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COMPREHENSIVE NEEDS ASSESSMENT FOR HIV SERVICES IN EGYPT : BASELINE STUDY REPORT

AL SHEHAB INSTITUTION
FOR COMPREHENSIVE DEVELOPMENT
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Also, we would like to thank Magar center for legal services for informing the legal part of the report.

List of abbreviations and acronyms

CSOs	Civil society organizations
FSWs	Female sex workers
GAM	Global aids monitoring
GOE	Government of Egypt
HIV	Human immunodeficiency virus
HMIS	Heath management information system
IBBS	Integrated bio behavioral survey
MOHP	Ministry of health and population
MSM	Men who have sex with men
NAP	National AIDS program
NGOS	Non governmental organizations
NSP	National strategic plan
PLHIV	People living with HIV
PSE	Population size estimate
PWIDs	People who inject drugs
SOPs	Standard operating procedures
STI	Sexual transmitted infections
TTR	Test treat retain cascade
WHO	World heath organization

Executive Summary

The HIV prevalence in Egypt remains below 0.02%. However, there is an annual increase of newly detected cases about 25-35% every year for the last 10 years. This increase might be attributed to updating the testing strategies and using new testing approaches in different health facilities, other factor might be the fact that awareness of HIV risk factors was augmented due to wide spread of internet based communications especially that evidence shows that "early detection, early treatment = healthy life without complications and less chance to transmit the infection".

By the end of 2018; about 11 700 cases were registered alive as per the National AIDS Program (NAP) with an estimated number of 16 000 PLHIV, yet, no systematic mechanism is available to estimate the deaths from AIDS in Egypt.

Evidence has shown that HIV is affecting predominantly key population groups with an increased risk of infection among people who inject drugs (PWIDS), and men who have sex with men (MSM). Similar to other settings, the key populations contribute significantly to the national HIV epidemic in Egypt.

The present study was conducted to assess the availability, accessibility and utilization of HIV services by PLHIV and key population in Egypt, to determine whether theses services are adequate to the PLHIV and key population needs and also to analyze the legal framework within the Egyptian context.

To accomplish these aims, primary and secondary data collection was conducted. Secondary data were collected through systematic review of all the documents relevant to the available HIV services in Egypt on both the national and global level. Additionally, primary data was collected through a snapshot to assess the needs for HIV services in Egypt in terms of availability, accessibility and utilization of services in regard to stigma and discrimination issues as well as any structural barriers undermine their abilities to access such services. The primary data collection was conducted on two phases;

- Focus group discussion with PLHIV and key populations (FSWs, MSM and PWIDs) to explore their perceptions and to gain in-depth understanding of the insights and experiences about the HIV services availability and accessibility on the basis of common group characteristics.
- In- depth interviews with the key informants (MOHP officials, and service providers from governmental and non-governmental organizations) to validate information about services availability and quality, service integration and partnership as well as stigma and discrimination.

The desk review process revealed that one of the strategic priorities for NSP 2018-2022 is to assess the key population needs in relation to HIV prevention. Integration of HIV services with sexual and reproductive health care service can build a more sustainable HIV prevention programs. Youth is at increased risk of infection with a need to educate them on risky behaviors. With the limited preventive interventions targeting those key population, the prevalence will continue to increase.

The Focus group discussions and in-depth interviews have identified several challenges in regards to provision of prevention, treatment and care services: administrative barriers to HIV prevention, treatment and care, limited affordability ,social seclusion and stigma preventing PLHIV and specifically key population to access the services, lack of trained health professionals, lack of consistent integration between HIV and other health services . Peers are the main source of knowledge among most of PLHIV

RECOMMENDATIONS

Policy level

- Establish common policy on universal access to HIV treatment and HIV related services to cover more geographical areas.
- Establish a clear probing strategic intervention for stigma free health care facilities
- Implement an effective national information system and tracking records
- Establish organized networks for PLHIV to be able to participate in policy processes

Service delivery level

- Assess the costs and benefits of ensuring universal access to HIV related services and mobilize additional resources from donor funds to establish more testing services universal access in action.
- Unifying and simplifying the linkage system to ensure closing the second 90% gap.
- Improve integration and linkage between HIV testing and treatment services.

