



# National HIV Programme Situation and Gap Analysis

**Egypt**

**2015**

# National HIV Programme Situation and Gap Analysis Egypt April 2015

## ***Introduction***

This draft programme gap analysis is based on a consultative process undertaken by an international consultant “*Jamie Uhrig*” providing technical support to the National AIDS Programme of the Ministry of Health in Egypt in March 2015. The terms of reference for the international consultant include describing “current policies and programmes, including thematic areas, related to the national HIV response in Egypt and identifying programmatic gaps”. The process involved email questionnaires sent to stakeholders and a process of face to face meetings with individual stakeholders and groups of stakeholders. A stakeholder workshop was held 11 and 12 March 2015 to discuss the achievements and gaps.

Egypt is recognized by all stakeholders to have a national epidemic concentrated in the two populations of people who inject drugs and men who have sex with men in a setting of overall low prevalence among the general population. At present there is no evidence of an epidemic among any other population that has been confirmed through HIV testing.

According to the UNAIDS annual global gap report<sup>1</sup> based on national data, the number of people over fifteen years of age living with HIV in 2014 was 7,200 with a range of 4,400 to 12,000. If Egypt has a population of 84 million and 68% of this population is over the age of fifteen years then 0.013% of the population over fifteen years old is living with HIV. There were 4,631 people known to be living with HIV at the end of 2014. 1,715 or 37% of them were currently taking antiretroviral and this percentage is 24% when the denominator is 7,200.

There have been positive developments in the national response over the last several years. Most notably, there are prevention programmes currently being implemented for the key populations of people who inject drugs and men who have sex with men. Prevention services for these populations are beginning to be made available outside the two largest cities. Smaller programmes reach female sex workers. HIV testing is available for diagnostic purposes and both governmental and nongovernmental voluntary testing and counselling are being expanded. Treatment centres have been set up in fever hospitals. Stigma and discrimination is low in these care settings and there are legal services available for people living with HIV.

There have also been several valuable analyses of programmes and themes to inform the response. They include a study on stigma<sup>2</sup>, a gender assessment<sup>3</sup>, a prevention assessment<sup>4</sup>, a

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1 Global AIDS Response Progress Report, Egypt, 2014

2 The Egyptian Society for Population Studies and Reproductive Health, Stigma experienced by people

cost benefit analysis of prevention<sup>5</sup>, a population size estimation<sup>6</sup>, and an analysis of the test-treat-retain care cascade<sup>7</sup>.

Terms used in this report will be in the prevention and care packages recommended by WHO in the new consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations<sup>8</sup> or by UNODC and other UN system organizations in their guidance on setting goals for meeting the needs of people who inject drugs.<sup>9</sup>

## **Prevention**

### **People who inject drugs**

There are several countries in the Middle East and North Africa in which there are epidemics among people who inject drugs<sup>10</sup>. One population in which all stakeholders agree there is a concentrated epidemic in Egypt is people who inject drugs<sup>11</sup>. Incidence studies have not been performed and integrated biobehavioural surveillance data has not yet been used to estimate incidence or incidence trends in this population. But integrated biobehavioural surveillance has been used to determine HIV prevalence which increased between the two rounds of surveillance in 2006 and 2010. It has most recently been estimated at 6.8% in Cairo and 6.5% in Alexandria<sup>12</sup>. A recent urban population estimate of people who inject drugs has been undertaken<sup>13</sup>. There were estimated to be about 30,000 people who inject drugs in Greater Cairo (Cairo & Giza) and Alexandria with a further 1,000 in Menia. There is no official national population estimate for people who inject drugs.

