious leaders, media on HIV topics

All these resources have been secured in the project budget.

Partnerships

The project will be implemented by the national TB programme, the national HIV programme, both attached to the ministry of health (MOH). They will implement the country-wide programmes, the information system related activities, will receive the medicines and medical products, train the health care workers, supervise the operational research and perform the monitoring and evaluation activities.

The MOH activities will be complemented by actions undertaken by NGOs with key populations. The NGOs have been selected based on their previous experience with key populations as well as their capacity to handle donations from international financial partners[2].The selected NGOs are:

1. Al Shehab : HIV Prevention Services for Female Sex Workers (FSWs) in Cairo
2. Friends of Al Menia: HIV Prevention Services for People who Inject Drugs (PWIDs) and Men-who-have-sex with-Men (MSM) in Al-Menia.
3. Befrienders: HIV Prevention Services for People who Inject Drugs (PWIDs) in Cairo
4. Al Dhahrya: HIV Prevention Services for Men-who-have-sex with-Men (MSM) in Alexandria Governorate

Two other internationally-funded initiatives can complement the activities undertaken by the project:

- A project financed by the French technical cooperation ("initiative 5%"), also working with key populations
- A regional project financed by the Global fund, with actions in Egypt, and implemented regionally by the HIV/AIDS alliance, and in Egypt by Caritas.

Synergies will need to be found with these two progammes to maximize the impact of the actions and avoid duplications.

It is finally important to note that the UNAIDS and WHO national offices have been key in the project formulation and grant making phases of the grant, and would certainly continue to play an important role in the project implementation phase.

[2] The assessment was done using the corporate sub recipient assessment process

Risks and Assumptions

The following table summarizes the risks identified and possible mitigation measures

Risk	Mitigation measures
Late initiation of the programme due to difficulties to obtain clearances from the national authorities	Support from UNDP
Poor reporting from the Sub Recipients, delaying the reporting and leading to a poor grant rating	Sub Recipients training (already conducted), proactiveness with the Sub Recipients
Poor financial delivery jeopardizes the possibility to obtain additional funding for the project	Front load the procurement of medicines and medical products
Difficulties to implement outreach programmes with key populations	Concentrate ressources on outreach activities and work in coordination with the MOH and other two projects

Stakeholder Engagement

The main stakeholders have been closely associated with the formulation of the grant at its different stages. During the implementation, regular meetings will be conducted to assess the performance of the project, identify best practices as well as implementation challenges.

South-South and Triangular Cooperation (SSC/TrC)

The project will certainly benefit from the experience from other similar initiatives either in the region, or globally. UNDP's Global Fund / Health Implementation Support Team based in Geneva will facilitate knowledge sharing and organize, upon request, the communication with successful initiatives

Knowledge

The project includes three annual programme reviews, to be conducted by the implementers. Two operational researches will also be conducted. Finally, the programme will benefit from the communication support provided by UNDP headquarters

Sustainability and Scaling Up.

The project supports the national systems and represents only a small fraction of the overall budget devoted by the national authorities to the responses to HIV and TB.

IV. PROJECT MANAGEMENT (1/2 PAGES - 2 PAGES RECOMMENDED)

Cost Efficiency and Effectiveness

All the cost of the project have been assessed during a two days collective budgeting exercise, in presence of the donor and international auditors. All the medicines and health products purchased under the grant are part of the national treatment protocols, vetted by WHO. Their prices have been verified internationaly. The actions to be implemented are considered as standard actions undertaken to achieve the targets of the project. Finally, the overall coherence and effectiveness of the project have been reviewed twice by an independent Technical Review Panel, as part of the standard Global Fund procedure to access funding. It is therefore reasonable assume that the project is well designed to deliver the objectives defined in the performance framework.

Project Management

The project will be managed by UNDP Egypt country office, by two national staff members and the support from the operations of the Country Office as well as the Global Fund Health Implementation Support Team based in Geneva. It will be audited once by UNDP's Office of Audit and Investigation (OAI). Sub Recipients will be audited annually by an international audit firm. The project will benefit from synergies with other programmes implemented in Egypt, as well as from UNDP initiatives conducted in the region.

V. RESULTS FRAMEWORK[3] (PLEASE SEE THE PERFORMANCE FRAMEWORK ATTACHED)

VI. MONITORING AND EVALUATION (PLEASE REFER TO THE PREFORMANCE FRAMEWORK ATTACHED)

VII. MULTI-YEAR WORK PLAN [4][5]

All anticipated programmatic and operational costs to support the project, including development effectiveness and implementation support arrangements, need to be identified, estimated and fully costed in the project budget under the relevant output(s). This includes activities that directly support the project, such as communication, human resources, procurement, finance, audit, policy advisory, quality assurance, reporting, management, etc. All services which are directly related to the project need to be disclosed transparently in the project document.

EXPECTED OUTPUTS	PLANNED ACTIVITIES	Planned Budget by Year			RESPONSIBLE PARTY	PLANNED BUDGET		
		Y1	Y2	Y3		Funding Source	Budget Description	Amount
Output 1: Main Allocation *Gender marker:2*	1.1 TB care and prevention	254,980	14,640	16320	UNDP, NTP	GFATM		285,940
	1.2 RSSH: Health management information systems and M&E	87,236	31,894	33,614	UNDP ,NTP	GFATM		152,744
	1.3 MDR - TB	150,320	215,465	362,581	UNDP, NTP	GFATM		191,691
	1.4 TB/HIV	2,458	3,277	4,097	NTP	GFATM		9,832
	1.5 Comprehensive prevention programs for people who inject drugs (PWID) and their partners	16,606	62,424	78,030	NAP, NGOs	GFATM		157,060
	1.6 Comprehensive prevention programs for MSM	42,222	97,266	93,120	UNDP, NGOs	GFATM		232,608

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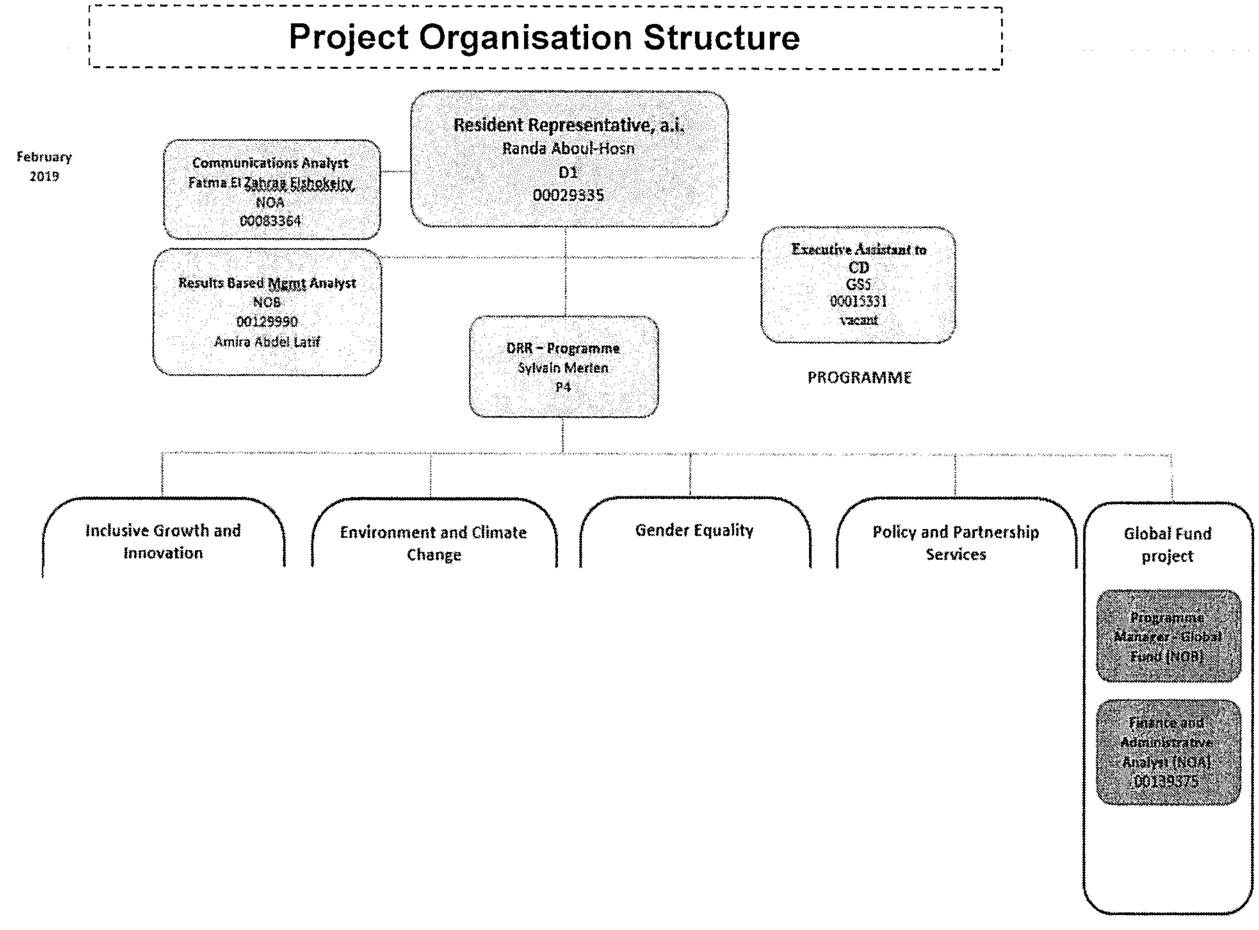
[3] UNDP publishes its project information (indicators, baselines, targets and results) to meet the International Aid Transparency Initiative (IATI) standards. Make sure that indicators are S.M.A.R.T. (Specific, Measurable, Attainable, Relevant and Time-bound), provide accurate baselines and targets underpinned by reliable evidence and data, and avoid acronyms so that external audience clearly understand the results of the project.