- Strengthen national and subnational prevention campaigns and interventions (establish network of pre-defined organizations which refer and receive referrals, agree on common information activities, set up regular format for review of progress and discussion of challenges, etc)
- Work on eliminating administrative and legal barriers to access the services.
- More Training of health professionals in provision of prevention, treatment and care services. (build a wide network of competent professional health care providers capable of dealing with profound HIV clinical care, ART and opportunistic infections.
- Stimulate the cross-country dialogue to share best practices and experience, to identify mutual benefit in improving access to the services.

HIV awareness

- Design a well-organized program aiming at raising awareness or outreach for mobile groups, providing full information on HIV, transmission routes, prevention, treatment, care and HIV rights, using different appropriate forms of information delivery destined to mobile groups.

Strategic partnership

- Development of multi sectorial collaboration between different ministries for example ministry of interior and ministry of health while conducting outreach activities for key populations.
- Official mainstreaming HIV services to other health care services is essential to improve accessibility to services

Aim of the study

To assess the needs of people living with HIV (PLHIV) in Egypt as well as key populations in terms of available HIV services.

General Objective:

To determine the availability and accessibility of HIV services in Egypt and its appropriateness to the needs of PLHIV and key population.

Specific Objectives:

1. To review all the available documents related to HIV services in Egypt on the national and global level.
2. To assess the availability and accessibility of HIV services in Egypt.
3. To determine the utilization of HIV services by PLHIV and Key population in Egypt.
4. To assess whether theses services are adequate to the beneficiaries needs.
5. To analyze the legal framework within the Egyptian context.

Methodology

This study was conducted on six phases:

1. Planning: Involved preparatory meetings with the Al-Shehab foundation to review the proposed methodology and the deliverables of the project. Also to identify their assistance in focus groups in terms of recruitment of the participants and the venue and to agree on the different potential stakeholders in the field to participate in the in –depth interviews. Additionally, preparatory meetings were held with the project team to identify the roles, plan for the next steps and identify the way of reporting to the consultant.
2. Literature (Desk) review.
3. Development of data collection tools; including focus group discussion guide (Annex II) and the in-depth interview questionnaire (Annex IV).
4. Training of the project team on data collection.
5. Field work and data collection.
6. Data analysis.

1. STUDY DESIGN

Qualitative research. This study used mixed methods design, in the form of:

- Systematic review of the available documents relevant to the available HIV services in Egypt on both the national and global level.
- Primary data collection to assess the needs for HIV services in Egypt in terms of availability, accessibility and utilization of services in regard to stigma and discrimination issues.

2. STUDY SETTING AND TARGET POPULATION

Study setting: The study involved the two big cities in Egypt; Cairo and Alexandria

Target population: Data was collected from:

1. Relevant key stakeholders
2. MOHP officials
3. HIV service providers
4. PLHIV
5. Key population (MSM, PWIDS and FSWs).

3. PLAN FOR DATA COLLECTION

The data was collected on two steps:

STEP ONE: COMPLETE DESK AND LITERATURE REVIEW: SECONDARY DATA SOURCES

The desk review served an important function in the assessment, providing a foundation upon which to build the subsequent steps. Desk review activities include scanning the literature, analyzing secondary data, and creating a reference list so that all documents are organized and easily accessible. The team coordinator led the desk review process. The purpose of this step was to:

- Understand the country context including priority health issues.
- Identify key themes, gaps, and opportunities by analyzing available secondary data.
- Gather data and information to inform the final report.

The literature review covered global and national publications related to Egypt policy such as; (Annex I)

- Reports (GAM report 2017 and 2018 including the national situation analysis, NCPI and global indicators)
- Guidelines (Care and ART, VCT)
- Polices and protocols
- Researches and studies (stigma index., health care stigma study, gender assessment, PSE, preventive study, TTR Cascade Analysis …)
- Relevant laws and legislations.
- Other relevant literatures as GF concept note. As well as other unpublished documents and further studies.

STEP TWO: FIELD WORK: PRIMARY DATA SOURCES

The purpose of this step was to get a snapshot on the real ground to assess the available services available from two different perspectives:

- Key stakeholders including (policy makers and service providers from governmental and non -governmental organizations) through key informant interviews.
- PLHIV and key population through focus group discussions.