There are many civil society organizations working in prevention of HIV infection among people who inject drugs. Fifteen of them work together as part of the Network of Associations for Harm Reduction in greater Cairo, offering a comprehensive programme of

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- living with HIV in Egypt, November 2013
  - 3 National AIDS Programme, UNAIDS, UNWomen RCT, Gender Assessment of the National HIV Response, December 2014
  - 4 Kabbash, Assessment of National HIV Prevention response in Egypt, 2015
  - 5 Gaumer, The Costs and Benefits of HIV and AIDS Prevention Programs in Egypt, 2012
  - 6 Jacobsen, Saidel, Loo, Estimating the size of key affected populations at elevated risk for HIV in Egypt, 2014
  - 7 Armstrong, Test-Treat-Retain Analysis Egypt, 2015
  - 8 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014
  - 9 WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2009
  - 10 Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time for Strategic Action, World Bank 2010
  - 11 Mumtaz, Reidner, Abu-Raddad, The emerging face of the HIV epidemic in the Middle East and North Africa, Curr Opin HIV AIDS 2014, 9:183–191
  - 12 HIV/AIDS Integrated Biological and Behavioural Surveillance Survey, Round 2, Summary Report, FHI & Centre for Development Services, 2010
  - 13 Jacobsen, Saidel, Loo, Estimating the size of key affected populations at elevated risk for HIV in Egypt, 2014

activities including comprehensive condom promotion, needle and syringe distribution, and targeted education. Testing is not part of prevention but it is included here as the civil society organizations are involved in testing. Voluntary counselling and testing is offered to all people reached and people who test positive for HIV may join support groups. They are referred for care but no systematic tracking of care is 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 ten 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 for substance use disorder, targeted education, condom promotion, & voluntary counselling and testing. People who test positive for HIV may join support groups and are referred for care but no systematic tracking of care is done.

There are small new prevention programmes for people who inject drugs in Luxor and Menya 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. A feasibility study for oral substitution treatment for people who inject drugs and who have opiate ‘substance use disorder’ has recently been disseminated. There are as yet no concrete plans for a pilot study but it has been proposed by the author of the feasibility study<sup>14</sup> that a pilot demonstration initiative in Cairo be implemented.

WHO guidelines<sup>15</sup> recommend condom programmes for people who inject drugs and their sexual partners, needle and syringe programmes, opioid substitution therapy and other evidence-based drug dependence treatment, and targeted education to have a direct impact on HIV incidence among people who inject drugs.

### **Critical gaps and action**

The current reach of prevention activities will have a limited impact in the geographic areas in which activities take place. Much higher reach and coverage would be necessary to have an impact on the national epidemic among people who inject drugs. The reach of prevention activities would need to be increased to reach 80% of people who inject drugs in the places where the largest populations of people who inject drugs live. Their sexual partners and spouses would also need to be reached with condom programming.

The essential recommended activities are needle and syringe distribution, targeted

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14 Feasibility Study and Operational Plan For Opioid Substitution Treatment in Egypt, 2015

15 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014

education, and condom promotion. Opioid substitution therapy and other evidence-based drug dependence treatment can be added if they are available.

### **Men who have sex with men**

There are nascent epidemics among men who have sex with men in the Middle East and North Africa region<sup>16</sup>. Egypt is no exception. Incidence studies have not been performed and integrated biobehavioural surveillance data has not yet been used to estimate incidence or incidence trends in this population. But integrated biobehavioural surveillance has been used to determine HIV prevalence which was similar in the two rounds of surveillance in 2006 and 2010. It has most recently been estimated at 5.7% in Cairo and 5.9% in Alexandria<sup>17</sup>. A recent urban population estimate of men who have sex with men has been undertaken and a best national estimate of about 43,000 has been determined. The best estimate of men who have sex with men in Greater Cairo and Alexandria is about 18,000<sup>18</sup>.

As described in the above section on people who inject drugs, a package of prevention activities is implemented: targeted education, and comprehensive condom promotion. For men who have sex with men reached by the programme who also inject drugs, the package of activities for people who inject drugs is offered. Voluntary counselling and testing is also offered and people who test positive for HIV may join support groups and are referred for care but no systematic tracking of care is 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.

WHO guidelines<sup>19</sup> recommend comprehensive condom and lubricant promotion and education. There is no specific recommendation to reach women sexual partners of men who have sex with men.

### **Critical gaps and action**

Current reach of prevention will have a limited impact in the geographic areas in which activities take place. Much higher reach and coverage would be necessary to have an impact on the national epidemic among men who have sex with men. The reach of prevention activities would need to be increased to reach 80% of men who have sex with men in the places where the largest populations of men who have sex with men live. Their regular women sexual partners could also be reached if the men who have sex with men consent.