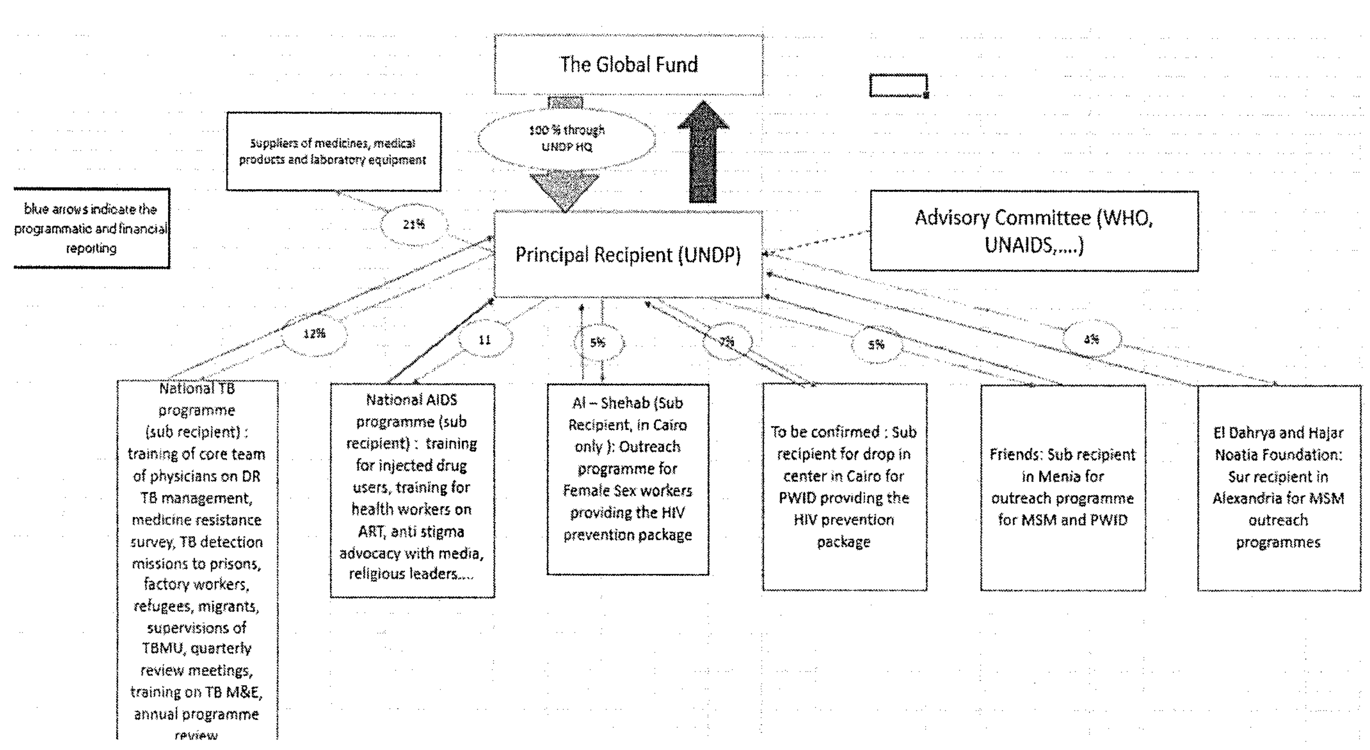
[4] Cost definitions and classifications for programme and development effectiveness costs to be charged to the project are defined in the Executive Board decision DP/2010/32

[5] Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. This procedure may be applied for example when the purpose of the revision is only to re-phase activities among years.

	1.7 Comprehensive prevention programs for sex workers and their clients	9,312	37,248	46,560	NGOs	GFATM		93,120
	1.8 HIV Testing Services	15,987	35,870	8,968	NAP, UNDP	GFATM		60,824
	1.9 Treatment, care and support	29,619	44,428	44,428	NAP	GFATM		118,475
	1.10 Programs to reduce human rights-related barriers to HIV services	3,459	13,838	10,378	NAP	GFATM		27,676
	Sub-Total for Output 1							1,329,969
General Management Support		150,320	215,465	362,581	UNDP	GFATM		728,366
TOTAL								$2,058,336

VIII. Governance and Management Arrangements





IX. LEGAL CONTEXT

This project document shall be the instrument referred to as such in Article 1 of the Standard Basic Assistance Agreement between the Government of Egypt and UNDP, signed on 19/01/1978. All references in the SBAA to "Executing Agency" shall be deemed to refer to "Implementing Partner."

This project will be implemented by United Nations Development Programe - UNDP as Premier Receipent-PR ("Implementing Partner") in accordance with its financial regulations, rules, practices and procedures only to the extent that they do not contravene the principles of the Financial Regulations and Rules of UNDP. Where the financial governance of an Implementing Partner does not provide the required guidance to ensure best value for money, fairness, integrity, transparency, and effective international competition, the financial governance of UNDP shall apply.

X. RISK MANAGEMENT

1. UNDP as the Implementing Partner will comply with the policies, procedures and practices of the United Nations Security Management System (UNSMS.)

2. UNDP as the Implementing Partner will undertake all reasonable efforts to ensure that none of the [project funds][6] [UNDP funds received pursuant to the Project Document][7] are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml. This provision must be included in all sub-contracts or sub-agreements entered into under this Project Document.

3. Social and environmental sustainability will be enhanced through application of the UNDP Social and Environmental Standards (http://www.undp.org/ses) and related Accountability Mechanism (http://www.undp.org/secu-srm).

4. UNDP as the Implementing Partner will: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.

5. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.

6. UNDP as the Implementing Partner will ensure that the following obligations are binding on each responsible party, subcontractor and sub-recipient:

    a. Consistent with the Article III of the SBAA *[or the Supplemental Provisions to the Project Document]*, the responsibility for the safety and security of each responsible party, subcontractor and sub-recipient and its personnel and property, and of UNDP's property in such responsible party's, subcontractor's and sub-recipient's custody, rests with such responsible party, subcontractor and sub-recipient. To this end, each responsible party, subcontractor and sub-recipient shall:

        i. put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;

        ii. assume all risks and liabilities related to such responsible party's, subcontractor's and sub-recipient's security, and the full implementation of the security plan.

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[6] To be used where UNDP is the Implementing Partner

[7] To be used where the UN, a UN fund/programme or a specialized agency is the Implementing Partner

b. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the responsible party's, subcontractor's and sub-recipient's obligations under this Project Document.

c. Each responsible party, subcontractor and sub-recipient will take appropriate steps to prevent misuse of funds, fraud or corruption, by its officials, consultants, subcontractors and sub-recipients in implementing the project or programme or using the UNDP funds. It will ensure that its financial management, anti-corruption and anti-fraud policies are in place and enforced for all funding received from or through UNDP.

d. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to each responsible party, subcontractor and sub-recipient: (a) UNDP Policy on Fraud and other Corrupt Practices and (b) UNDP Office of Audit and Investigations Investigation Guidelines. Each responsible party, subcontractor and sub-recipient agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.

e. In the event that an investigation is required, UNDP will conduct investigations relating to any aspect of UNDP programmes and projects. Each responsible party, subcontractor and sub-recipient will provide its full cooperation, including making available personnel, relevant documentation, and granting access to its (and its consultants', subcontractors' and sub-recipients') premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with it to find a solution.

f. Each responsible party, subcontractor and sub-recipient will promptly inform UNDP as the Implementing Partner in case of any incidence of inappropriate use of funds, or credible allegation of fraud or corruption with due confidentiality.

   Where it becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, each responsible party, subcontractor and sub-recipient will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP's Office of Audit and Investigations (OAI). It will provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.

g. *Choose one of the three following options:*

   Option 1: UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of this Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement. Recovery of such amount by UNDP shall not diminish or curtail any responsible party's, subcontractor's or sub-recipient's obligations under this Project Document.

   Option 2: Each responsible party, subcontractor or sub-recipient agrees that, where applicable, donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities which are the subject of the Project Document, may seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

   Option 3: UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement.

   Where such funds have not been refunded to UNDP, the responsible party, subcontractor or sub-recipient agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may

seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

Note: The term "Project Document" as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with responsible parties, subcontractors and sub-recipients.

h. Each contract issued by the responsible party, subcontractor or sub-recipient in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds from it shall cooperate with any and all investigations and post-payment audits.

i. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project or programme, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.

j. Each responsible party, subcontractor and sub-recipient shall ensure that all of its obligations set forth under this section entitled "Risk Management" are passed on to its subcontractors and sub-recipients and that all the clauses under this section entitled "Risk Management Standard Clauses" are adequately reflected, *mutatis mutandis*, in all its sub-contracts or sub-agreements entered into further to this Project Document.

XI. ANNEXES

1. **Project Performance Framework**

2. **Project Quality Assurance Report**

3. **Social and Environmental Screening Template** [English][French][Spanish], including additional Social and Environmental Assessments or Management Plans as relevant.
(NOTE: The SES Screening is not required for projects in which UNDP is Administrative Agent only and/or projects comprised solely of reports, coordination of events, trainings, workshops, meetings, conferences, preparation of communication materials, strengthening capacities of partners to participate in international negotiations and conferences, partnership coordination and management of networks, or global/regional projects with no country level activities).

