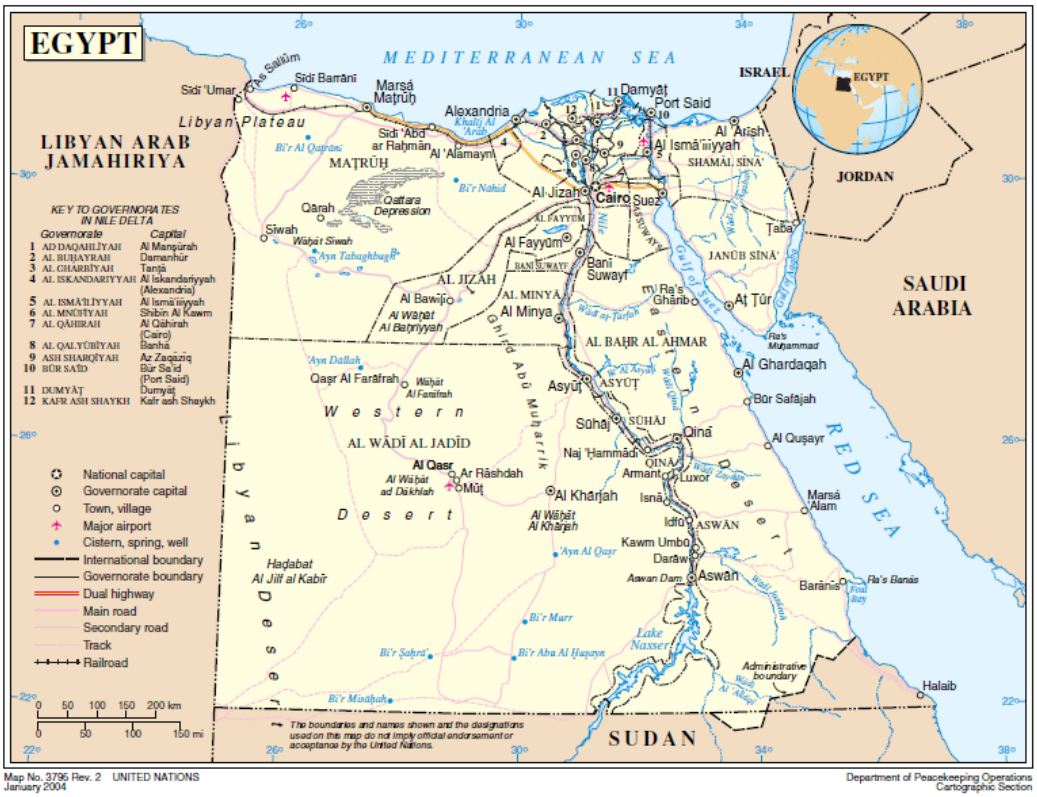

# HIV/AIDS Situation, Response, and Gap Analysis

# 2010

# Arab Republic of Egypt




## The Context of Egypt

Egypt is a lower middle income country situated at the heart of the Middle East and the northeast corner of Africa. Geography, population, history, and diplomatic position give Egypt political influence. Egypt shares its geographical borders with, Libya, Palestine (including Gaza Strip)/ Israel, and Sudan. The total area of the country is one million square kilometres, out of which 6% is populated. The total population of Egypt (excluding Egyptians living abroad) is 74.3 million according to estimates of CAMPMAS in 2008. Ratio of general government expenditure on health to total government expenditure is about 7.1 %

# HIV and AIDS Situation Analysis in Egypt

## 1. Epidemiology:

Egypt has low HIV prevalence among the general population (below 0.02 %) with concentrated epidemic among men having sex with men (MSM) and injecting drug users (IDU) in some governorates as detected by the latest biological/behavioral surveillance survey in 2010. Till the end of 2010, a total of 4,313 HIV cumulative cases were detected in Egypt, of which 3,328 were Egyptians (985 foreigners). Currently, 2,103 Egyptians are known to be living with HIV; among whom, 353 (16.8 %) developed AIDS. Since 1990 and to date, there has been a regular increase in HIV detected cases. Over the past ten years, the number of detected cases has increased from 1,040 HIV and AIDS cases (from 2001-2005) to 1,663 cases (from 2006-2009). This increase in the number of detected HIV positive cases could be explained by the efforts of the National AIDS Program to improve HIV surveillance, testing and reporting. However, it is important to highlight that the prevalence of HIV in the country remains constant below 0.02%. NAP/UNAIDS/WHO estimate the number of people living with HIV in Egypt to be 10,400 till the end of 2008i.

Data regarding detected cases indicates that the population group most affected is adults in the age group 25 – 40 years (54% of all detected cases). Females represent 20.4% of all detected cases. There is an increase in the number of detected HIV infections among youth where 14.1% are among 15-24 years at the end of 2009ii.

In 2010, most transmissions occurred sexually (66.8%). Out of the total detected cases 46.2% are heterosexual transmission and 20.6% are homosexual transmission. Transmission through Injecting drug use represents around 28.3%. Among detected cases in 2010, 14 (4.9%) were children of various ages denoting probable mother to child transmission. It is worth noting that out of the total number of people who presented for voluntary counseling and testing services in 2010, 18.2% were women.