This step involved:

1. Exploring perceptions of PLHIV and key population through focus group discussions:

Focus group discussions had been utilized to help researcher to learn the social norms of affected and most at-risk population (MARP), as well as to learn the variety of experiences, opinions, perceptions and attitudes that exist within that community or its subgroups. Moreover, it enables in-depth understanding of the insights and experiences about the HIV services availability and accessibility on the basis of common group characteristics (WLHIV, MSM, FSWs, IDUs).

Data collection tool: The focus group questions guide (see Annex II) for this study was developed based on a review of recent literature and past HIV needs assessment focus group questions. The focus group interview schedule included a group of predetermined open -ended questions that were covering the following issues: quality of life issues, health problems, behavioral risk factors related to health problems, barriers to accessing prevention and/or treatment services and any other thoughts related to the needs of people living with HIV. This interview schedule provided a basic structure for the presentation of the aforementioned topics; however, if other issues that were relevant arose during discussion, those issues were discussed as well. The focus group questions were shared with Al-Shehab foundation.

Before starting the focus group, the participants were given a comprehensive information about the purpose of the study and were asked to provide verbal consent rather than a written consent (In this way, group participants' names were not connected to the study). It was taken by the facilitator while ensuring privacy and confidentiality. Also they were provided with the opportunity to ask questions. Participants were reminded that the names of individuals and information shared within the group were confidential and should not be shared outside the group meeting.

The researcher and research assistant conducted the focus groups. The focus groups were audio recorded. Participants received incentive at the beginning of the focus group and were offered snacks during the group. Immediately following the focus group the audio files were transcribed. No identifying information was included in the transcription.

Contact summary sheets were completed after each focus group to help the researcher organize immediate thoughts on the themes and issues, impressions, questions, speculations, and any information to be included in future focus groups.

During the focus group, the researcher solicited information regarding participants' perceptions of their HIV prevention needs. Specifically, information about risk behaviors, barriers to HIV testing, treatment and prevention services were solicited. Focus groups lasted from 1 to 2 hours. The focus group questionnaire was tested in one pilot focus group conducted in Alex to ensure conformity and reliability. Focus group discussion guide (Annex II).

Sampling method: Purposive sampling technique (snowball sampling). Participants were recruited by Al- Shehab institution. Those who agreed to participate were informed about the scheduled time and place for the focus group.

Sample size: 11 focus groups were conducted with an average from 8-10 participants in each focus group with a total of 99 participants. For more representativeness, people living with HIV/AIDS from different transmission routes were recruited as follows;

Governorate	PLHA	PWID	MSM	FSW
Cairo	2 (one WLHIV and one mixed)	1	1	1
Alex	3 (one WLHIV and two mixed)	1	1	1

The focus group was directed by a facilitator (moderator) to guide the discussion according to thematic areas and controlled the group discussion with a recorder to record and document the information accurately.

2. Key informant interview questionnaire with relevant stakeholders

This include MOHP officials, service providers from governmental and non -governmental organizations as well as with different UN agencies among the UN Joint team on HIV. This was done in two successive steps:

First: The list of potential stakeholders was identified and revised by Al-Shehab (Annex IIIa).

Second: Development of the interview questionnaire guide (Annex IV).

Interviews serve three purposes:

1. Address information gaps or validate information to ensure an accurate description of the available HIV services .
2. Gauge perceptions and attitudes about the role of the different sectors contribution to HIV and health.
3. Vet ideas for potential partnerships or interventions.

Data collection tool:

Interview questions for this study were developed based on a review of recent literature and past HIV needs assessment interview questions. The interview guide includeed questions that were aimed at the following issues: services provided and its quality, service integration and partnership, HIV testing and treatment, linking to care, monitoring and evaluation, stigma and discrimination and legal context and regulatory barriers. (see Annex IV).

The questionnaire were tested statistically for its validity and reliability and shared with Al-Shehab foundation.

Sample selection:

A convenient sample of 31 individuals were invited to participate in face-to-face, phone, or email interviews regarding HIV services. (see Annex III b).

All the potential interviewees (31) were contacted by the researcher who explained the study and asked if they were interested in participating in an interview.

Only 24 stakeholders actually responded to the questionnaire. Some Key informants preferred to answer interview questions via email were sent a description of the study, and the interview questions. Each individual interview lasted approximately from thirty minutes to slightly over one hour.

During the interview, the researcher solicited information regarding the interviewees' perceptions of the HIV services.