4. **Risk Analysis**. Use the standard Risk Log template. Please refer to the Deliverable Description of the Risk Log for instructions

Performance Framework

Country	Egypt			
Grant Name	EGY-C-UNDP			
Implementation Period	01-Apr-2019 - 31-Mar-2022			
Principal Recipient	United Nations Development Programme			
Reporting Periods	Start Date	01-Apr-2019	01-Jan-2020	01-Jan-2021
	End Date	31-Dec-2019	31-Dec-2020	31-Mar-2022
	PU includes DR?	Yes	Yes	No

Program Goals and Impact Indicators

1 Strengthen Sustainable Responses to HIV in Egypt to achieve the International fast-track targets (90-90-90)

2 Strengthen the national response to TB to reduce the incidence and prevalence of TB including Multi-Drug Resistance (MD-R) TB

	Impact Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	2020	Comment
1	HIV I-9a(M): Percentage of men who have sex with men who are living with HIV	Egypt	6.15%	2010 2010 HIV AIDS Biological and Behavioral Surveillance Survey 2010 (IBBS)	Age	N: D: P: 6.099381199664 17% Due Date: 01-Apr-2021	Numerator: Number of Men who have Sex with Men (MSM) who tested positive to HIV in Egypt Denominator: Total number of Men wo have Sex with Men (MSM) who tested for HIV in Egypt. The Baseline data for this indicator is as per Egypt's HIV AIDS Biological and Behavioral Surveillance Survey 2010 (IBBS). Targets: The target for this indicator differs from the NSP because it is taking into account the other multiple factors including the significant interruption of services and the NSP calculating information under this indicator at the Outcome level . The NSP's targets for this indicator are 4.9% and 3.9% for 2021 and 2022 respectively. Targets are based on consensus among partners and NAP leadership. The baseline and target(s) will be revised contingent on the scheduled new IBBS taking place in 2019 with funding in the process of approval under the upcoming French 5% initiative grant for Egypt. As the programme is recommencing after a reported interruption of almost 5 years, and the baseline is from 2010, it is anticipated that the prevalence has risen beyond the 2010 reported baseline given the nature of the concentrated epidemic and especially the interruption of services. Accordingly, with this target, the program is aiming to reduce the prevalence to-and-below the previously reported baseline.
2	TB I-4(M): RR-TB and/or MDR-TB prevalence among new TB patients: Proportion of new TB cases with RR-TB and/or MDR-TB	Egypt	TBD	2019 Drug resistance surveillance survey		N: D: P: % Due Date:	Numerator:Number of new TB cases with RR-TB and/or MDR-TB x 100 Denominator:Total number of new TB cases with DST results/ Xpert result Baseline : The baseline will be set with the 2019 DRS results Targets: The targets will be calculated based on the surveillnace data and expected results from the upcoming Drug-Resistance Survey funded under the grant, scheduled for 2019. The targets will also be included within the on-going TB-M&E review, scheduled to conclude in 2019. Accordingly, the targets will be set for the remaining two years of grant implementation. Results will be informed with Drug resistance surveillance system since the next DRS will take place outside of this grant implementation life-cycle.

Program Objectives and Outcome Indicators

1 Achieving the global target of HIV testing and diagnosis: Ensuring that 90% of PLHIV know their HIV status by 2022.

2 Achieving the global target on HIV treatment and care: Ensuring that 90% of PLHIV who know their status are on treatment.

3 Achieving the global target on Zero HIV new infections: Ensuring that the new HIV infections are reduced by 50% by 2022.

4 Expansion and scaling up successful interventions and introduce evidence based new technology and processes to improve case finding within identified key populations,

5 Building strong, sustainable and resilient community and health services to deliver HIV services.

6 To detect 90% of estimated TB cases including among key-affected-populations and successfully treat 90% of them by 2022.

7 To detect 85% of estimated MDR-TB patients and successfully treat 80% by 2022

8 To strengthen TB surveillance , M&E and program management including implementing comprehensive systems for data management, to meet the NSP targets

	Outcome Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	2019	2020	2021	Comment
1	HIV O-1(M): Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	Egypt	74.5%	2017 NAP Reports:HIV Test Treat and Retain Cascade Analysis (TTR) 2017	Duration of treatment,Age,Gender	N: D: P: 79.5% Due Date: 29-Feb-2020	N: D: P: 84.5% Due Date: 01-Mar-2021	N: D: P: 88.5% Due Date: 01-Apr-2022	The targets for this indicator were calculated on a baseline of 74.5% (NAP Records and Egypt TTR Report 2017): Numerator: Number of adults and children who are still alive and receiving antiretroviral therapy at 12 months after initiating treatment Denominator: Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period Baseline: calculated as per Egypt's TTR 2017 report : 851/1142 Targets: Calculated based on an annual increment of 4.5% based on the national trend of almost 75% in 2017 and 70% in 2016 . Data from Egypt's HIV Test Treat and Retain Cascade Analysis (TTR) reports 2016 and 2017. The Data Source : NAP Reports : HIV Test Treat and Retain Cascade Analysis . The NAP will be responsbile for collecting this data. The target as well as the baseline in this Performance Framework(PF) differ from those indicated in Egypt's National Strategic Plan(NSP) because the baseline in the NSP was not calculated correctly; not as per the standard definition of the indicator. The baseline in the NSP was erroneously calculated using the " Number of Detected HIV cases" as a denominator, as opposed to the " persons initiated on ART" as per the correct definition of the indicator. The PR has already drawn the attention of the National AIDS Program (NAP) to this error which the NAP will correct. Accordingly, we opted to use the correct figures/calculations as per the TTR report.Targets are based on consensus among partners and NAP leadership.

Coverage Indicators

Coverage Indicator	Country and Geographic Area	Baseline	Baseline Year and Source	Required Dissagregation	Cumulation for AFD	01-Apr-2019 31-Dec-2019	01-Jan-2020 31-Dec-2020	01-Jan-2021 31-Mar-2022	Comments
Comprehensive prevention programs for people who inject drugs (PWID) and their partners									
KP-1d(M): Percentage of people who inject drugs reached with HIV prevention programs - defined package of services	Country: Egypt; Coverage: Subnational	N: D: P:	NAP Reports		N-Non-cumulative	N: 888 D: 23,706 P: 3.7%	N: 1,332 D: 23,706 P: 5.6%	N: 2,264 D: 23,706 P: 9.5%	Geographical Coverage: This activity is targeting Cairo and Menia Governorates Baseline: There is no baseline for this indicator. Data collected in the first year of this grant will serve as baseline for future implementation. The target-Numerators: Nr of PWIDs reached with HIV prevention programs - defined package of services. The Numerators were calculated based on the projected service delivery: The services will be provided through one Drop-in Center in Cairo and one Outreach program in Menia. The Drop-in center in Cairo will have 8 outreach workers with a target of 15 PWIDs reached per month per worker The Outreach program in Menia will have 4 outreach workers with the target of 7 PWIDs reached per worker per month Cairo: 8 Outreach workers X15 PWIDs per month per worker X 30 months= 3600 PWIDs reached Menia: 4 Outreach workers X 7 PWIDs per month per workerX 30 months= 840 PWIDs reached Denominator: The denominator for this indicator is the estimated nr. of PWIDs in Cairo and Menia. The estimated numbers of PWIDs in Cairo: 22,701+ Menia 1005 = 23,706(As per UNAIDS Size Estimation of Key Affected Populations at Elevated HIV Risk Egypt 2014). The target's distribution across the years: The program targets reaching a total 4,484 PWIDs over the three years period. The target was further distributed across the years: 888 PWIDs in year 1 with a projected 1.5% increase in year 2 and 1.7 in year 3 respectively. This taking into consideration that the experience in implementation would have improved with a possible expansion in service-provision. Targets are set for Y1 to cover 9 nine months (April-December) and Y2 15 months (January-March) of grant implementation. As there is no Baseline for this indicator, targets will be revised following the first year of implementation, according to the collected data. The Baseline for this indicator will be provided in Q1 2020 following the first year of implementation. The package of services for PWIDs consists of: 1.Targeted Information 2 Conduction and/or Referral to. HIV testing and counseling services 3.Distribution of Condoms /Condoms and Lubricants (currently funded through UNFPA and UNAIDS with provision in the GF's approved PAAR Funding) 4.Distribution of Needles and Syringes 5.Referral to other facilities/further management as needed. Counting: The beneficiary will be counted once, only after receiving at least 2 services from the package. The programme counts with UIC system. Data Sources: NAP and SR Reports. The SRs will be responsible for collecting the data and reporting to the UNDP and the NAP. The NAP will be responsible for aggregating the information received from the SRs. Additional Notes: -The number of Outreach Workers and average PWIDs targeted-to-be reached in Cairo differs from that of Menia because of the size of the 2 programs. Cairo sizably bigger than Menia and the estimated number of PWIDs in Cairo being significantly bigger than Menia. This in addition to the implementation context, Cairo being more "open" as opposed to Menia which is more conservative. - The interventions under this section could -like the other sections of the programme- undergo further reprogramming following the approval of the PAAR. -The reprogramming could lead of a review/change of the targets under this indicator -The NSP targets for this indicator are as follows: 50% in 2020 and 90% in 2022 representing National targets. - Targets are set for Year 1 to cover 9 nine months (April-December) and Year 2 to cover 15 months (January-March) of grant implementation. -The National Coverage for this indicator will be reported in the Comments when reporting the subnational results on this indicator.