The most recent bio-behavioural surveillance survey conducted by the Ministry of Health, Family Health International and CDS in 2010 has demonstrated a concentrated epidemic among men having sex with men in Cairo (MSM) at 5.7% (2.6-10.1%) and in Alexandria at 5.9% (3.0-10.2%)iii. Additionally concentrated epidemic was also detected among male injecting drug users in Cairo at 6.8% (3.9-10.8%) and in

Alexandria at 6.5% (3.3-10.3%). This is the second wave of biological/behavioral surveillance survey following the earlier one conducted in 2006, which only demonstrated a concentrated prevalence among MSM in Alexandria at 6.2%.

Nevertheless, risk behaviors suggest that a wider epidemic may be emerging especially among most at risk populations and bridging groups. Behavioral data from the biological behavioral surveillance survey conducted in 2010 reveals that among the studied MSM in three governorates (260 in Cairo, 262 in Alex and 269 in Luxor), 21.9%, 54.9% and 10.7%, and of MSM in Cairo Alexandria and Luxor respectively reported condom use among the most recent commercial client. In the meantime, condom use among the most recent non commercial client of MSM was reported to be 25%, 19.2% and 11.8% in Cairo Alexandria and Luxor respectively. Earlier studies have shown that 24% of MSM had one or more sexually transmitted infections (STIs) within the 3 months preceding the studyiv. The low level of condom use, coupled by high rate of STIs suggests high vulnerability of this population. Additionally 39.8%, 59.2% and 86.5%, of MSM in Cairo, Alexandria and Luxor respectively reported ever having sex with females. This highlights the vulnerabilities of female sex partners as well. A population size estimation was conducted in Egypt in 2009 by the Ministry of Health and UNAIDS using several methods as capture recapture, multiplier and enumeration methods and suggested an estimated percentage of MSM to be 0.2% of total adult male population in Cairo.

Among Studied group of Injecting Drug users (275 in Cairo, and 285 in Alex), 22.9% and 40.5% in Cairo and Alexandria respectively shared needles with one or more persons in the 30 days preceding the survey. Additionally 48.7% and 29.3% in Cairo and Alexandria respectively are currently married and only 4.3% and 18.7% in Cairo and Alexandria respectively reported using condom in the last 12 months with regular non commercial partner. The estimated number of IDU users in Egypt range from 57,000- 120,000v.

Despite low prevalence among female sex workers, risk behaviors caution for potential increase in infections. Out of studied female sex workers (200 in Cairo), 25% reported condom use in the last sex, and 41% reported condom use at least once in the previous 30 days. Additionally, 45.5% reported being currently married.

Street Children are a population that is greatly marginalized and highly mobile. There is no national consensus on the actual numbers of street children. A studied population of street children showed that 8.1% and 9.1% of boys and girls respectively aged 15-17 in Cairo reported ever injecting drugs (8.2% and 10.5% of boys and girls in Alexandria)vi. The biological behavioural surveillance survey in 2010 (200 street boys and 200 girls in Cairo), demonstrated low HIV prevalence among this group 0.5%. Nevertheless, 46.5% and 16% of the studied population of street boys and girls respectively reported ever having sex. Median age at first sex was reported to be 13 and 14 years old for boys and girls respectivelyiii.

## 2. Social Context and Special Considerations

Despite low HIV prevalence among the general population, HIV is considered a development concern. This is due to the fact that social and other development indicators have an influence on HIV situation in Egypt and likewise HIV situation affects development. Egypt has a large population of close to 80 million people. The government of Egypt estimates the percentage of people who live below poverty line to be 21.6% in 2008/09 (less than 2 dollars a day)vii. The national illiteracy and unemployment rates in Egypt are up to 40% and 9.4% respectivelyvii. Young people aged 15-24 form about 1/4 of the population in Egypt. Among this age group, illiteracy rate is 15.1%; 12.1% for males and 18.2% for femalesviii.Unemployment among university graduates is nearly 45% for females and 25% for males according to the 2006 Census. All those factors are relevant social drivers that should be considered as part of the HIV response in the country. The following section will focus on illustrating in depth analysis of the social and contextual factors that are essential to the HIV response in Egypt.

### Population Knowledge about HIV and AIDS:

According to the Demographic and Health survey in 2008, among the general population, knowledge about HIV and AIDS varies greatly where 73% of women and 87% of men age 15-59 have heard about it. Knowledge about the role of having one sex partner in reducing the risk of HIV infection was relatively high where 58% of women and 73% of men correctly stated this. However, comprehensive knowledge

Among most at risk populations, basic knowledge about HIV and AIDS is generally high but major misconceptions exist. Among a studied group of Female sex workers, 89% heard of HIV and half of them stated correct modes of transmission. In the mean time 56.2% of the same group stated that a healthy looking person cannot be HIV positive, 36.5% thought that HIV can be transmitted through sharing a meal and 20.8% thought HIV can be transmitted through mosquito bites. Among men having sex with men, the majority has heard of HIV and about 75.5% and 81.1% in Cairo and Alex respectively knew that a confidential HIV test could be attained.