4. DATA TRIANGULATION

Using various collection methods under the case study design for this research, will be achieved by interviewing a range of stakeholders at different levels from a variety of institutions, focus group discussions with PLHIV and key population together with reviewing a wide range of documents.

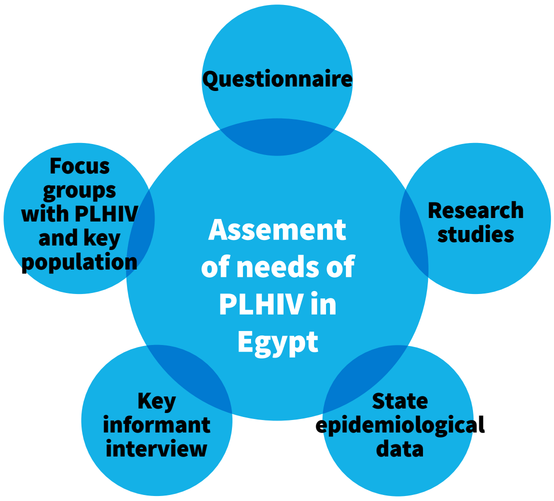

Figure 1: Data triangulation for needs assessment For HIV services in Egypt

5. DATA ANALYSIS:

Primary data was analyzed qualitatively. Immediately after each focus group and key informant interview took place, the research assistant reviewed all notes and audio recordings. Each focus group and key informant interview was transcribed in its entirety.

6. ETHICAL CONSIDERATIONS:

- The primary ethical concern in the present study was protection of subjects privacy and the confidentiality of the data (i.e. The determination that information will not be disclosed without permission). Participants were fully assured concerning the degree of anonymity and confidentiality by the researcher.
- Confidentiality of data was ensured.
- Recordings were anonymous to ensure privacy and confidentiality
- An informed consent was obtained from all participants either in the focus group or in the personal interview to ensure that participation was voluntary

7. WORK PLAN

	February (3rd week)	February (4th week)	March (1st week)	March (2nd week)	March (3rd week)	March (4th week)
Literature review	■	■	■			
Focus groups		■	■			
interviews			■	■		
Data processing				■	■	
Data analysis				■	■	
Report writing					■	■

Desk Review

The literature review served an important function in the assessment, providing a foundation upon which to build the subsequent steps. Literature review activities include scanning the literature, analyzing secondary data, and creating a reference list so that all documents are organized and easily accessible. The reviewed documents were compared to the international standards and to the current performance.

The purpose of this step was to:

- Understand the country context related to HIV services available.
- Identify key themes, gaps, and opportunities by analyzing available secondary data.

The review team conducted a desk review of documents at both global and country levels. Global documentation included UNAIDS global policy documents and health strategies. Country documents include national strategic plan (NSP), national guidelines and further studies. A list of references and documents reviewed is included as Annex I.

Epidemiology of HIV

Globally, new HIV infections have been reduced by 47 % since the peak in 1996. The number of new HIV infections (all ages) declined from a peak of 3.4 million in 1996 to 1.8 million in 2017. New HIV infections continue to fall and more people than ever are starting treatment. With research providing solid evidence that antiretroviral therapy can prevent new HIV infections through reducing sexual transmission and mother to child transmission (MTCT), it is encouraging that 6.6 million people are now receiving treatment in low and middle-income countries.[1] However, progress is far slower than what is required to reach the 2020 global targets of less than 500 000 new infections. [2]

Regionally, the WHO African Region is the most affected region, with 25.7 million people living with HIV in 2017. The African region also accounts for over two thirds of the global total of new HIV infections. Between 2000 and 2017, new HIV infections fell by 36%, and HIV-related deaths fell by 38% in the same period.[3]

In the UNAIDS Middle East and North Africa (MENA) region, the HIV epidemic continues to rise. By the end of 2017, around 222,000 people were living with HIV (PLHIV) in the region. There was a rapid increase in the estimated number of adults and children living with HIV in the region during the period 2000 and 2017. [4]

This rising burden is a reflection of a new characteristic of the HIV epidemic in the region, which is the increasing number of new infections each year. During the period spanning between the years 2010 and 2017, the new HIV infections rose by 12%. In 2017 alone, 18,000 new HIV infections estimated in the MENA region of UNAIDS. Almost two-thirds of new HIV infections in 2017 were in Iran, Sudan and Egypt (37%, 31% and 9% respectively) which is consistent with the population density and go in line with the strengthened response at those countries Fig.2