Coverage Indicators

Coverage Indicator	Country and Geographic Area	Baseline	Baseline Year and Source	Required Dissagregation	Cumulation for AFD	01-Apr-2019 31-Dec-2019	01-Jan-2020 31-Dec-2020	01-Jan-2021 31-Mar-2022	Comments
KP-3d(M): Percentage of people who inject drugs that have received an HIV test during the reporting period and know their results	Country: Egypt; Coverage: Subnational	N: D: P:	NAP Reports		N-Non-cumulative	N: 660 D: 23,706 P: 2.7%	N: 990 D: 23,706 P: 4.1%	N: 1,683 D: 23,706 P: 7.0%	Geographical Coverage: This activity is targeting Cairo and Menia Governorates Baseline: There is no baseline for this indicator. Data collected in the first year of this grant will serve as baseline for future implementation. The target-Numerators : Nr of people who inject drugs that have received an HIV test during the reporting period and know their results Denominator: The denominator for this indicator is the estimated nr. of PWIDs in Cairo and Menia. The estimated numbers of PWIDs in Cairo: 22,701+ Menia 1005 = 23,706(As per UNAIDS Size Estimation of Key Affected Populations at Elevated HIV Risk Egypt 2014). As there is no Baseline for this indicator, targets will be revised following the first year of implementation, according to the collected data. The Baseline for this indicator will be provided in Q1 2020 following the first year of implementation The target is calculated based on the previous implementation experience. With the assumption that 80% of PWIDs reached through the Drop-in Center in Cairo will accept testing and 50% of the PWIDs reached through the Outreach program in Menia will accept testing. The target is further distributed across the implementation years in alignment with the targets for the service-provision. - The NSP target for this indicator is : 50% in 2020 and 90% in 2022, representing National Targets. - Targets are set for Year 1 to cover 9 nine months (April-December) and Year 2 to cover 15 months (January-March) of grant implementation. -The National Coverage for this indicator will be reported in the Comments when reporting the subnational results on this indicator. -The possible reprogramming of activities following the approval of the PAAR could lead of a review/change of the targets under this indicator. Data Source :NAP and SR Reports .The SRs will be responsible for collecting the data and reporting to the UNDP and the NAP. The NAP will be responsible for aggregating the information received from the SRs."

Coverage Indicators

Coverage Indicator	Country and Geographic Area	Baseline	Baseline Year and Source	Required Dissagregation	Cumulation for AFD	01-Apr-2019 31-Dec-2019	01-Jan-2020 31-Dec-2020	01-Jan-2021 31-Mar-2022	Comments
Comprehensive prevention programs for MSM									
KP-1a(M): Percentage of men who have sex with men reached with HIV prevention programs - defined package of services	Country: Egypt; Coverage: Subnational	N: D: P:	NAP Reports		N-Non-cumulative	N: 912 D: 9,089 P: 10.0%	N: 1,368 D: 9,089 P: 15.0%	N: 2,325 D: 9,089 P: 25.5%	Geographical Coverage: This activity is targeting Alexandria and Menia Governorates Baseline: There is no baseline for this indicator. Data collected in the first year of this grant will serve as baseline for future implementation. The target-Numerators: Nr. of men who have sex with men reached with HIV prevention programs - defined package of services The Numerators were calculated based on the projected service delivery: The services will be provided through two Outreach Programs: One in Alexandria and one in Menia. Alexandria: 8 Outreach workers X15 MSMs per month per worker X 30 months= 3600 MSMs reached Menia: 4 Outreach workers X8 MSMs per month per workerX 30 months= 960 MSMs reached Denominator: The denominator for this indicator is the estimated nr. of MSM in Alexandria and Menia. The estimated numbers of MSMs in Alexandria: 7,939+ Menia 1150 = 9,089 (As per UNAIDS Size Estimation of Key Affected Populations at Elevated HIV Risk Egypt 2014). The target's distribution across the years: The program targets reaching a total 4,605MSM over the three years period. The target was further distributed across the years 912 in year 1 with a projected 1.5% increase in year 2 and 1.7 in year 3 respectively. This taking into consideration that the experience in implementation would have improved with a possible expansion in service-provision. As there is no Baseline for this indicator, targets will be revised following the first year of implementation, according to the collected data. The Baseline for this indicator will be provided in Q1 2020 following the first year of implementation The Package of Services for MSM Consists of: 1.Targeted Information 2.Refferal to HIV testing and counseling services 3.Distribution of Condoms and Lubricants (currently funded through UNFPA and UNAIDS with provision in the GF's approved PAAR Funding) 4.Referral to other facilities/further management as needed. Counting: The beneficiary will be counted once, only after receiving at least 2 services from the package. The programme counts with UIC system. Additional Notes: -The number of Outreach Workers and average MSMs taregted-to-be reached in Alexandria differs from that of Menia baceuse of the size of the 2 programs. Alexandria sizably bigger than Menia and the estimated number of MSM in Alexandria being significanly bigger than Menia. This in addition to the implementation context, Alexandria being more "open" as opposed to Menia which is more conservative. -The interventions under this section could -like the other sections of the programme- undergo further reprogramming following the approval of the PAAR. -The reprogramming could lead of a review/change of the targets under this indicator -The NSP targets for this indicator are as follows : 50% in 2020 and 90% in 2022 representing National targets. - Targets are set for Year 1 to cover 9 nine months (April-December) and Year 2 to cover 15 months (January-March) of grant implementation. -The National Coverage for this indicator will be reported in the Comments when reporting the subnational results on this indicator. Data Source :NAP and SR Reports .The SRs will be responsible for collecting the data and reporting to the UNDP and the NAP. The NAP will be responsible for aggregating the information received from the SRs..

The Global Fund

Coverage Indicators

Coverage Indicator	Country and Geographic Area	Baseline	Baseline Year and Source	Required Dissagregation	Cumulation for AFD	01-Apr-2019 31-Dec-2019	01-Jan-2020 31-Dec-2020	01-Jan-2021 31-Mar-2022	Comments
KP-3a(M): Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results	Country: Egypt; Coverage: Subnational	N: D: P:	NAP Reports		Y- Cumulative annually	N: 465 D: 9,089 P: 5.1%	N: 698 D: 9,089 P: 7.6%	N: 791 D: 9,089 P: 8.6%	Geographical Coverage: This activity is targeting Alexandria and Menia Governorates Baseline: There is no baseline for this indicator. Data collected in the first year of this grant will serve as baseline for future implementation. The target-Numerators : Nr. of men who have sex with men that have received an HIV test during the reporting period and know their result Denominator: The denominator for this indicator is the estimated nr. of MSM in Alexandria and Menia. The estimated numbers of MSMs in Alexandria: 7,939+ Menia 1150 = 9,089 (As per UNAIDS Size Estimation of Key Affected Populations at Elevated HIV Risk Egypt 2014). As there is no Baseline for this indicator, targets will be revised following the first year of implementation, according to the collected data. The Baseline for this indicator will be provided in Q1 2020 following the first year of implementation. The target is calculated based on the previous implementation experience with the assumption that 50% of MSMs reached through the Outreach program in Alexandria will accept testing and 50% of the MSMs reached through the Outreach program in Menia will accept testing. The target is further distributed across the implementation years in alignment with the targets for the service-provision - The NSP target for this indicator is : 50% in 2020 and 90% in 2022 representing National targets. Targets are set for Year 1 to cover 9 nine months (April-December) and Year 2 to cover 15 months (January-March) of grant implementation. -The National Coverage for this indicator will be reported in the Comments when reporting the subnational results on this indicator. -The possible reprogramming of activities following the approval of the PAAR could lead of a review/change of the targets under this indicator. Data Source :NAP and SR Reports .The SRs will be responsible for collecting the data and reporting to the UNDP and the NAP. The NAP will be responsible for aggregating the information received from the SRs.
Treatment, care and support									
TCS-1(M): Percentage of people living with HIV currently receiving antiretroviral therapy	Country: Egypt; Coverage: National	N: 3,913 D: 16,000 P: 24.45625%	NAP Reports	Target / Risk population group,Age,Gender | Age,Gender	N-Non - cumulative (other)	N: 5,500 D: 20,000 P: 27.5%	N: 6,700 D: 22,000 P: 30.4%	N: 8,400 D: 25,000 P: 33.6%	The targets for this indicator were calculated on a baseline of 24.5%): Numerator: Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period Denominator: Estimated nr of PLWHIV. (Denominators here as per UNAIDS Spectrum Data for Egypt) Baseline: calculated as per NAP data : 3,913/16000 Targets: Calculated based on an annual increment of 3.5% based on the average national trend of 17%,22%,27% for 2015,2016 and 2017 respectively as per UNAIDS Data for Egypt. and the average regional trend for MENA region of 22%, 26%,29% for 2015, 2016, 2017 . -The NSP targets for this indicator are : 50% in 2020 and 90% in 2022. Data Sources : NAP reports. NAP will be responsible to collect this data. This is a National indicator.
MDR-TB									
MDR TB-2(M): Number of TB cases with RR-TB and/or MDR-TB notified	Country: Egypt; Coverage: National	N: 152 D: P:	WHO Country TB Profie for Egypt	Age,Gender	Y- Cumulative annually	N: 175 D: P:	N: 225 D: P:	N: 250 D: P:	Baseline :WHO Country TB Profile for Egypt The Target was calculated taking into the account the projected expansion in molecular as of the 2nd year of implementation. The NTP currently has 152 DR-TB notified cases, a 35% augmentation is molecular testing is projected leading to an estimated 35% capacity in diagnosis and notification of DR-TB cases. The target gradually augmenting to 175 in Y1 (because the expansion in molecular testing would not have been fully in-place yet),200 In Y2 and 250 in Y3. The target is different from the NSP's target because these targets were set following the adjustment of the baseline: using the baseline of 2017, whereas the NSP targets were set using WHO estimations for 2013. All targets for this indicator will be revised in Q1 2019, upon the finalization of the NSP and updating of the National M&E framework. Data Source: NTP Reports .The NTP will be responsible for collecting the data. This is a National indicator.