## Stigma and Discrimination

HIV/AIDS is often considered a taboo because of the nature of HIV transmission. HIV positive persons are generally stigmatized and thus find it difficult to publically disclose their HIV status. The Demographic and Health Survey highlighted that 23% of women and 20% of men who heard of AIDS were willing to care for a relative who could be living with HIV at home. About 14% and 19% of women and men respectively reported that they would buy fresh vegetables from a shopkeeper with AIDS; and 13% and 9% of women and men respectively would allow a teacher living with HIV to continue teaching8. This HIV related stigma in many cases has led to discrimination against people living with HIV with cases of expelling from jobs, and in some cases even rejection by family members. Women with HIV are often cut off from family and community support. Widowed women with HIV encounter significant problems in finding ways to support their children, due to ill health, social isolation and absence of income-earning optionsxi.

## Situation of Women:

There is a special vulnerability of women in society due to existing gender gap indicators. According to 2006 census, unemployment rate for women (15-64 years) was 30% and for young female university graduates to be up to 45%[vii]. Additionally, illiteracy rate among young females 15-24 years old is 18.2%. Those indicators

highlight the possible limited access to information and economic independency which could increase vulnerability to HIV.

As highlighted previously, 7.1% of women age 15-59; and 4.8% of 15-24 years old young females have comprehensive knowledge of HIV. Among currently married women, only 1.2% reported current use of condoms for family planning[8].

Information from voluntary counseling and testing demonstrate that 21% of all VCT visitors are females[x]). During 2010, the total number of pregnant HIV +ve was 6 which represented 100% of known pregnant women living with HIV.

A study of the needs of females living with HIV in Egypt have indicated that many women are not only at risk of infection, but they get infected without knowing and remain uninformed of their infection status until they are confronted with a sick and dying husband. Many women still require permission from their husbands to seek healthcare. If women become ill before they know of their husband's HIV status, they often go misdiagnosed.[xi]

## Migration and HIV

Egypt is a transit country for many refugees and asylum seekers to their final destinations in Europe or the US. The number of recognised refugees in Egypt is estimated at 3,763,921 mostly from Sudan, Iraq and Somalia. It is also estimated that currently 50,000 to 70,000 Palestinian refugees are residing in Egypt[xii]. NAP in collaboration with refugees organizations is providing HIV preventive and treatment and care services.

## Legal Environment

The Egyptian constitution does not call for any form of discrimination against people because of their disease status. Thus there are no laws specific for people living with HIV Egyptian laws prohibit commercial sex and use or trade of narcotics in Egypt. Homosexuality is not prohibited but is socially and culturally rejected.

## Resource Environment:

Egypt is a lower middle income country. External resources for AIDS (ODA) are estimated at USD 4,151,900 according to the World Bank. The expenditures on HIV from international and national resources in 2008 was accounted for USD 7,538,436[xiii]. The government of Egypt contributes with almost 50% of the

expenditures on HIV response. National resources are provided by the ministry of finance. The largest external donor on HIV is the Global Fund on HIV, TB and Malaria. The Ministry of Health is the Principal recipient of the round 6 grant from the Global Fund with a total signed grant agreement for five years of US$ 10,469,362. Other external resources were availed by UN agencies and bilateral organizations as USAID, Italian cooperation and private not for profit funds as Ford Foundation and Drosos.

## Partners

### MOHP and Other Governmental Bodies

The NAP has active partnership with some MOH units such as the Central Labs, Blood Safety, TB, ANC, Drug rehabilitation units, Skin and venereal department, Gynecology department and Infection Control Unit. The NAP has collaborative relations with other Ministries as the Ministry of Interior, Ministry of Foreign Affairs, Ministry of International Cooperation, Ministry of Education, Ministry of Higher Education, Ministry of Social Solidarity, ....

### Civil Society

The NAP collaborates with civil society organizations on various issues of HIV/AIDS response. The majority of NGOs that do address HIV/AIDS are mostly based in Cairo and Alexandria. Awareness is the most covered area of work related to HIV/AIDS followed by drug use. A handful of civil society organizations work on issues addressing most at risk groups or support to PLHIV. To date, only one NGO address female sex workers in Cairo (Alshehab); Four NGOs recently addressed primarily men having sex with men in Cairo and Alex (Caritas, Almofid Association for Training and Development, National Association for Family Development, Ryadah and Abnaa ElDahria); and several NGOs in Cairo and Alex address injecting drug users (Caritas, Freedom, Waey, Be- Frienders and Alhayat). The number and capacity of NGOs working on HIV needs strengthening to encourage work on priority issues necessary for the response; and scaling up to other governorates is crucial.

## International Organizations:

Collaboration exist between NAP and several international organizations, as UN organization interested in HIV interventions (UNAIDS, UNICEF, UNFPA, UNODC, WHO, UNDP). Other International organizations include (Ford Foundation, Family Health International, CARE, DROSOS).

# National response to the Aids epidemic

## Prevention of HIV/AIDS

### A. Infection control:

The MOH is ensuring strict infection control measures in different health settings since 1992. The MOH is working on ensuring infection control measures in renal dialysis units and blood banks to prevent HIV transmission through blood and blood products.