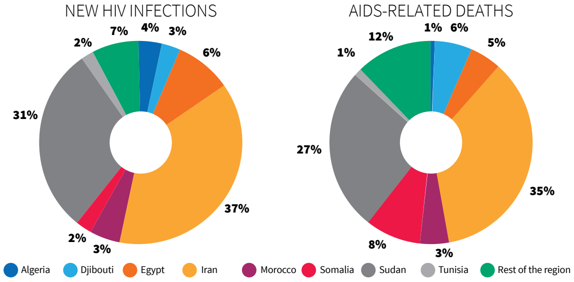

Figure 2: Distribution of HIV new infections and AIDS related deaths by country, MENA region 2017[5]

Moreover, at the regional level, around 50% of PLHIV know their status by the end of 2017, however only 29% among the estimated cases are on ART. Viral suppression remains low at 22% of those receiving treatment, which is a reflection of challenges around quality of care.

People who inject drugs and clients of female sex workers and other sexual partners of key populations constituted 68% of new infections in 2017 in the region. Fig.3.

Prevention programmes are not reaching key populations in sufficient numbers, and progres towards the 90–90–90 targets remains well behind the global average. Therefore, special consideration should be given to key populations at higher risk, to further promote equity in the prevention and treatment of HIV.

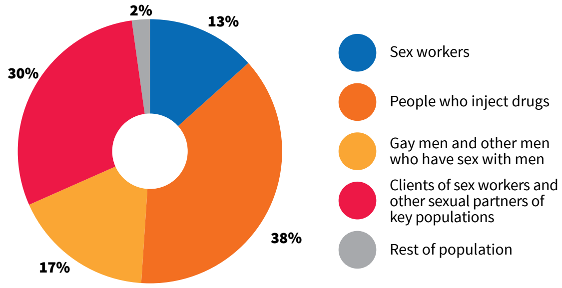

Figure 3: contribution of key population to the new infections in the MENA region 2018[6]

[1] UNAIDS global report 2017

[2] Global AIDS monitoring progress report 2018

[3] WHO 2017 fact sheet

[4] UNAIDS MENA region update 2018

[5] UNAIDS 2018 estimates

[6] UNAIDS special analysis 2018

In Egypt

The population in Egypt was about 95 million people in 2017 with an annual increase of 2.5%. Life expectancy reached 68 years for males and 73 years for females in 2018.[7]

The HIV prevalence in Egypt remains below 0.02%. However, there is an annual increase of newly detected cases about 25-35% every year for the last 10 years. This increase might be attributed to updating the testing strategies and using new testing approaches in different health facilities, other factor is the fact that awareness of HIV risk factors was augmented due to wide spread of internet based communications especially that evidence shows that "early detection, early treatment = healthy life without complications and less chance to transmit the infection"[8].

By the end of 2018; about 11 700 cases were registered alive as per the National AIDS Program (NAP) with an estimated number of 16,000 PLHIV, yet, no systematic mechanism is available to estimate the deaths from AIDS in Egypt.

Evidence has shown that HIV is affecting predominantly key population groups with an increased risk of infection among people who inject drugs (PWIDS), and men who have sex with men (MSM). Similar to other settings, the key populations contribute significantly to the national HIV epidemic in Egypt.

The Integrated Bio Behavioral Survey (IBBS) conducted in two rounds in 2006 and 2010 alarming that Egypt has a concentrated HIV epidemic among PWIDs with HIV sero prevalence 7.7% in Cairo and 6.7% in Alexandria; and MSM with HIV sero prevalence 5.4% in Cairo and 6.9% in Alexandria. There is no HIV prevalence data for FFSWs, except from Al Shehab foundation field work which is also limited to a small geographic area and cannot be used to inform national figures [9].

While there are no official nationwide population, size estimates of key population, there are recent (2014) urban national population estimates as follows:

- MSM - 64,318 of males aged 18 - 59 years in urban areas
- PWIDs - 93,314 of the male population aged 18 - 59; and
- FSWs - 22,986 of females aged 15 to 49 living in urban areas.[10]

There are many concerns to the above-mentioned studies in addition to obvious limitations, which highly recommend conducting a recent IBBS and PSE to inform the updated HIV epidemic among key populations and expand to include street children and prisoners as well. Except for the small scaled outreach programs in Cairo, Alex, Gharbia and Menia and governmental VCTs , there are no program data specific to key populations.