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16 Mumtaz G, Hilmi N, McFarland W, Kaplan RL, Akala FA, et al. (2011) Are HIV Epidemics among Men Who Have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis. *PLoS Med* 8(8): e1000444. doi:10.1371/journal.pmed.1000444

17 HIV/AIDS Integrated Biological and Behavioural Surveillance Survey, Round 2, Summary Report, FHI & Centre for Development Services, 2010

18 Jacobsen, Saidel, Loo, Estimating the size of key affected populations at elevated risk for HIV in Egypt, 2014

19 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014

The essential activities are targeted peer education, and condom promotion. Women sexual partners could be reached with condom promotion activities. Men who have sex with men who also inject drugs should benefit from the entire package of services offered to people who inject drugs.

### **Female sex workers**

There are at present few concentrated epidemics among female sex workers in the Middle East and North Africa. Djibouti, Somalia, and South Sudan are the exceptions<sup>20</sup>. Female sex workers in Egypt mostly work on the streets, in small food and drink and entertainment venues, in hair salons, or through contacts made through mobile phones. Making a population estimate, conducting integrated biobehavioural surveillance among them, and implementing programmes are all challenges.

A recent urban national population estimate of about 23,000 has been made<sup>21</sup> with Greater Cairo and Alexandria accounting for about 10,000 women. Both rounds of integrated biobehavioural surveillance have been performed using proxy populations as a full sample of women who meet the definition criteria as female sex workers was not found. This is not helpful for programming. Only a few female sex workers are offered services in the Network of Associations for Harm Reduction programme in Greater Cairo.

One local nongovernmental organization, Shehab, has activities for female sex workers in parts of Greater Cairo. Outreach workers, , currently reach about fifty women per month. Half of them are newly reached and half have been reached before. The key 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 Shehab 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 outreach staff will be more effective than men outreach staff.

WHO guidelines<sup>22</sup> recommend targeted education and comprehensive condom and lubricant promotion.

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20 Setayesh et al, HIV and AIDS in the Middle East and North Africa, Population Research Bureau, 2014

21 Jacobsen, Saidel, Loo, Estimating the size of key affected populations at elevated risk for HIV in Egypt, 2014

22 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014

## **Critical gaps and action**

Previous rounds of integrated biobehavioural surveillance have not revealed any epidemic among female sex workers in Egypt. High quality integrated biobehavioural surveillance should be undertaken when funds are available.

In the absence of evidence of an epidemic among female sex workers in Egypt, the scale of reach of female sex workers in Greater Cairo and Alexandria by civil society organizations should be maintained. If prevalence is found to be five per cent or greater, the scale of activities should be increased to reach 80% of female sex workers in the places where the greatest populations of female sex workers live.

## **Prisoners**

Prisoners, defined here as all people in closed settings, are listed as a key population by UNAIDS and are at risk of HIV acquisition and onward transmission because of 1) behaviour that resulted in them being detained and 2) behaviour that may happen in prison.

There are no publicly released epidemiological studies of HIV among prisoners in Egypt though a few such studies have been undertaken. There is no mandatory HIV testing in prisons. During a programme that ran in four men's prisons in 2009<sup>23</sup>, more than eight thousand prisoners attended HIV awareness sessions and 1,526 chose to attend pretest counselling (Please add reference) . 1,470 prisoners among them chose to get an HIV test . There are prisoners living with HIVs who take antiretroviral treatment. These pieces of information indicate an understudied problem for which a response is necessary. A memorandum of understanding was recently reactivated between the Ministry of Health and the Ministry of the Interior to restart a programme of HIV information sessions and HIV testing with treatment for those who test positive and transfer of released patients to get ART in the place they choose to live.

UNAIDS and some of its cosponsors including UNODC and WHO<sup>24</sup> has published guidance to provide HIV prevention services to prisoners that are available to people outside prisons. This includes, at minimum, targeted education. All other activities should be undertaken if prison authorities allow them and advocacy to include them may help to protect their human right to health. Prevention of transmission through medical services is also included.

## **Critical gaps and action**

There is almost no strategic information to determine reach, scope, and effectiveness of an HIV prevention programme for prisoners. The National AIDS Programme needs to work with the Ministry of the Interior to ensure programmes that meet international quality standards and protects all the human rights of prisoners.