In renal dialysis units each new patient is tested for HBV, HCV and HIV and then routinely tested every three month.

### B. Ensuring blood safety:

Blood safety policy applies to all blood banks of Egypt which include screening blood donated for (HBV, HCV, HIV, and Syphilis). All blood donated is screened using ELISA technique through 244 blood banks (17 of them are private). In 2010 an estimated 1.000.000 blood units were collected & tested in a quality assured manner (58 positive blood bags were detected and discarded).Plans are currently underway to build “a safe donor base” in Egypt. A national blood donor tracking system is implemented to ensure safe blood supply.

### C. Raising awareness and Combating stigma:

Knowledge among the general population is documented in the latest Demographics and Health Survey where 7.1% of Females age 15-59 and 18.1% of males in the same age group had comprehensive knowledge about HIV and AIDS.

In 2010 NAP has conducted 145 campaigns attended by around 30,000 persons in different governorates, Also NAP has conducted a number of 1089 raising awareness sessions addressing the general population and specific populations as youth (239), women (239), uniformed services (240), tourism workers (100), refugees (85), Ministry of Foreign Affairs leaders (1),women leaders (40), religion leaders (20), teachers (30), Scouts (2),Ministry of Interior leaders (2), street children (40) and prisoners (52) attended by around 35,000 personnel.

The conservative culture in Egypt has long saved the country against STIs and slowed down the HIV epidemic growth. However, the cultural norms contribute markedly to profound stigma towards PLHIV. The perceived shame and disgrace that link risk behaviors to PLHIV and their families hinder the HIV preventive efforts, HIV testing, social support and health care.

During 2010 NAP has conducted 9 anti stigma campaigns in different governorates all over the country attended by around 1800 community figures.

## D. Training:

Several training activities were conducted during 2010 by NAP. These trainings were related to Surveillance, M&E, PMTCT, ANC, ARVs, Home Based Care, refreshing VCT, Clinical care, Nursing care, TOT and building capacity of NGOs. Target population for these trainings were physicians, nurses, other health care personnel, social workers, VCT counselors, NGO staff and NAP staff. During 2010 the total number of trainings was 48 attended by 1132 persons.

NGOs conducted several trainings targeting MARPs, refugees and their own staff.

## E. Prevention among MARPS:

The importance of addressing MARPs with preventive messages and providing commodities and IEC materials is an essential strategy of the NAP. VCTs have been established to reach these groups.

Moreover, civil society organizations have been approached to help reaching these groups. With the support of the NAP, UNAIDS, FHI and others, NGOs have initiated outreach programs targeting MARPs. The programs are mostly a combination of outreach, counseling and peer education, with a facility based referral for comprehensive medical, psychosocial, legal and other services.

In 2010 and to date 3045 MARPS have been reached in the field, among these 2,234 female sex workers, 1168 MSM have been reached and 27718 condoms have been distributed.

Drop-in centers have been established particularly in Cairo & Alexandria. All drop-in centers provide free access to condoms, syringes, counseling and testing.

Programs on harm reduction have been established for active IDUs, who are considered a key entry point to other vulnerable groups. These programs focused on building the institutional and programmatic capacity of local NGOs, to provide much needed HIV/AIDS prevention and care services to active IDUs in Cairo and Alexandria.

## F. Prevention among most vulnerable population

1- The number of recognized refugees in Egypt is estimated at 3,802,911 till the end of 2010. It is also estimated that currently 50,000 to 70,000 Palestinian refugees are residing in Egypt. Factors that encourage the spread of HIV among refugees exist, accordingly several preventive measures have been instituted including VCT, Awareness raising, and care and treatment. A total number of 22 HIV+ adults and 2 HIV+ children are receiving ARVs from the NAP.

2- Street children:

The estimated number of street children in Egyptian cities varies greatly. Yet this group is an important target for HIV/AIDS prevention. In a recent Behavioral Survey among street children in Greater Cairo and Alexandria it was found that about 67% of study participants 15–17 years old have ever had sex with someone of the opposite sex. Among those who had sex during the last 12 months, 54% had sex with more than one partner, and 25% reported using condoms. About 26% of street girls in Greater Cairo and 58% in Alexandria reported participating in commercial sex (this is less common among street boys). Around 28% of street boys reported having sex with boys. The above behaviors are coupled with poor knowledge of HIV and AIDS. While 79% had heard of AIDS before, 16% did not know how to avoid contracting the infection.

Second round Bio BSS reveals that the prevalence among studied street children is 0.5% among boys and girls. All sexually active street boys did not use condoms with commercial sex partners, while only 4.1 used it with non commercial sex partners in the last sex. Street children were victim of sexual abuse (30 % among street girls & 11.5% among street boys). MSM activity was also reported by 44.2%.

3- Prevention among prisoners :

During 2008, an initiative for Strengthening HIV prevention, treatment, care and support services in prisons and community aftercare services has been implemented in four prisons in Egypt.