In addition ,its noted that except for NAP reports, there are no national studies conducted to assess comprehensive HIV services package (prevention , care and support) , most of the reviewd studies are conducted long time ago and need to be updated.

Sustainable Development Goals (SDGs) and current strategies

The 2030 Agenda for Sustainable Development includes 17 SDGs, known as the Global 2030 Goals for Sustainable Development. HIV/AIDS in included in goal 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. In this context, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has recently adopted a 2016–2021 Strategy, entitled On the Fast-Track to End AIDS, in order to align its work with the SDGs.

The renewed UNAIDS 2016–2021 Strategy lays out 10 targets that must be reached by 2020 in order to meet the SDG target to end AIDS as a public health threat by 2030. Of which is the most widely known: Target 1 ("90/90/90"): 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads.

Program context:

The Government of Egypt through the National AIDS Program (NAP) leads the national response to the HIV/AIDS epidemic in Egypt. The NAP declare the MOH commitment to follow SDGs. The program encompassed a more inclusive collaboration with national stakeholders which has contributed to the broader spirit of ownership and partnership in the national response.

The NAP had conducted a midterm strategic review in 2018 focused on ensuring sustainability and supporting impact oriented and cost efficient interventions to scale up and

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[7] CAPMAS 2017

[8] HIV midterm strategic review 2018-2022

[9] IBBSS 2010

[10] PSE 2014

fast track Egypt national response to HIV. This new strategic plan is extending the scope of the operations beyond 2020 to cover the period until 2022 to align the national framework with the Global Health Sector Strategy on HIV 2016-2021.

The National Strategic Plan 2018 to 2022 has also been built on the four pillars which include

1) Closing the testing gap and reaching the global targets.
2) Achieving the global targets of 90% on ART and retained.
3) Prevent new infections, and
4) Ensure sustainability, coordination and knowledge generation.

Being guided and aligned with the health strategic policy (HSP) of the MOH, the global health strategy, fast track strategy and the 2016 high level meeting political declaration on ending AIDS

Counselling and testing services:

There were an estimated 16,000 people to be living with HIV by the end of 2018. With an actual registered number of 11,000 cases, i.e, about 67% achievement of the first 90 on HIV cascade.

HIV testing in Egypt is based on voluntary and informed consent with pre and post- test counselling. HIV sero-negative patients are encouraged to repeat the test for those with recent exposure (<3months) or ongoing risk behavior. Routine testing without consent is done in some cases of pre surgical interventions especially in the private sector, other governmental routine testing such as in the ANC, TB centers, fever hospitals, dialysis and visa seeking are based upon the provider-initiated testing and counselling (PITC) approach.

Egypt adopted the recommendations from the WHO consolidated guidelines on HIV testing services in a national testing guideline with some areas needs to be enhanced including strengthening of assisted HIV partner notification.

Different testing modalities are provided in Egypt for provision of testing and counselling services including: Voluntary, counseling and Testing (VCT) centers in both governmental and non -governmental sectors where initial positive results will be sent for confirmation by Western blot in the central labs.

Provider initiated testing performed in TB clinics, MCH, drug rehabilitation centers, and in some sexual transmitted infections (STI) health facilities. However, HIV testing is not offered routinely to HCV/HBV patients till the end of 2018. Those who are already diagnosed with HIV are notified and encouraged to assist their sexual partners to undertake HIV testing if they do not know their status.

HIV testing policy is adopted in all TB clinics, Fever hospital and some ANC clinics, but still some challenges to expand HIV testing to STIs clinics. NAP is now re-establishing a national STI strategy to scale the HIV integrated services to all STI clinics in Egypt by 2022.

Community based counselling and testing services are provided through a limited number of CSOs mainly serving key populations as a part of combination prevention and harm reduction interventions. However, the coverage of those programs is very low with limited geographical coverage and lack of sustainability especially in recent years due to declining levels of resources and external funds.

Regarding HIV testing for pregnant women and their children, NAP has adopted an initiative in collaboration with MCH to provide HIV testing in some antenatal care centers (31 centers in 8 governorates) with a noticeable high turnout from pregnant women to perform the HIV testing. This aim to increase the awareness among women and prevent mother to child transmission.