Coverage Indicators

Coverage Indicator	Country and Geographic Area	Baseline	Baseline Year and Source	Required Dissagregation	Cumulation for AFD	01-Apr-2019 31-Dec-2019	01-Jan-2020 31-Dec-2020	01-Jan-2021 31-Mar-2022	Comments
MDR TB-3(M): Number of cases with RR-TB and/or MDR-TB that began second-line treatment	Country: Egypt; Coverage: National	N: 125 D: P:	WHO Country TB Profie for Egypt	Age,Gender,TB regimen	Y- Cumulative annually	N: 175 D: P:	N: 225 D: P:	N: 250 D: P:	The Baseline for this indicator is from the WHO Country TB Profile for Egypt Targets were calculated with a projection of 40% increment in the first year, 80% in the second year and 100% in the 3rd year. In correlation with the anticipated expansion and improvement of the MDR-TB diagnosis. The target is different from the NSP's target because these targets were set following the adjustment of the baseline: using the baseline of 2017, whereas the NSP targets were set using WHO estimations for 2013. All targets for this indicator will be revised in Q1 2019, upon the finalization of the NSP and updating of the National M&E framework. Data Source: NTP Reports . The NTP will be responsible for collecting the data. This is a National indicator.
TB care and prevention									
TCP-6a: Number of TB cases (all forms) notified among prisoners	Country: Egypt; Coverage: National	N: 318 D: P:	NTP Reports		Y- Cumulative annually	N: 349 D: P:	N: 381 D: P:	N: 445 D: P:	The Baseline : The baseline for this indicator is from the NTP records. Targets were calculated with a projection of 10% increment in the first year, 20% in the second year and 40% in the 3rd year. In correlation with the roll-out and continuation of interventions for Prisoners All targets for this indicator will be revised in Q1 2019, upon the finalization of the NSP and updating of the M&E framework. Data Source : NTP Reports.The NTP will be responsible for collecting the data. This is a National indicator.
TCP-6b: Number of TB cases (all forms) notified among key affected populations/ high risk groups (other than prisoners)	Country: Egypt; Coverage: National	N: 526 D: P:	NTP Reports	Target / Risk population group	Y- Cumulative annually	N: 578 D: P:	N: 631 D: P:	N: 736 D: P:	The Baseline : The baseline for this indicator is from the NTP records. Targets were calculated with a projection of 10% increment in the first year, 20% in the second year and 40% in the 3rd year. In correlation with the roll-out and continuation of interventions for KPs. The NSP's targets include the prisoners. The target here different from the NSP's target because these targets were set following the adjustment of the baseline: using the baseline of 2017, whereas the NSP targets were set using WHO estimations for 2013. All targets for this indicator will be revised in Q1 2019, upon the finalization of the NSP and updating of the M&E framework. This indicator targets the following KPs : factory workers and Refugees Data Source : NTP Reports.The NTP will be responsible for collecting the data. This is a National indicator.

PROJECT QA ASSESSMENT: DESIGN AND APPRAISAL

OVERALL PROJECT ◎◎◎◎◎

EXEMPLARY (5) ◎◎◎◎◎	HIGHLY SATISFACTORY (4) ◎◎◎◎○	SATISFACTORY (3) ◎◎◎○○	NEEDS IMPROVEMENT (2) ◎◎○○○	INADEQUATE (1) ◎○○○○
At least four criteria are rated Exemplary, and all criteria are rated High or Exemplary.	All criteria are rated Satisfactory or higher, and at least four criteria are rated High or Exemplary.	At least six criteria are rated Satisfactory or higher, and only one may be rated Needs Improvement. The Principled criterion must be rated Satisfactory or above.	At least three criteria are rated Satisfactory or higher, and only four criteria may be rated Needs Improvement.	One or more criteria are rated Inadequate, or five or more criteria are rated Needs Improvement.

DECISION ; APPROVE

- **APPROVE** – the project is of sufficient quality to be approved in its current form. Any management actions must be addressed in a timely manner.
- **APPROVE WITH QUALIFICATIONS** – the project has issues that must be addressed before the project document can be approved. Any management actions must be addressed in a timely manner.
- **DISAPPROVE** – the project has significant issues that should prevent the project from being approved as drafted.

RATING CRITERIA

For all questions, select the option that best reflects the project

STRATEGIC

Criteria	Rating
1. Does the project specify how it will contribute to higher level change through linkage to the programme's Theory of Change? • 3: The project is clearly linked to the programme's theory of change. It has an explicit change pathway that explains how the project will contribute to outcome level change and why the project's strategy will likely lead to this change. This analysis is backed by credible evidence of what works effectively in this context and includes assumptions and risks. • 2: The project is clearly linked to the programme's theory of change. It has a change pathway that explains how the project will contribute to outcome-level change and why the project strategy will likely lead to this change. • 1: The project document may describe in generic terms how the project will contribute to development results, without an explicit link to the programme's theory of change. **Note: Projects not contributing to a programme must have a project-specific Theory of Change. See alternative question under the lightbulb for these cases.*	3 / **2** / 1 **Please revert to the Performance framework**
2. Is the project aligned with the UNDP Strategic Plan? • 3: The project responds to at least one of the development settings as specified in the Strategic Plan[1] and adapts at least one Signature Solution[2]. The project's RRF includes all the relevant SP output indicators. *(all must be true)* • 2: The project responds to at least one of the development settings as specified in the Strategic Plan[4]. The project's RRF includes at least one SP output indicator, if relevant. *(both must be true)* • 1: The project responds to a partner's identified need, but this need falls outside of the UNDP Strategic Plan. Also select this option if none of the relevant SP indicators are included in the RRF.	3 / **2** / 1 **Yes the project responds to Eradicating poverty development setting and**

[1] The three development settings in UNDP's 2018-2021 Strategic Plan are: a) Eradicate poverty in all its forms and dimensions; b) Accelerate structural transformations for sustainable development; and c) Build resilience to shocks and crises

[2] The six Signature Solutions of UNDP's 2018-2021 Strategic Plan are: a) Keeping people out of poverty; b) Strengthen effective, inclusive and accountable governance; c) Enhance national prevention and recovery capacities for resilient societies; d) Promote nature based solutions for a sustainable planet; e) Close the energy gap; and f) Strengthen gender equality and the empowerment of women and girls.

<table>
<tr><td></td><td colspan="2">several development indicators mainly the Adolescent health and HIV : SDG3.3.1, however it also contributes to gender equality SDG5.2.1 and strengthening data for sustainable development SDG 17.18.1 as well as eradicating poverty SDG1.3.1</td></tr>
<tr><td>3. Is the project linked to the programme outputs? (i.e., UNDAF Results Group Workplan/CPD, RPD or Strategic Plan IRRF for global projects/strategic interventions not part of a programme)</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">RELEVANT</td></tr>
<tr><td rowspan="3">4. Does the project target groups left furthest behind?
• <u>3:</u> The target groups are clearly specified, prioritising discriminated and marginalized groups left furthest behind, identified through a rigorous process based on evidence.
• <u>2:</u> The target groups are clearly specified, prioritizing groups left furthest behind.
• <u>1:</u> The target groups are not clearly specified.
*Note: Management Action must be taken for a score of 1. Projects that build institutional capacity should still identify targeted groups to justify support</td><td>3</td><td>2</td></tr>
<tr><td colspan="2">1</td></tr>
<tr><td colspan="2">The project targets Key populations, MSM, FSW & IDUs</td></tr>
<tr><td rowspan="3">5. Have knowledge, good practices, and past lessons learned of UNDP and others informed the project design?
• <u>3:</u> Knowledge and lessons learned backed by credible evidence from sources such as evaluation, corporate policies/strategies, and/or monitoring have been explicitly used, with appropriate referencing, to justify the approach used by the project.
• <u>2:</u> The project design mentions knowledge and lessons learned backed by evidence/sources, but have not been used to justify the approach selected.
• <u>1:</u> There is little or no mention of knowledge and lessons learned informing the project design. Any references made are anecdotal and not backed by evidence.
*Note: Management Action or strong management justification must be given for a score of 1</td><td>3</td><td>2</td></tr>
<tr><td colspan="2">1</td></tr>
<tr><td colspan="2">Project design has been based on the updated HIV/TB national strategies</td></tr>
<tr><td rowspan="3">6. Does UNDP have a clear advantage to engage in the role envisioned by the project vis-à-vis national/regional/global partners and other actors?
• <u>3:</u> An analysis has been conducted on the role of other partners in the area where the project intends to work, and credible evidence supports the proposed engagement of UNDP and partners through the project, including identification of potential funding partners. It is clear how results achieved by partners will complement the project's intended results and a communication strategy is in place to communicate results and raise visibility vis-à-vis key partners. Options for south-south and triangular cooperation have been considered, as appropriate. (all must be true)</td><td>3</td><td>2</td></tr>
<tr><td colspan="2">1</td></tr>
<tr><td colspan="2">Without the involvement of UNDP as the PR for this national grant, HFATM would not</td></tr>
</table>

• **2:** Some analysis has been conducted on the role of other partners in the area where the project intends to work, and relatively limited evidence supports the proposed engagement of and division of labour between UNDP and partners through the project, with unclear funding and communications strategies or plans. • **1:** No clear analysis has been conducted on the role of other partners in the area that the project intends to work. There is risk that the project overlaps and/or does not coordinate with partners' interventions in this area. Options for south-south and triangular cooperation have not been considered, despite its potential relevance. *Note: Management Action or strong management justification must be given for a score of 1	**have made this grant possible for Egypt due to previous history**
PRINCIPLED	
7. Does the project apply a human rights-based approach? • **3:** The project is guided by human rights and incorporates the principles of accountability, meaningful participation, and non-discrimination in the project's strategy. The project upholds the relevant international and national laws and standards. Any potential adverse impacts on enjoyment of human rights were rigorously identified and assessed as relevant, with appropriate mitigation and management measures incorporated into project design and budget. *(all must be true)* • **2:** The project is guided by human rights by prioritizing accountability, meaningful participation and non-discrimination. Potential adverse impacts on enjoyment of human rights were identified and assessed as relevant, and appropriate mitigation and management measures incorporated into the project design and budget. *(both must be true)* • **1:** No evidence that the project is guided by human rights. Limited or no evidence that potential adverse impacts on enjoyment of human rights were considered. *Note: Management action or strong management justification must be given for a score of 1	**3** 2 1 **Considering the sensitivity of this project and working with key populations**
8. Does the project use gender analysis in the project design? • **3:** A participatory gender analysis has been conducted and results from this gender analysis inform the development challenge, strategy and expected results sections of the project document. Outputs and indicators of the results framework include explicit references to gender equality, and specific indicators measure and monitor results to ensure women are fully benefitting from the project. *(all must be true)* • **2:** A basic gender analysis has been carried out and results from this analysis are scattered (i.e., fragmented and not consistent) across the development challenge and strategy sections of the project document. The results framework may include some gender sensitive outputs and/or activities but gender inequalities are not consistently integrated across each output. *(all must be true)* • **1:** The project design may or may not mention information and/or data on the differential impact of the project's development situation on gender relations, women and men, but the gender inequalities have not been clearly identified and reflected in the project document. *Note: Management Action or strong management justification must be given for a score of 1	**3** 2 1 **There are specific activities & targets focused on Female Sex workers and clearly indicated in the PF**
9. Did the project support the resilience and sustainability of societies and/or ecosystems? • **3:** Credible evidence that the project addresses sustainability and resilience dimensions of development challenges, which are integrated in the project strategy and design. The project reflects the interconnections between the social, economic and environmental dimensions of sustainable development. Relevant shocks, hazards and adverse social and environmental impacts have been identified and rigorously assessed with appropriate management and mitigation measures incorporated into project design and budget. *(all must be true)*. • **2:** The project design integrates sustainability and resilience dimensions of development challenges. Relevant shocks, hazards and adverse social and environmental impacts have been identified and assessed, and relevant management and mitigation measures incorporated into project design and budget. *(both must be true)* • **1:** Sustainability and resilience dimensions and impacts were not adequately considered. *Note: Management action or strong management justification must be given for a score of 1	3 **2** 1 **Evidence**
10. Has the Social and Environmental Screening Procedure (SESP) been conducted to identify potential social and environmental impacts and risks? The SESP is not required for projects in which UNDP is Administrative Agent only and/or projects comprised solely of reports, coordination of events, trainings, workshops, meetings, conferences and/or	**Yes** No SESP Not Required