The project is a collaborative effort between the National AIDS Program, the Ministry of Interior (prison sector), and UNODC. So far, knowledge, and attitudes assessment was conducted among prison inmates and prison staff. Capacity building of prison officers and medical staff took place.

The VCT centers have been inaugurated in March 2010 to provide services of HIV counseling and testing on a voluntary and confidential basis to inmates.

In addition a comprehensive training program was conducted to stakeholders, health staff and working personnel in these VCT units.

Follow up testing, treatment of opportunistic infections and ARVs are provided for HIV positive prisoners according to their needs by NAP in collaboration with Ministry of Interior.

## G. VCT:

VCT services have been one of the crucial HIV prevention interventions in Egypt since 2004. Two models of VCT services are available; stand –alone (fixed) and mobile units. All service units are providing pre-test counseling sessions by well trained counselors to all clients coming to HIV testing with complete anonymity, secured level of confidentiality and well established referral network.

There are 23 governmental VCT centers (14 fixed and 9 mobile VCT centers) in 17 governorates attracting 9472 beneficiaries where 18.2 were female. MARPs accounted for about 15.4% of total visits during 2010. In addition 4 NGOs provide VCT services for 1869 MARPs.

VCT clients received pre and post HIV test counseling and HIV positive cases were referred to NAP for follow up, testing, receiving ARVS and treatment of opportunistic infections.

## H. PMTCT:

Services for preventing mother to child transmission have been established in Egypt based on the estimates of women needing PMTCT services generated by the National AIDS Program. This estimate has been obtained based the number of actual pregnant women receiving PMTCT from the total known HIV positive women. In 2010 a total number of 6 HIV positive pregnant women were covered by PMTCT program. These represent all known HIV positive pregnant women

## Surveillance:

To strengthen surveillance system a national HIV surveillance plan was developed in 2004. To date the NAP has established 99 sentinel sites all over the country covering TB clinics (41), fever hospitals (9) STIs (8), ANC units (37) and drug rehabilitation centers (4). In each of these sites a minimum of five members were trained on HIV surveillance by the NAP.

The government conducts an average of 166,000 individual HIV tests per year in different sentinel sites. The prevalence rate of HIV in Egypt is <0.02%.

## Monitoring and Evaluation

A national M&E system was developed in 2010 to ensure routine follow up HIV/AIDS response in the country. All personnel working on HIV/AIDS activities were trained on M&E .In addition all NGOs working on HIV/AIDS were also trained and participated in the M&E system.

Data are collected from different sites in all levels including surveillance sites, VCTs, HIV/AIDS focal points, blood banks and civil societies.

A web based application of M&E was established allowing on line real time access to data in all levels and electronic dissemination of M&E report. Moreover, a patient database was developed including all data related to HIV/AIDS persons.

## Care, treatment &support of PLHIV:

Medical care is the responsibility of the NAP and is conducted through free provision of ARVs for people who need it according to the Egyptian national guideline based on WHO recommendations. First, second and third line regimens are provided according to needs. The NAP has activated a process of decentralization of ARVs distribution system as a result PLHIV are now able to access ARVs through six distribution points located in 5 governorates (Cairo, Giza, Gharbia, Alexandria and Menia). These sites also provide tratmnt counseling and follow up care for persons on ARVs.

The total number of persons receiving ARVs by the end of December 2010 amount to 538.

Follow-up, counseling and treatment of opportunistic infections are also offered by the NAP.

Home-Based Care (HBC) is also provided by the NAP to empower PLHIV in all steps of care and support. This is based mainly on strengthening PLHIV self care and their care takers in dealing with common perceived symptoms related to their condition. Also HBC cover different aspects as medical care, social care and support and psychological care.

A total number of 203 nurses and 165 PLHIV and their care takers from 20 governorates attended 9 and 11 training courses respectively on HBC up to 2010 (43 nurses & 30 PLHIV and care takers in 2010). HBC for outreach PLHIV is currently provided in Giza and Alexandria through home visits to HIV affected people. In addition, as part of the home based care initiative, the HBC group has been working with health care providers in health settings to improve treatment and care for PLHIV and to provide health teaching for HIV positive persons and their families.

To help PLHIV adjust and live positively with HIV infection, the NAP instituted support group activities in different governorates.

This started with developing a guideline for support groups including purpose, objectives, optimal number of participants etc…..

Trainings for support group leaders were conducted.

In 2010 NAP conducted 63 support group sessions in greater Cairo, Gharbya and Fayoum.

Even in health care settings, cases of discrimination and denial for service have been observed. Accordingly trainings and awareness raising sessions were conducted for health care personnel to create an enabling environment within the health care settings.

## Research:

Expansion of health surveys among MARPS and surveillance centers takes a priority in the plan of NAP in Egypt. In 2010 NAP has implemented:

- A study on the practices and attitudes towards AIDS among MSM in Cairo.
- A study on the practices and attitudes towards AIDS among Female commercial sex workers in Cairo.
- Bio Behavioral Surveillance Survey (BBSS)

  The NAP and FHI conducted the second round (BBSS) in 2010 among high risk population in Egypt (MSM, FSW, Male IDUs and street children) to determine the status of HIV epidemic and collecting data on HIV prevalence to monitor the epidemic's trend.