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23 Best Practice in HIV and AIDS in Egypt, UNAIDS. 2014

24 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014

## **Other populations**

There is no biological evidence of an HIV epidemic among any other population in Egypt. Populations of concern by some stakeholders include pregnant women, street children, non-Egyptian labour migrants and refugees. For refugees, MOH NAP has sustainably extended HIV prevention, care, support and treatment through a civil society organisation. Services offered for refugees and other persons of concern to UNHCR varied between VCT from as early as 2003, PMTCT, PEP for HIV among survivors of sexual violence, access to Fever hospitals for HIV related illnesses treatment, support groups and access to life saving ARVs since 2008. A gap remains however related to scaling up access to these services along with nationals as part of enhancing universal access to prevention, care, support and treatment among vulnerable populations in need for HIV related prevention and treatment services

In the general population, the percentage of young women and men who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was reported to be under 25% for males and under 10% for females in the last Egypt country Global AIDS Response Report.<sup>25</sup> And 7 percent of women and 18 percent of men had comprehensive correct knowledge about AIDS in the last DHS in 2008<sup>26</sup>.

## **Critical gaps and action**

Some stakeholders suggest there is a need to collect strategic information about sexual behaviour among street children and non-Egyptian labour migrants in order to form a baseline for behaviour change programmes. Developing a model of care for the prevention of mother to child transmission is also seen as necessary by some stakeholders.

There are no internationally accepted guidelines for HIV prevention among the general population when prevalence is low. Prevention services for the general population in low prevalence middle income countries are not recommended.

## ***Testing, care, support, and treatment***

### **Testing**

HIV testing is not a prevention activity<sup>27</sup> but is the first step to care, support and treatment. A recent review of HIV testing in Egypt has been undertaken as part of a care cascade analysis<sup>28</sup>.

HIV testing in Egypt is undertaken in several ways. Voluntary counselling and testing is

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25 Global AIDS Response Progress Report, Egypt, 2014

26 Demographic and Health Survey, Egypt, 2008

27 Fonner et al, Voluntary counseling and testing (VCT) for changing HIV-related risk behavior in developing countries

28 Russell Armstrong, Test-Treat-Retain Cascade Analysis Egypt, 2015



performed in both governmental and nongovernmental sectors. Voluntary counselling and testing services are offered in one governmental site in most of the twenty-four governorates. There are also about fifteen nongovernmental organizations providing voluntary counselling and testing services.

Provider initiated testing and counselling is offered in twenty-eight tuberculosis centres, in sixteen drug rehabilitation centres in mental health centres, twelve maternal child health centres, and three sexually transmitted infection care sites. Test kit stock-outs have affected services in some provider initiated testing and counselling sites. By far the most common source of positive tests is diagnostic HIV testing in hospitals.

Testing in the private sector is largely unregulated and there are no known reports on the extent of private testing. Lack of consent to HIV testing in all health facilities is thought to be common.

There is little official mandatory testing in the country. Stakeholders mentioned testing for visas to other countries and blood safety testing as the only documented types of mandatory testing in the country.

Provider initiated testing is not a routine for people newly-diagnosed with pulmonary tuberculosis. In 2010 almost half of all tuberculosis patient were tested for HIV and the prevalence of coinfection with HIV was only 0.2% or seven patients. Two years ago only ten per cent of tuberculosis patients were tested but the yield was still only seven patients. There is provider and geographic selection in the testing programme. Testing of sexually transmitted infection clinic attenders also yielded just three patients in the year 2013.

The yield, or number of people found to be seropositive, is most useful in determining which forms of testing should be scaled up. The seropositive rate can then be used as a measure of testing programme effectiveness. But the highest yield is likely to continue to be provider-initiated diagnostic testing in fever hospitals and other governmental hospitals. It will be followed by voluntary counselling and testing among people who inject drugs and men who have sex with men: both governmental and nongovernmental testing will yield positive cases and nongovernmental programme yield will increase as more beneficiaries are reached. Finally, provider-initiated testing in tuberculosis and sexually transmitted infection clinics could yield small numbers of patients.

Greater Cairo and Alexandria have about a third of the population of the country but account for almost two thirds of all HIV case detections.