communication materials and information dissemination. [if yes, upload the completed checklist. If SESP is not required, provide the reason for the exemption in the evidence section.]	

Management & Monitoring

Question	Score	
11. Does the project have a strong results framework? • 3: The project's selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators that measure the key expected development changes, each with credible data sources and populated baselines and targets, including gender sensitive, target group focused, sex-disaggregated indicators where appropriate. *(all must be true)* • 2: The project's selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators, but baselines, targets and data sources may not yet be fully specified. Some use of target group focused, sex-disaggregated indicators, as appropriate. *(all must be true)* • 1: The project's selection of outputs and activities are not at an appropriate level; outputs are not accompanied by SMART, results-oriented indicators that measure the expected change and have not been populated with baselines and targets; data sources are not specified, and/or no gender sensitive, sex-disaggregation of indicators. *(if any is true)* *Note: Management Action or strong management justification must be given for a score of 1	3	2
	1	
	Please revert to project Performance framework	
12. Is the project's governance mechanism clearly defined in the project document, including composition of the project board? • 3: The project's governance mechanism is fully defined. Individuals have been specified for each position in the governance mechanism (especially all members of the project board.) Project Board members have agreed on their roles and responsibilities as specified in the terms of reference. The ToR of the project board has been attached to the project document. *(all must be true).* • 2: The project's governance mechanism is defined; specific institutions are noted as holding key governance roles, but individuals may not have been specified yet. The project document lists the most important responsibilities of the project board, project director/manager and quality assurance roles. *(all must be true)* • 1: The project's governance mechanism is loosely defined in the project document, only mentioning key roles that will need to be filled at a later date. No information on the responsibilities of key positions in the governance mechanism is provided. *Note: Management Action or strong management justification must be given for a score of 1	3	2
	1	
	Please revert to the Governance & Management Arrangements in the Prodoc	
13. Have the project risks been identified with clear plans stated to manage and mitigate each risk? • 3: Project risks related to the achievement of results are fully described in the project risk log, based on comprehensive analysis drawing on the programme's theory of change, Social and Environmental Standards and screening, situation analysis, capacity assessments and other analysis such as funding potential and reputational risk. Risks have been identified through a consultative process with key internal and external stakeholders. Clear and complete plan in place to manage and mitigate each risk, reflected in project budgeting and monitoring plans. *(both must be true)* • 2: Project risks related to the achievement of results are identified in the initial project risk log based on a minimum level of analysis and consultation, with mitigation measures identified for each risk. • 1: Some risks may be identified in the initial project risk log, but no evidence of consultation or analysis and no clear risk mitigation measures identified. This option is also selected if risks are not clearly identified and/or no initial risk log is included with the project document. *Note: Management Action must be taken for a score of 1	3	2
	1	
	Please revert to Risk Management section in the ProDoc	

Efficient

Question		
14. Have specific measures for ensuring cost-efficient use of resources been explicitly mentioned as part of the project design? This can include, for example: i) using the theory of change analysis to explore different options of achieving the maximum results with the resources available; ii) using a portfolio management approach to improve cost effectiveness through synergies with other interventions; iii) through joint operations (e.g., monitoring or procurement) with other partners; iv) sharing resources or coordinating delivery with other projects, v) using innovative approaches and technologies to reduce the cost of service delivery or other types of interventions.	Yes (3)	No (1)

(Note: Evidence of at least one measure must be provided to answer yes for this question)		
15. Is the budget justified and supported with valid estimates? • 3: The project's budget is at the activity level with funding sources, and is specified for the duration of the project period in a multi-year budget. Realistic resource mobilisation plans are in place to fill unfunded components. Costs are supported with valid estimates using benchmarks from similar projects or activities. Cost implications from inflation and foreign exchange exposure have been estimated and incorporated in the budget. Adequate costs for monitoring, evaluation, communications and security have been incorporated. • 2: The project's budget is at the activity level with funding sources, when possible, and is specified for the duration of the project in a multi-year budget, but no funding plan is in place. Costs are supported with valid estimates based on prevailing rates. • 1: The project's budget is not specified at the activity level, and/or may not be captured in a multi-year budget.	3 1 **Please revert to detailed project budget**	2
16. Is the Country Office/Regional Hub/Global Project fully recovering the costs involved with project implementation? • 3: The budget fully covers all project costs that are attributable to the project, including programme management and development effectiveness services related to strategic country programme planning, quality assurance, pipeline development, policy advocacy services, finance, procurement, human resources, administration, issuance of contracts, security, travel, assets, general services, information and communications based on full costing in accordance with prevailing UNDP policies (i.e., UPL, LPL.) • 2: The budget covers significant project costs that are attributable to the project based on prevailing UNDP policies (i.e., UPL, LPL) as relevant. • 1: The budget does not adequately cover project costs that are attributable to the project, and UNDP is cross-subsidizing the project. *Note: Management Action must be given for a score of 1. The budget must be revised to fully reflect the costs of implementation before the project commences.	3 1 **Please revert to detailed project budget.**	2
EFFECTIVE		
17. Have targeted groups been engaged in the design of the project? • 3: Credible evidence that all targeted groups, prioritising discriminated and marginalized populations that will be involved in or affected by the project, have been actively engaged in the design of the project. The project has an explicit strategy to identify, engage and ensure the meaningful participation of target groups as stakeholders throughout the project, including through monitoring and decision-making (e.g., representation on the project board, inclusion in samples for evaluations, etc.) • 2: Some evidence that key targeted groups have been consulted in the design of the project. • 1: No evidence of engagement with targeted groups during project design.	3 1 **Key marginalized groups are focused on in this project activities**	2
18. Does the project plan for adaptation and course correction if regular monitoring activities, evaluation, and lesson learned demonstrate there are better approaches to achieve the intended results and/or circumstances change during implementation?	Yes (3)	No (1)
19. The gender marker for all project outputs are scored at GEN2 or GEN3, indicating that gender has been fully mainstreamed into all project outputs at a minimum. *Note: Management Action or strong management justification must be given for a score of "no"	Yes (3) **Evidence**	No (1)
SUSTAINABILITY & NATIONAL OWNERSHIP		
20. Have national/regional/global partners led, or proactively engaged in, the design of the project? • 3: National partners (or regional/global partners for regional and global projects) have full ownership of the project and led the process of the development of the project jointly with UNDP. • 2: The project has been developed by UNDP in close consultation with national/regional/global partners. • 1: The project has been developed by UNDP with limited or no engagement with national partners.	3 1 **Close engagement of the MOH**	2

21. Are key institutions and systems identified, and is there a strategy for strengthening specific/ comprehensive capacities based on capacity assessments conducted? • 3: The project has a strategy for strengthening specific capacities of national institutions and/or actors based on a completed capacity assessment. This strategy includes an approach to regularly monitor national capacities using clear indicators and rigorous methods of data collection, and adjust the strategy to strengthen national capacities accordingly. • 2: A capacity assessment has been completed. There are plans to develop a strategy to strengthen specific capacities of national institutions and/or actors based on the results of the capacity assessment. • 1: Capacity assessments have not been carried out.	3	2
	1	
	Raising capacities of the national programs as well as the CSOs involved is among the project's mandates	
22. Is there is a clear strategy embedded in the project specifying how the project will use national systems (i.e., procurement, monitoring, evaluations, etc.,) to the extent possible?	Yes (3)	No (1)
23. Is there a clear transition arrangement/ phase-out plan developed with key stakeholders in order to sustain or scale up results (including resource mobilisation and communications strategy)?	Yes (3)	No (1)

Annex [#]. Social and Environmental Screening Template

The completed template, which constitutes the Social and Environmental Screening Report, must be included as an annex to the Project Document. Please refer to the Social and Environmental Screening Procedure and Toolkit for guidance on how to answer the 6 questions.