  The study has been conducted among 8 groups in 3 different governorates. Biological STIs and behavioral data were collected and analyzed.

# Key Challenges and Gaps in the National HIV response

The overriding goal of the national HIV response in Egypt is to maintain low HIV prevalence in the country and to achieve universal access to prevention, care, support and treatment.

Major progress has been made in the national response in Egypt through availing wide range of services including but not limited to confidential counselling and testing services, ARVs for all PLHIV in Egypt who need it; and enhancing capacity of civil society organizations to have an active role in the response.

With 80 million people, limited resources and small numbers of detected PLHIV, targeting of the response is essential. It is impractical to reach all the people of Egypt with the same level of services, education and information on HIV. The National AIDS Program realizes that an effective response needs to address the priorities that would redeem the results and would rationalize investments made. Based on a review of the national HIV situation and response analysis at the end of 2010; and keeping in mind the overriding goal of the responses, the following challenges have been formulated. Those challenges in the HIV response are summarized against the following key priorities: 1) Strategic Information; 2) Enhancing Prevention; 3) Strengthening Care, Support and treatment; 4) reinforcing the Enabling Environment; and 5) Developing Institutional Capacity.

## 1. Strategic information:

A large number of studies on HIV and specific populations have been carried out in Egypt over the past two decades. A recent summary of these studies has found 72 such studies[xiv]. Several studies have examined knowledge, attitudes and behaviour among the general population to HIV. But no population based survey has ever been

done. According to the National surveillance plan, a general population based survey should be done every 5-7 years.

Strategic information about most at risk populations has recently increased including behavioural, qualitative studies and surveys. Information from such sources has all highlighted the abundance of risk factors and contextual barriers with regards most at risk populations. Nevertheless, there are still existing gaps in the knowledge related to injecting drug users, men having sex with men and sex workers.

With regards to most at risk population, estimates of the population size become crucial information in order to plan for the scale up and scope of programs. The 2004 population size estimate of the number of injecting drug users urgently requires updating and should take into account female injecting drug users, together with generating a clearer picture of any differences in injecting practices. In 2009, an estimate of men who have sex with men was 0.2% in Cairo. This estimate needs to be verified and to explore how this figure of Cairo varies from other areas. Estimates need to be made for the number of female sex workers in Egypt. Additionally more information is needed on the types of sex work and the specific risks related to sex work. This also needs to take into account the situation of sex work outside Cairo.

Qualitative and quantitative research is needed to deepen the understanding of some key subpopulations, specifically aimed at identifying the most appropriate way to reach these groups and to connect them with the health services they need. In all the previously conducted studies, condom use was found to be quite low. An analysis of the barriers and means to overcome them need to be conducted in order to design appropriate condom promotion interventions.

More attention needs to be paid to female sex partners of most-at-risk men who are at significant risk of HIV infection. In order to start programming for this group, more information needs to be collected to understand the context of risk and health-seeking behaviour. Additionally, all previously conducted studies highlighted a strong overlap of most-at-risk populations. Thus, any intervention for one population needs

to have activities targeting subpopulations who may also be injecting drug users, sex workers, clients of sex workers, and men who have sex with men. Many recently conducted studies have highlighted the engagement of population in sex work. Nevertheless the profile of sex work and the extent to which it could drive the HIV epidemic need to be further explored. Lastly, an understanding of the links between drug injecting, sex work and men having sex with men require further contextual understanding. Several models for addressing most at risk populations in Egypt have been piloted. A review is required of the effectiveness and efficiency of models developed to date to reach MARPs in Egypt. This should include an assessment of the models' achievements in reaching and working with MARPs and the costs of carrying out this work. From this models review, a suggested group of models for replication should be developed to be scaled-up.

Universal access is the goal of the new National Strategic Plan. Actually 538 PLHIIV are on ART to date. Additionally, ongoing prevention, treatment, care and support needs of People Living with HIV has to be furthered studied.

*Targets in Summary:*

By end of the second year of the Strategy:

- Population size estimations for:
  - Injecting drug users
  - Female Sex workers
  - Men who have sex with men
  - Female partners of men who have sex with men, and IDUs
  - Clients of Female sexworkers.

- ongoing prevention, treatment, care and support needs of People Living with HIV

By end of the Strategy:

- Explore attitudes to condom use and specific barriers to condom use among most at risk populations.
- Male and female health-seeking behaviour

## 2. Enhancing HIV prevention

Evidence has shown that HIV prevalence in Egypt is low with concentration among injecting drug users and men having sex with men. High risk behaviors among them as well as other groups as female sex workers, and street children. Additionally, particular emphasis is placed on other special populations. Those special populations include prisoners, uniformed services, street children and mobile populations including refugees and migrants. Lastly, positive prevention among people living with HIV is of utmost priority to improve the quality of life of those affected and prevent further transmission of HIV. The route of the epidemic is driven by the size of those most at risk and special populations and the links between those groups and the general population on one side; and the degree of addressing the needs of the affected groups on the other side. The following section will highlight the programmatic challenges with the above mentioned categories of the population.