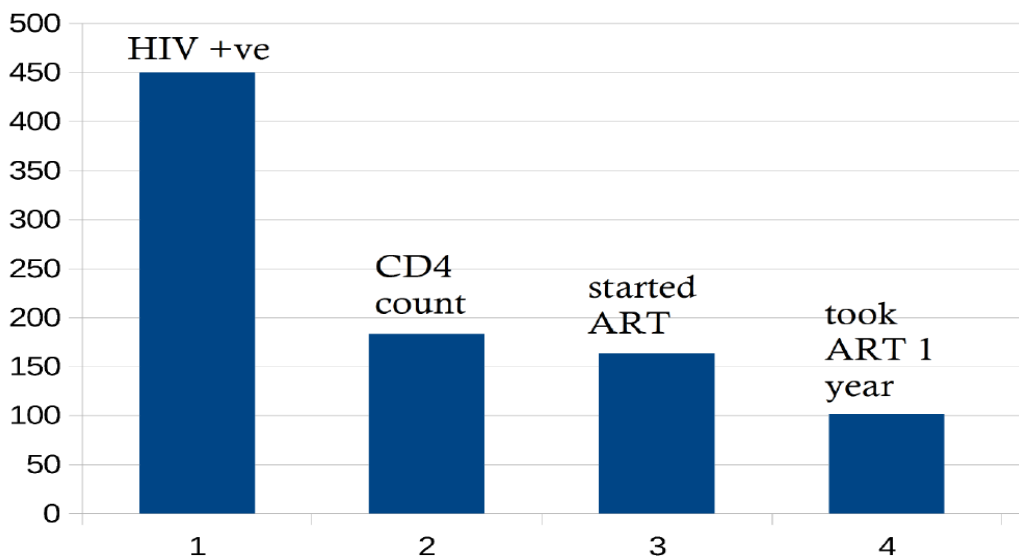
### **Care, support, and treatment**

Positive screening tests are confirmed at the central health laboratory and people who are found to be living with HIV are referred to care centres. These care centres are usually situated in fever hospitals. Care is entirely free of charge to the end user for all laboratory services, treatment of opportunistic infections, and antiretroviral treatment. The only exception is a low charge for hepatitis C testing for higher income patients. Almost the

entire care, support and treatment programme is currently funded through domestic resources and the Global Fund.

There were 4,631 people known to be living with HIV at the end of 2014. 1,715 or 37% of them were currently taking antiretroviral and this percentage was 24% when the denominator is 7,200.

There are new national HIV care guidelines<sup>29</sup>. Care begins with CD4 cell count testing and those eligible with a CD4 cell count of 500 or lower are offered ART. A treatment cascade has been developed for the country and a cohort analysis was performed for newly diagnosed patients for nine months<sup>30</sup>. A summary care cascade as a bar chart is shown below. The biggest drop in the cascade was in people who were diagnosed (1) but did not receive a CD4 cell count test (2). That is, they were diagnosed but did not enter care. There was a 60% drop. A second large drop of 40% was observed in people who began treatment (3) but were not observed to be continuing it after one year (4).



Hepatitis C is a common co-infection among people living with HIV in Egypt. This is due to the extremely high background of hepatitis C prevalence in the general population, almost 15%<sup>31</sup> and the risk of blood borne hepatitis C infection from using non-sterile injecting equipment. There have been no known recent hepatitis C prevalence studies conducted among people who inject drugs. Most, but not all, people newly diagnosed with HIV are routinely tested for hepatitis C. There is domestically-funded national free treatment programme of hepatitis C beginning this year and some but not all people living with HIV with hepatitis C co-infection are entered into the national registry so that they can be treated when they meet treatment initiation criteria.

29 National Guideline on Clinical Care and Antiretroviral Drugs for Treating and Preventing HIV Infection

30 Russell Armstrong, Test-Treat-Retain Cascade Analysis Egypt, 2015

31 Mohamoud et al, The epidemiology of hepatitis C virus in Egypt: a systematic review and data synthesis, BMC Infectious Diseases 2013, 13:288

The number of people with newly diagnosed tuberculosis who are found to have HIV and the patients themselves are reported to the National AIDS Programme. This programme currently does not screen HIV patients for tuberculosis so does not report to the National Tuberculosis Programme.