Project Information

Project Information	
1. Project Title	Strengthening the HIV and TB Response in Egypt
2. Project Number	00119017
3. Location (Global/Region/Country)	Egypt

Part A. Integrating Overarching Principles to Strengthen Social and Environmental Sustainability

QUESTION 1: How Does the Project Integrate the Overarching Principles in order to Strengthen Social and Environmental Sustainability?
Briefly describe in the space below how the Project mainstreams the human-rights based approach
The National HIV Strategic Plan (NSP) 2018-2022 has been developed through a multi-stakeholder consultative process that involved a mid-term program review and analysis. It is a revised document of an already existing HIV/AIDS Strategic Framework 2015 – 2020. It was essential that the NSP revision focuses on ensuring sustainability and supporting impact-oriented, cost-efficient interventions to scale up and fast-track Egypt's national response to HIV. This new strategic plan is extending the scope of the operations beyond 2020 to cover the period until 2022, aligning itself with the Global Health Sector Strategy on HIV 2016-2021. It is has drawn from lessons learned through the implementation of the previous national strategies. The new NSP contains four Strategic Impact Targets that have also guided the design and prioritization of modules and interventions included in this Funding Request. Strategic impact target 1: Achieve the global targets on HIV testing and diagnosis. HIV testing remains the entry point for HIV prevention, treatment, and care services. It is a strategic pillar for achieving the global targets of 90-90-90. The Government of Egypt, through its national AIDS program, is committed to meeting the global commitments and ensure that 90% of all people living with HIV know their status by the end of 2022. Strategic impact target 2: Achieve the global targets on HIV/AIDS treatment and quality of care. Globally, countries have committed to ensuring that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020. Egypt had committed to fast track the response during in the period 2016-2020. Given the progress and its challenges in recent years, the country is aiming to catch-up on some of its key targets has now reset its goal of achieving these targets by 2022. Strategic impact target 3: Achieve the global targets on Zero new HIV infection. Egypt is committed to achieving zero new infections as a global target of the Fast Track strategy to end AIDS as a public health threat by 2030. The growing trend of the new infections in Egypt calls for urgent actions to reverse this trend, and to focus on high impact interventions and strategies to achieve this goal. The country aims at reducing the estimated number of new HIV infections by 50% of its 2017 baseline by the year 2022. Strategic impact target 4: Build strong and sustainable systems for delivery of HIV services. The global architecture of global health financing calls for more focus on strengthening systems to deliver ambitious programs like HIV epidemic control. Effective, efficient and comprehensive health and community systems are vital for ensuring accessible, affordable and sustainable HIV services. At the same time, HIV innovation and investment are helping to transform health systems and empower communities in ways that benefit other public health and social areas. Enhanced capacity of data, finance, HR, supplies and service delivery systems, are all essential to deliver a successful response, together with collaborative contributions from community and civil society players.
Briefly describe in the space below how the Project is likely to improve gender equality and women's empowerment

One local nongovernmental organization has activities for female sex workers in parts of Greater Cairo and Alexandria. Peer education outreach workers currently reach about fifty women per month due to underfunding. Half of beneficiaries are newly reached and half have been reached before. The key peer education outreach activities are targeted education and condom promotion. A wide range of other services are offered through a drop in centre, including legal services, psychosocial support, referral for health services, and voluntary counselling and testing. It is remarkable that NGO staff accompany women who test positive on their first visits to ART provision centres and continue contact with them in their first year of treatment. Current reach of prevention will have almost no impact in the geographic areas in which activities take place. Higher reach and coverage would be necessary among the female sex workers who have the most sexual partners in places where the highest number of female sex workers work to prevent an epidemic. There is value in having female sex worker-specific services programmes as women peer education outreach staff will be more effective than men peer education outreach staff and a full-fledged programme could include interventions for clients and gate keepers. WHO guidelines recommend targeted education and comprehensive condom and lubricant promotion as well as structural interventions.

The package of services for female sex workers is composed of behavioural interventions and condom distribution. HIV testing is also included in this package as it is largely delivered by the same organizations that deliver prevention interventions. During outreach activities of the NGOs/CBOs in FSW "gathering spots", the outreach teams provide prevention and awareness messages, but most importantly they also provide referrals to drop-in centres and associated services.

As with the other key population groups, outreach work and drop in centres are being proposed in this funding request. An attempt will be made to reach the halfway point to universal access to prevention services (40%) for the population of female sex workers over the three year grant period. By the third year of the grant, annual service coverage in Cairo will reach 2,597 representing all of the targeted population, and in Alexandria 775 representing 46% of the targeted population. Annual HIV testing coverage in Cairo/Giza will be 70% of those reached and in Alexandria 70%. Given the limited allocation for this proposal, one comprehensive care center is proposed within allocation to cover Cairo, while one outreach model in Alexandria proposed above allocation. This is based on estimates of number of FSW in Egypt.

This funding request is for one drop in centre model programme in Cairo, and one peer education outreach model programme in Alexandria. Funding to implement the national operational plan will be mobilized from other donors due to the current limits of Global Fund's allocation for Egypt's country response to HIV and TB.

Briefly describe in the space below how the Project mainstreams environmental sustainability

The project as previously mentioned is focusing on HIV-TB prevention focusing on interventions targeting Key affected Populations, in addition to improving the overall HIV and TB services delivery in EGYPT through other capacity development interventions that target the improvement of the overall detection & treatment, with no direct impact on the environment sustainability.

Part B. Identifying and Managing Social and Environmental Risks

QUESTION 2: What are the Potential Social and Environmental Risks? *Note: Describe briefly potential social and environmental risks identified in Attachment 1 – Risk Screening Checklist (based on any "Yes" responses). If no risks have been identified in Attachment 1 then note "No Risks Identified" and skip to Question 4 and Select "Low Risk". Questions 5 and 6 not required for Low Risk Projects.*	**QUESTION 3: What is the level of significance of the potential social and environmental risks?** *Note: Respond to Questions 4 and 5 below before proceeding to Question 6*			**QUESTION 6: What social and environmental assessment and management measures have been conducted and/or are required to address potential risks (for Risks with Moderate and High Significance)?**
Risk Description	*Impact and Probability (1-5)*	*Significance (Low, Moderate, High)*	*Comments*	*Description of assessment and management measures as reflected in the Project design. If ESIA or SESA is required note that the assessment should consider all potential impacts and risks.*
Risk 1: No Risks have been identified	I = P =			
Risk 2	I = P =			

Risk 3: ….	I = P =			
Risk 4: ….	I = P =			
[add additional rows as needed]				

	QUESTION 4: What is the overall Project risk categorization?		
	Select one (see SESP for guidance)		**Comments**
	Low Risk	☒	
	Moderate Risk	☐	
	High Risk	☐	
	QUESTION 5: Based on the identified risks and risk categorization, what requirements of the SES are relevant?		
	Check all that apply		**Comments**
	Principle 1: Human Rights	☐	
	Principle 2: Gender Equality and Women's Empowerment	☐	
	1. Biodiversity Conservation and Natural Resource Management	☐	
	2. Climate Change Mitigation and Adaptation	☐	
	3. Community Health, Safety and Working Conditions	☐	
	4. Cultural Heritage	☐	
	5. Displacement and Resettlement	☐	
	6. Indigenous Peoples	☐	
	7. Pollution Prevention and Resource Efficiency	☐	

Final Sign Off

Signature	*Date*	*Description*
QA Assessor – Alyaa Nabil	10 June 19	UNDP staff member responsible for the Project, typically a UNDP Programme Officer. Final signature confirms they have "checked" to ensure that the SESP is adequately conducted.
QA Approver		UNDP senior manager, typically the UNDP Deputy Country Director (DCD), Country Director (CD), Deputy Resident Representative (DRR), or Resident Representative (RR). The QA Approver cannot also be the QA Assessor. Final signature confirms they have "cleared" the SESP prior to submittal to the PAC.
PAC Chair		UNDP chair of the PAC. In some cases PAC Chair may also be the QA Approver. Final signature confirms that the SESP was considered as part of the project appraisal and considered in recommendations of the PAC.

SESP Attachment 1. Social and Environmental Risk Screening Checklist

Checklist Potential Social and Environmental Risks		
Principles 1: Human Rights		**Answer (Yes/No)**
1.	Could the Project lead to adverse impacts on enjoyment of the human rights (civil, political, economic, social or cultural) of the affected population and particularly of marginalized groups?	No
2.	Is there a likelihood that the Project would have inequitable or discriminatory adverse impacts on affected populations, particularly people living in poverty or marginalized or excluded individuals or groups? [1]	No
3.	Could the Project potentially restrict availability, quality of and access to resources or basic services, in particular to marginalized individuals or groups?	No
4.	Is there a likelihood that the Project would exclude any potentially affected stakeholders, in particular marginalized groups, from fully participating in decisions that may affect them?	No
5.	Is there a risk that duty-bearers do not have the capacity to meet their obligations in the Project?	No
6.	Is there a risk that rights-holders do not have the capacity to claim their rights?	No
7.	Have local communities or individuals, given the opportunity, raised human rights concerns regarding the Project during the stakeholder engagement process?	No
8.	Is there a risk that the Project would exacerbate conflicts among and/or the risk of violence to project-affected communities and individuals?	No
Principle 2: Gender Equality and Women's Empowerment		
1.	Is there a likelihood that the proposed Project would have adverse impacts on gender equality and/or the situation of women and girls?	No
2.	Would the Project potentially reproduce discriminations against women based on gender, especially regarding participation in design and implementation or access to opportunities and benefits?	No
3.	Have women's groups/leaders raised gender equality concerns regarding the Project during the stakeholder engagement process and has this been included in the overall Project proposal and in the risk assessment?	No
4.	Would the Project potentially limit women's ability to use, develop and protect natural resources, taking into account different roles and positions of women and men in accessing environmental goods and services? *For example, activities that could lead to natural resources degradation or depletion in communities who depend on these resources for their livelihoods and well being*	No
Principle 3: Environmental Sustainability: Screening questions regarding environmental risks are encompassed by the specific Standard-related questions below		
Standard 1: Biodiversity Conservation and Sustainable Natural Resource Management		
1.1	Would the Project potentially cause adverse impacts to habitats (e.g. modified, natural, and critical habitats) and/or ecosystems and ecosystem services?	No

[1] Prohibited grounds of discrimination include race, ethnicity, gender, age, language, disability, sexual orientation, religion, political or other opinion, national or social or geographical origin, property, birth or other status including as an indigenous person or as a member of a minority. References to "women and men" or similar is understood to include women and men, boys and girls, and other groups discriminated against based on their gender identities, such as transgender people and transsexuals.