### HIV prevention among key at risk populations

HIV prevention services addressing most at risk population have been initiated in Egypt for injecting drug users, men having sex with men and female sex workers. There is an urgent need to increase coverage of those projects and to involve new organisations, not only in cities such as Cairo and Alexandria, but in other areas of Egypt.

> As previously mentioned, in order to provide appropriate cost effective education and services targeted at the subpopulations who are most at risk, an evaluation of the effectiveness and efficiency of the various existing models that have been developed to date is important. This comparative analysis allows for the development of models that can, be expanded over time to meet Egypt's HIV prevention needs. Innovative initiatives and projects must be documented and shared for directing resources, and for advocacy purposes.

Sexual transmission constitutes the majority of infections in Egypt. In order to reduce sexual transmission, the first priority should be to scale up sexual health services offered through stand-alone STI clinics (five exist in Egypt), Gynaecology and Obstetric units (where the majority of females attend for diagnosis and treatment of STIs) and skin/ venereal clinics that receive the majority of men with STIs. In the selected cities, an integrated system of governmental, private and NGO services should work to provide, by the end of the strategy, a spectrum of appropriate health and other relevant services for most-at-risk populations. This will be combined with a

scale up of outreach services to most at risk populations provided by NGOs that will assist in bringing people from most at risk populations and awareness campaigns among the general population into these clinics. Health care workers need to be trained to sensitively diagnose anal STIs, provide provider initiated counselling and testing, support people identified as HIV positive and refer them to appropriate HIV services. By marketing STI services and by training health service providers in working with the various subpopulations, substantial HIV prevention can be achieved.

Currently, a small group of civil society organisations has the skills and techniques needed to address sex workers, drug users and, more recently, men who have sex with men. Significant investment is required to build the capacity of civil society organisations who are willing to work closely with most at risk populations in selected cities.

*Targets in Summary:*

- Expressions of willingness and capacity assessment by NGOs interested to engage in addressing most at risk populations by the end of the first year of the strategy
- Initial training in working with most at risk populations provided to selected 25 NGOs in 4 cities (Cairo, Alex, Gharbiya and Luxor) by the end of the second year of the strategy
- Following this training, mentoring and funding process to increase capacity for selected NGOs to work closely with most at risk populations by the end of the strategy.
- 5 stand alone STI clinics, 20 Gyn &Obs clinics and Venereal clinics fully operational by end of the second year of the strategy, offering the full range of services identified above.

## HIV prevention among Special Population

Prevention programs focused on special populations that for various reasons could be at higher vulnerability than the general population. Those special populations include mobile populations, subpopulations of male and female young people, street children, prison inmates and uniformed services.

*Young men and women (20-40 years old):*

Among the general population, youth are considered more vulnerable than other age categories. This is due to the fact that youth are more sexually active and are more likely to engage in risk behaviours. The majority of HIV positive cases detected is in the age category of 20-40 years old (which represent close to 43% of the population)[xv]. Currently activities targeting youth are mostly focused on awareness raising either through peer education or promoting youth friendly services.

*Street Children:*

The findings from all studies conducted among street children signify disturbing factors, not simply because they paint a picture of strong HIV risk among some street children, but also because these street children become adults and likely take many of their risk behaviours into adult life as injecting drug users, sex workers and men who have sex with men. Substantial rates of drug injecting, commercial sex and low condom use have been recorded among street children. A number of organizations offer support programs to street children. However those projects are usually short term and face structural and operational barriers that need to be addressed. Consensus has to be reached on the core set of principles that need to be addressed in working with street children including consensus on counselling and testing for HIV, condom promotion, and services that address the risk factors and pertinent needs of street children without further stigmatizing them. Social workers dealing with street children need to be trained on addressing street children, providing counselling, ensuring confidentially and need to be clear on a referral mechanism for services. The work of NGOs and social workers addressing street children need to be monitored and assessed for quality to ensure stigma free services.

### *Mobile and Migrant populations*

The literature has emphasized the link between HIV and human mobility (including displacement). Population mobility is expressed in many forms in Egypt. The country hosts 12,535,885 tourists annually[xvi]. Recognized refugees is estimated at 3,763,921 mostly from Sudan, Iraq and Somalia. It is also estimated that currently 50,000 to 70,000 Palestinian refugees are residing in Egypt[xvii]. Furthermore, 1,100,033 Egyptians work abroad either in the Gulf or other areas of the world[xviii]. It may also be pertinent to highlight the vulnerability of Egypt's migrant communities to HIV and other infectious diseases. The National AIDS program provides access to ARVs and other HIV related services to refugees. Collaboration with civil society organizations

that work in that area has been strengthened in recent years. This collaboration needs to be utilized further to increase coverage for people who need support.

*Prisoners*

It is globally estimated that at any given time there are over nine million people in prisons, with an annual turnover of 30 million moving from prison to the community and back again. Conditions reigning in prison settings signify existence of high-risk behaviours and thus HIV transmission can occur. Four VCT sites have been introduced inside prisons and accompanied by education of prison officers and medical staff. Direct service delivery, education, and programmes targeting vulnerable populations' prisoners must be strengthened to prevent sharing of injection equipments, unprotected sex and violence. A comprehensive package of services including prevention, treatment and after care need to be reinforced.