The major challenge for NAP is how to secure resources to scale up access to and coverage of HIV testing services for targeted population and key populations (PWID, FSW, and MSM) which are hindered by high stigma and discriminatory attitude together with misconceptions. The ideal model combine outreach program services entirely offered by civil society organizations (CSOs), to be linked and integrated with governmental VCT services.

However, the uptake of VCT services by key population as observed in the IBBS was within the range of 5% to 10 % only. With a significant challenge found in the outreach programs which is difficult to be implemented and covered by the governmental resources.

Linking to care

The national strategic plan recommends to establish a strong linkage system to ensure the continuum of care cycle. Once people diagnosed with HIV from different entry points, they should be linked to an integrated process of clinical care and treatment. Continuum of care should include timely referral between different service providing facilities with effective discharge planning and follow-up at each level. The different elements of comprehensive care may not come from the same institution but can be provided through networking with other services, institutions and projects in the community.

MoHP has adopted the “Test and Treat” approach in dispensing treatment since November 2017

No recommended CD4 threshold for initiating ART in adults and adolescents who are asymptomatic. The general guidance to treat all regardless of the CD4 count. These guiding principles are implemented in all treatment centers in fever hospitals, where PLHIV pick-up their ARVs every month from these centers. The National policy does not promote or recommend community delivery (outside governmental ART facilities) of antiretroviral therapy.

Moreover, ART centers in fever hospitals follow the pharmacovigilance approaches implemented by Central Administrative of Pharmaceutical Affairs (CAPA) to monitor toxicity and adverse effects of ARVs with no parallel or specific mechanism to monitor these signs.

All of these Efforts are in place to improve the linking of care system and to ensure closing the gap between detected cases and access to health care services mainly by expanding the distribution of treatment sites, laboratory follow up (CD4 and PCR) and establishing a patient follow up profile.

Procurement and supply management system was restructured since 2014 to meet the international standards. In addition, an automated system for patients’ records is being rolled out through WHO support and is expected to be functional by 2019.

NAP conducted a test, treat and retain cascade analysis in March 2018 to follow up on the findings of the TTR cascade analysis conducted in 2014 and 2015 and to focus more efforts on the care and treatment provided to PLHIV.

The exercise was conducted in two cohorts the 1st one for newly detected cases in 2017, reveals a significant improvement in the percent of cases whom were reached 88% and were aware of their status and received the required information and counseling, from which about 92.3 % initiate ART and registered in the treatment database.

In contrast to the second cohort which include all PLHIV in 2017 (newly detected and on ART from previous years), there was a significant gap appeared as follows: 61.5 % detected, 57.7 % linked to care, 96% on ART, 67.7% retained.

	Newly detected	**Cumulative**
90% detection	100%	61.5%
90% linked to care	88%	57.7%
90% on ART	92%	96%
90% retention	74.5%	67.7%
90% virally suppressed	NA	NA

Cannot be expressed as national figure as the adherence to perform the test is below 25%.

This significant increase most probably attributed to the newly implemented system for patient tracking, counselling and support.

Viral load testing is available on a routine basis every six months for each patient according to the WHO recommendations only in the central laboratories in Cairo.

About 26% of PLHIV on treatment has performed viral load testing in 2016 (at least once during treatment period). That was significant progress compared to 2015 as only 4% of people on treatment performed viral load testing. This low adherence level for performing PCR testing hinders assessing extent of viral load suppression however from whom those performed PCR testing about 97.5% achieve viral load suppression[11].

The NAP implement the recommended new guidelines of treating all children under ten years without any limitation criteria.

In 2018, NAP provided PMTCT services to 55 mothers and infant prophylaxis for 44 newly born children, with evidence that since 2014 all WLHA whom received PMTCT package delivered HIV free infants. NAP succeeded to procure more ARVs regimen options for adults and children living with HIV. Periodic national meetings are done to evaluate and review the PMTCT progress level countrywide. However,

[11] Test-Treat-Retain cascade analysis (TTR) 2016

awareness of the females in the child bearing period remain a big challenge.

Despite the gains from expanding health care treatment centers in Egypt, the proportion of individuals who are lost to follow-up (LTFU) between HIV diagnosis and initiating ART remains high for the cumulative number of PLHA which is not the case for patients new on treatment. The greatest gap was noticed in the rate of PLHA losses regarding the PCR follow up as previously mentioned.