	For example, through habitat loss, conversion or degradation, fragmentation, hydrological changes	
1.2	Are any Project activities proposed within or adjacent to critical habitats and/or environmentally sensitive areas, including legally protected areas (e.g. nature reserve, national park), areas proposed for protection, or recognized as such by authoritative sources and/or indigenous peoples or local communities?	No
1.3	Does the Project involve changes to the use of lands and resources that may have adverse impacts on habitats, ecosystems, and/or livelihoods? (Note: if restrictions and/or limitations of access to lands would apply, refer to Standard 5)	No
1.4	Would Project activities pose risks to endangered species?	No
1.5	Would the Project pose a risk of introducing invasive alien species?	No
1.6	Does the Project involve harvesting of natural forests, plantation development, or reforestation?	No
1.7	Does the Project involve the production and/or harvesting of fish populations or other aquatic species?	No
1.8	Does the Project involve significant extraction, diversion or containment of surface or ground water? *For example, construction of dams, reservoirs, river basin developments, groundwater extraction*	No
1.9	Does the Project involve utilization of genetic resources? (e.g. collection and/or harvesting, commercial development)	No
1.10	Would the Project generate potential adverse transboundary or global environmental concerns?	No
1.11	Would the Project result in secondary or consequential development activities which could lead to adverse social and environmental effects, or would it generate cumulative impacts with other known existing or planned activities in the area? *For example, a new road through forested lands will generate direct environmental and social impacts (e.g. felling of trees, earthworks, potential relocation of inhabitants). The new road may also facilitate encroachment on lands by illegal settlers or generate unplanned commercial development along the route, potentially in sensitive areas. These are indirect, secondary, or induced impacts that need to be considered. Also, if similar developments in the same forested area are planned, then cumulative impacts of multiple activities (even if not part of the same Project) need to be considered.*	No
Standard 2: Climate Change Mitigation and Adaptation		
2.1	Will the proposed Project result in significant[2] greenhouse gas emissions or may exacerbate climate change?	No
2.2	Would the potential outcomes of the Project be sensitive or vulnerable to potential impacts of climate change?	No
2.3	Is the proposed Project likely to directly or indirectly increase social and environmental vulnerability to climate change now or in the future (also known as maladaptive practices)? *For example, changes to land use planning may encourage further development of floodplains, potentially increasing the population's vulnerability to climate change, specifically flooding*	No
Standard 3: Community Health, Safety and Working Conditions		
3.1	Would elements of Project construction, operation, or decommissioning pose potential safety risks to local communities?	No
3.2	Would the Project pose potential risks to community health and safety due to the transport, storage, and use and/or disposal of hazardous or dangerous materials (e.g. explosives, fuel and other chemicals during construction and operation)?	No

[2] In regards to CO_2, 'significant emissions' corresponds generally to more than 25,000 tons per year (from both direct and indirect sources). [The Guidance Note on Climate Change Mitigation and Adaptation provides additional information on GHG emissions.]

3.3	Does the Project involve large-scale infrastructure development (e.g. dams, roads, buildings)?	No
3.4	Would failure of structural elements of the Project pose risks to communities? (e.g. collapse of buildings or infrastructure)	No
3.5	Would the proposed Project be susceptible to or lead to increased vulnerability to earthquakes, subsidence, landslides, erosion, flooding or extreme climatic conditions?	No
3.6	Would the Project result in potential increased health risks (e.g. from water-borne or other vector-borne diseases or communicable infections such as HIV/AIDS)?	No
3.7	Does the Project pose potential risks and vulnerabilities related to occupational health and safety due to physical, chemical, biological, and radiological hazards during Project construction, operation, or decommissioning?	No
3.8	Does the Project involve support for employment or livelihoods that may fail to comply with national and international labor standards (i.e. principles and standards of ILO fundamental conventions)?	No
3.9	Does the Project engage security personnel that may pose a potential risk to health and safety of communities and/or individuals (e.g. due to a lack of adequate training or accountability)?	No
Standard 4: Cultural Heritage		
4.1	Will the proposed Project result in interventions that would potentially adversely impact sites, structures, or objects with historical, cultural, artistic, traditional or religious values or intangible forms of culture (e.g. knowledge, innovations, practices)? (Note: Projects intended to protect and conserve Cultural Heritage may also have inadvertent adverse impacts)	No
4.2	Does the Project propose utilizing tangible and/or intangible forms of cultural heritage for commercial or other purposes?	No
Standard 5: Displacement and Resettlement		
5.1	Would the Project potentially involve temporary or permanent and full or partial physical displacement?	No
5.2	Would the Project possibly result in economic displacement (e.g. loss of assets or access to resources due to land acquisition or access restrictions – even in the absence of physical relocation)?	No
5.3	Is there a risk that the Project would lead to forced evictions?[3]	No
5.4	Would the proposed Project possibly affect land tenure arrangements and/or community based property rights/customary rights to land, territories and/or resources?	No
Standard 6: Indigenous Peoples		
6.1	Are indigenous peoples present in the Project area (including Project area of influence)?	No
6.2	Is it likely that the Project or portions of the Project will be located on lands and territories claimed by indigenous peoples?	No
6.3	Would the proposed Project potentially affect the human rights, lands, natural resources, territories, and traditional livelihoods of indigenous peoples (regardless of whether indigenous peoples possess the legal titles to such areas, whether the Project is located within or outside of the lands and territories inhabited by the affected peoples, or whether the indigenous peoples are recognized as indigenous peoples by the country in question)? *If the answer to the screening question 6.3 is "yes" the potential risk impacts are considered potentially severe and/or critical and the Project would be categorized as either Moderate or High Risk.*	No

[3] Forced evictions include acts and/or omissions involving the coerced or involuntary displacement of individuals, groups, or communities from homes and/or lands and common property resources that were occupied or depended upon, thus eliminating the ability of an individual, group, or community to reside or work in a particular dwelling, residence, or location without the provision of, and access to, appropriate forms of legal or other protections.

6.4	Has there been an absence of culturally appropriate consultations carried out with the objective of achieving FPIC on matters that may affect the rights and interests, lands, resources, territories and traditional livelihoods of the indigenous peoples concerned?	No
6.5	Does the proposed Project involve the utilization and/or commercial development of natural resources on lands and territories claimed by indigenous peoples?	No
6.6	Is there a potential for forced eviction or the whole or partial physical or economic displacement of indigenous peoples, including through access restrictions to lands, territories, and resources?	No
6.7	Would the Project adversely affect the development priorities of indigenous peoples as defined by them?	No
6.8	Would the Project potentially affect the physical and cultural survival of indigenous peoples?	No
6.9	Would the Project potentially affect the Cultural Heritage of indigenous peoples, including through the commercialization or use of their traditional knowledge and practices?	No
Standard 7: Pollution Prevention and Resource Efficiency		
7.1	Would the Project potentially result in the release of pollutants to the environment due to routine or non-routine circumstances with the potential for adverse local, regional, and/or transboundary impacts?	No
7.2	Would the proposed Project potentially result in the generation of waste (both hazardous and non-hazardous)?	No
7.3	Will the proposed Project potentially involve the manufacture, trade, release, and/or use of hazardous chemicals and/or materials? Does the Project propose use of chemicals or materials subject to international bans or phase-outs? *For example, DDT, PCBs and other chemicals listed in international conventions such as the Stockholm Conventions on Persistent Organic Pollutants or the Montreal Protocol*	No
7.4	Will the proposed Project involve the application of pesticides that may have a negative effect on the environment or human health?	No
7.5	Does the Project include activities that require significant consumption of raw materials, energy, and/or water?	No

OFFLINE RISK LOG

(see Δελιϖεραβλε Δεσχριπτιον for the Risk Log regarding its purpose and use)

UN DP

Project Title: Strengthening the HIV and TB Response in Egypt	Award ID: 00119017	Date:1 April 2019

#	Description	Date Identified	Type	Impact & Probability	Countermeasures / Mngt response	Owner	Submitted, updated by	Last Update	Status
1	Late initiation of the programme due to difficulties to obtain clearances from the national authorities *(In Atlas, use the Description field. **Note: This field cannot be modified after first data entry)***	Planning & Grant - making phase *(In Atlas, select date. Note: date cannot be modified after initial entry)*	Operational Organizational Political Other *(In Atlas, select from list)*	Enter probability on a scale from 1 (low) to 5 (high) P = 4 Enter impact on a scale from 1 (low) to 5 (high) I = 4 *(in Atlas, use the Management Response box. Check "critical" if the impact and probability are high)*	Support from UNDP & MOFA *(in Atlas, use the Management Response box. This field can be modified at any time. Create separate boxes as necessary using "+", for instance to record updates at different times)*	Country office focal point / Project coordinator *(in Atlas, use the Management Response box)*	*(In Atlas, automatically recorded)*	*(In Atlas, automatically recorded)*	*(in Atlas, use the Management Response box)*
2	Poor reporting from the Sub Recipients, delaying the reporting and leading to a poor grant rating	Planning & Grant - making phase	Financial Operational Organizational	P = 3 I = 3	Sub Recipients training (already conducted), proactiveness with the Sub Recipients	Project coordinator			
3	Poor financial delivery jeopardizes the possibility to obtain additional funding for the project	Planning & Grant - making phase	Financial Operational	P = 3 I = 2	Front load the procurement of medicines and medical products	Project coordinator			
4	Difficulties to implement outreach programmes with key populations	Planning & Grant - making phase	Financial Operational Organizational Political	P = 1 I = 2	Concentrate resources on outreach activities and work in coordination with the MOH and other two projects	Project coordinator			