## HIV prevention from mother to child

In 2010 6 HIV positive pregnant women have received PMTCT services. Even though this number represents 100% of all known HIV positive pregnant females, it is likely that more women could be in need of this service.

Additionally, particular risk of HIV transmission from mother-to-child accounts for the majority of all infections in children. Available strategies can reduce mother to child transmission from 30% to less than 1%[xix]. Provider initiated counselling and testing services would be crucial to educate mothers about risk behaviours and offer confidential testing for HIV. This service has been introduced in selected Antenatal care clinics. This service needs to be scaled up to ensure detection of HIV positive cases and elimination of new born HIV positive children. Safe delivery practices, counseling and support to reduce the risk of HIV transmission via breastfeeding should be part of the plan. To achieve that, health care workers need to be trained on provider initiated counseling and testing, means of support to females identified as HIV positive and refer them to appropriate HIV services.

## Provider Initiated Counseling and Testing

VCT services have been one of the crucial HIV prevention interventions in Egypt since 2004. Many people who live with HIV do not know their status and therefore are not receiving the needed support and risk continuous transmission of infection. Promoting knowledge of HIV status will require a significant scale-up of activity through VCT centres, in addition to provision of provider-initiated HIV testing and counselling (PITC). The highest priority sites for the PITC would be TB clinics, STI/GYN/Venereal and ANC services and expanded outreach into most-at-risk populations by NGOs.

Projected results:

- Visitors of VCT services increased to 150,000 by the end of the Strategy
- PITC available in 20 ANC clinics by end of second year, and in 50 by the end of the Strategy
- PITC in all TB clinics by end of second year
- PITC in 20 STI/GYN/Veneral clinics by end of second year.

## 3. Strengthening HIV Treatment, Care and Support

There is clear progress in increasing the number of PLHIV on treatment. About 538 PLHIIV have been enrolled on ART to date. In line with new guidelines to treat PLHIV with less than 350 CD4 cells, estimates of PLHIV in need of treatment need to be reviewed. Support groups, and services for CD4 and viral load monitoring are offered to PLHIV. In order to improve quality and expand on treatment coverage, the continuum of care between HIV testing and ongoing treatment care and support for PLHIV needs to be strengthened.

Societal stigma is exist. Programs need to be in place to improve the enabling environment in which PLHIV can live a positive supportive life. Home-based care services need to be coordinated with ongoing clinical care and support.

According to the comprehensive assessment carried out in 2008 a clear and practical set of recommendations for improving treatments access, clinical care and adherence were provided **Error! Bookmark not defined.**; this includes the following:

- Improve literacy among PLHIV concerning treatment initiation, side effects, counselling and adherence.

- Address stigma and discrimination in health care settings and amongst health care workers.

As more PLHIV get connected to monitoring their treatment, care and support services, there is a better chance to minimise HIV viral load across the population. This kind of follow up ensures maximum benefit from the treatments provided, reducing drug resistance or failure and increases quality of life. It also promotes positive prevention by providing opportunities to reinforce safer behaviours and promotes partner notification, couple counselling and other interventions that allow more PLHIV to know their status.

Similar to the positive collaboration between the TB and HIV programs, a connection between HIV and the other health services that PLHIV are likely to require need to be strengthened.

Targets in Summary:

- ARVs are available for an annual increase of 25% of PLHIV in need

## 4. Reinforcing the Enabling environment

Silence and stigma appear to be the greatest barriers to progress in providing an environment that enables effective HIV prevention and care. An improved enabling environment is essential for the current and planned activities to address HIV in Egypt. Some media campaigning is required to increase general HIV awareness and ensures that HIV remains on the public agenda. Many spokespeople have been mobilized in recent years and have publically spoken about HIV and broken the silence on many taboo issues. Those "champions" need to be guided by key messages and a communication strategy that address issues relevant to HIV prevention and treatment. Stigma reduction needs to be prioritized, using examples from countries that have successfully worked on these issues.

Projected results:

- Open and public (through mass media) discussion of the routes of HIV transmission and the main methods of prevention by the end of the Strategy
- Training for healthcare workers that address PLHIV on stigma and discrimination, setting and enforcing standards of behavior (including confidentiality) completed by the end of the second year of the Strategy,

## 5. Developing Institutional Capacity

The National AIDS Program has managed significant expansion of HIV activities in Egypt during the current National AIDS Strategy period. The number of people participating in VCT, attending STI clinics, addressed by NGOs, receiving ART has all increased. However, it is clear from the situation and response analysis that much more will be required of the NAP in the period of the next Strategic Plan, 2012-2016. The capacity and staffing of the NAP has to be strengthened to ensure proper fulfillment of the task required in next five years.

Mainstream NGOs have been reluctant to take on projects addressing most at risk population for fear of being stigmatized and of confronting conflict with authorities, a lot will be expected to address most at risk population and to ensure that the programmatic capacity and quality is strengthened for reaching hidden population and referral to services. This would require NGO strengthening project.

A strategy to invest in building the technical capacity of civil society organizations is needed.

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