### **Critical gaps and action**

Almost two thirds, 4,631, of the estimated 7,200 people estimated to be living with HIV in Egypt have been picked up through case detection. There is both a gap in case detection and a gap in detecting cases before they require diagnostic testing.

Both voluntary counselling and testing and provider initiated counselling and testing must be prioritized in service delivery sites that will lead to the highest yield or number of newly diagnosed people living with HIV. VCT must be increased among people who inject drugs and men who have sex with men. Yield is similar in both governmental and nongovernmental VCT sites. Provider initiated testing gives the highest yield for diagnostic testing in hospitals. All health care providers in the public sector who administer HIV testing need to take responsibility for ensuring that people who test positive are registered with the National AIDS Programme so that they receive confirmatory HIV testing, CD4 cell count tests and enter the system for HIV care.

Both initiation into care and retention in care for the first year require urgent attention. The system for getting people from testing to care must be streamlined and a method of navigation must be developed so that newly-diagnosed people living with HIV can more readily get the care they need. These people need support through their first year of treatment so that they do not stop their treatment.

All people newly found to be living with HIV need hepatitis C testing and registration in the new national hepatitis C treatment programme.

A record keeping system to track health care outcomes for people living with HIV must be developed so that a care cascade can be developed and continually updated to assess the effects of changes in the programme and to monitor progress towards global 90 90 90 targets.

### **Stigma and discrimination**

All stakeholders are concerned with stigma and discrimination against both populations of people who inject drugs, men who have sex with men, female sex workers, and people living with HIV. Stigma involves beliefs and attitudes and discrimination involves action and behaviour. Stigma and discrimination are worse for these populations than against people living with another chronic illness, hepatitis C. This is partly due to the greater prevalence of this hepatitis virus and the fact that it is seen to be transmitted through the behaviour of health care providers and not through the behaviour of the person at risk of infection or infected. Stakeholders think that there is greater discrimination against men who have sex with men than against people who inject drugs.

There are several reports on stigma and discrimination as it is experienced by people living with HIV and some include other populations. It is unknown whether action against stigma and discrimination will be successful outside of health care institutions when prevalence remains low and associated with sex and drugs. Even countries with high prevalence have not all experienced a decline in stigma as their epidemics progress. Discrimination against men who have sex with men is declining worldwide and some stakeholders think it is declining in Egypt. Whether this will translate into a decrease in discrimination against people living with HIV is unknown.

The global evidence base for what is effective at reducing stigma and discrimination is slim<sup>32</sup>. Most programmes in other countries that have conducted research studies and report success have reported reduced stigma and discrimination against people living with HIV among health care workers. There is a strong bias against the publication of negative findings. Training in the past of health care providers in fever hospitals may be partly responsible for the reduced stigma and discrimination in these settings in Egypt.

Decision makers are faced with a difficult decision. Resources can be spent to try to change the attitudes and behaviours of large numbers of people over many years so that a few thousand people living with HIV and a hundred thousand identified members of three populations can experience less stigma and discrimination. Or fewer resources can be spent over a shorter time to expand the small number of health care providers who do not discriminate and ensure that three populations and people living with HIV get care from them.

### **Critical gaps and action**

Discrimination in health care settings where people living with HIV get antiretroviral treatment must be zero. That is in all fever hospitals. There is a need for a system to report discrimination to hospital authorities and a need to have them act on it.

There is a need to provide general health services for people living with HIV. If they choose to disclose their status they will need to get care from health care providers who already provide discrimination-free services. These providers need to be identified and people living with HIV informed.

Some stakeholders think that the mass media should be used to disseminate messages against HIV-related stigma and discrimination. The evidence base for the effectiveness of this approach is slim.

### **Human rights and gender**

The legal environment for HIV prevention and care is complex and rapidly changing. Article 18 of the new constitution enshrines the right to health for all. But the behaviour of

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32 Stangl AL et al. Journal of the International AIDS Society 2013, 16(Suppl 2):18734

three major populations is criminalized. Drug use is illegal and can lead to prison though people who admit to drug use can be admitted to drug rehabilitation centres. Female sex work is illegal and prison terms are usually given for women convicted. Sex between men is usually prosecuted as the criminal offense of debauchery. There are reports of increased arrests of the latter two populations since the early part of 2014 including two heavily publicized mass arrests of men who have sex with men.

There are regulations against discrimination in health care but it is acknowledged by most stakeholders that there are few consequences for health care providers who discriminate. There is little discrimination against people living with HIV in the 'fever hospital' infectious disease centres that provide antiretroviral treatment. But not all health services needed by people living with HIV are provided there and segregation of care using fever hospitals may make discrimination worse in other health care settings where people living with HIV are rarely seen.

Most members of the three populations of people who inject drugs, men who have sex with men, and female sex workers and many people living with HIV are vulnerable people and can be served by the legal framework and service network for vulnerable people in the country. Most do not claim disability in order not to feed public discrimination and concerns about public pushback if too much positive discrimination is seen in provision of services.

### **Critical gaps and action**

Changes at many levels were suggested by stakeholders. Legal reform is a key action but few think that this would be easy. On the next level there could be development of regulations and enforcement by the Ministry of Health, health care institutions, or health care provider regulatory bodies. Networks of legal professionals and health care providers who do not discriminate are currently providing services.

Legal services should continue to be provided to people living with HIV and key populations that are currently being serviced through outreach to exercise their human rights.

### **Strategic information**

There are many gaps in strategic information needed for an effective response to the HIV epidemics in Egypt.

With respect to prevention, there is not yet a national standard reporting system with unique identifiers for outreach activities for the populations of people who inject drugs and men who have sex with men. Not all HIV prevention and testing activities conducted by nongovernmental organizations are reported regularly by nongovernmental organizations to the National AIDS Programme. There appears to be limited recognition that this is their responsibility as organizations accountable to both the populations they serve and the national response to HIV.

For care, support and treatment, there is not yet a system for monitoring the health care outcomes of all people tested, entering care, and continuing in treatment to develop a care cascade. Annual reports of the response must be developed de novo as reports are not made on implementation of the national strategic framework.

It was noted previously in this report that integrated biobehavioural surveillance needs updating and incidence estimates and incidence trajectories are needed for both people who inject drugs and men who have sex with men. Integrated biobehavioural surveillance is lacking for female sex workers. Serological evidence of infection is lacking for all other groups that are often proposed as ‘risk groups’.

Information on prisons and prisoners with respect to HIV is often not publicly released by the Ministry of the Interior. There have been no feasibility studies of prevention of mother to child transmission and there have been no sexually transmitted infection prevalence studies in the country for almost twenty years.

Informants often offered positive comments on the National AIDS Programme and its leadership in guiding the national response to HIV.

### **Critical gaps and action**

A national standard reporting system with unique identifiers for outreach activities for the populations of people who inject drugs and men who have sex with men should be developed and all HIV prevention and testing activities conducted by nongovernmental organizations should be reported by nongovernmental organizations to the National AIDS Programme. A system for monitoring the health care outcomes of all people tested and entering care needs development so that care cascade diagrams can be used as a management tool. Annual reports against the national strategic framework should be published.

Integrated biobehavioural surveillance needs updating and incidence estimates and incidence trajectories are needed for both people who inject drugs and men who have sex with men. Integrated biobehavioural surveillance is needed for female sex workers as a secondary priority.

There are lower priority gaps in strategic information. A feasibility study of prevention of mother to child transmission is in the pipeline. A sexually transmitted infection prevalence study should be conducted.

### **Management of the response**

There have been positive developments in management of the National AIDS Programme over the last year. Stakeholders noted the firm and effective working relationships between the National AIDS Programme and civil society.

## **Critical gaps and action**

There is a need to form a Technical Working Group to support the development of a three year casted operational plan from the national strategic framework and to guide the development of any potential future Concept Note development for the Global Fund. Unit costing is needed to develop a costed national strategic framework for HIV. A regular national forum is also needed to be part of the Country Coordinating Mechanism.

Funding and human resources are also needed by the National AIDS Programme in order to expand their capacity to manage a larger national response.

Expansion of prevention services needs to take place in a sustainable manner so that is can continue beyond the time when external funding ends. Existing nongovernmental organisations need to be supported in preference to new ones.