Finally, there are small-scale programmes in place to support adherence through NAP in collaboration with many partners focusing on treatment literacy. Moreover, the NAP support the peer educator programs and building a strong aware team of PLHA volunteers.

It is important to highlight that the entire care, support, and treatment are funded through the MOHP either locally manfactured or imported medicines. Also it should be noted that all treatments and care services are provided free of charge . The challenge is that most of the ARV are not registered in Egypt and the Middle East and this may lead to high expenses of treatment provision funded by government.

Gender issues

The only study conducted to assess the gender issues related to HIV in Egypt was conducted in 2015, revealed that there is no obvious difference in HIV service availability according to gender and no discriminatory issues specific to women. Partner notification for married couples regardless the gender of the positive partner is implemented as well.

Still the fact that there are some social norms that cause additional fear to women and young girls to seek HIV services due to social bond of HIV and premarital sex. There are no services tailored for women in general which is reflected on the very low utilization of HIV testing services by women and young females.

NAP established some women friendly services as expanding the routine awareness and testing among women attending antenatal care services to help dilute the stigma and promote for HIV testing.

Prevention activities

While there are some prevention interventions started in the early nineteenth, the impact of these interventions was not systematically measured or result in remarkable changes. Moreover, the increase in the detection rate might be attributed to active surveillance, however all studies indicated that the wide range of risky behaviors are not limited to geographical or socio-economic level.

Awareness and knowledge about HIV and AIDS in Egypt remain a significant challenge.

The 2015 EDHS found that 66 percent of women and 79 percent of men age 15 - 49 have heard about HIV/AIDS. Among both women and men, the proportions having heard of AIDS are lower than at the time of the 2008 EDHS.[12]

Evidence from other countries with similar settings has all confirmed needs to address the needs of adolescents and young men and women as strategic priority population groups to reduce and control HIV new infections. Only some scattered studies with limited scope that deal with this issue.

Knowledge is the starting point to create a better environment for people to understand and recognize the risky situations, including being at risk for getting HIV infections.

A panel survey of young people in Egypt (SYPE) 2014 men and women aged between 15 and 29 in Egypt in 2014 revealed that less than 10 percent knew all possible modes of HIV transmission. More - educated youth were only slightly more likely to know of all the modes of HIV transmission, reaching 15 percent for women and 19 percent for men who had 16 years of schooling or more.

Lastly, HIV prevention programs are usually varied and are diverse due to the needs of different populations at risk. These can include the key populations, namely PWID, MSM, and FSW; but also people in prisons, streets children, and other people with perceived vulnerable population groups.

Key population remain the most important aspect for successful HIV prevention and control activities as they are the primary driver of the concentrated HIV epidemic in Egypt, facing social exclusion, discrimination and stigma within the general health system. This negatively affects the accessibility of them to programs. Providing accessible HIV-related health services for key population shows a significant reduction in a country’s HIV prevalence.

Evidence shows that integration of services for key populations increases access to health however, stigma remains the main barrier.

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[12] Demographic health survey 2014

Integration of services has the potential to be sustainable and cost-efficient for both providers and service users, strengthens health systems and promotes the continuum of care. This makes an urgent need for addressing the needs for these populations at risk.

Many civil society organizations were working to provide prevention of HIV services among people who inject drugs and MSM. Combination prevention services implemented in Egypt through these organizations include raising awareness, condom, but no pre - exposure prophylaxis is included. However, lack of funding resources affect the activities of these CSOs to a great extent.

There is only one NGO conducted systemic prevention services to FSWs in a very small scale limited mainly to some areas of greater Cairo, the other outreach programs had no organized program for females and sex workers and only reach them accidentally as female IDUS or female partners of some other key populations.

No specific programs or intervention that working to attract the female partner of key population in a stigma free environment except the effort of NAP to provide comprehensive family testing package to all detected cases in the frame of counselling with total confidentiality.

To maximize the benefits of those programs people reached should be educated on how to communicate the risks to their sexual partners, as a method for prevention. Encouraging the key populations to bring their sexual partners to service delivery sites requires using innovative approaches. These strategies can help in preventing new infections.

Unfortunately, in 2018, almost all NGOs prevention programs stopped their work and face continuous threat due to interrupted external fund. NGOs were stopped to provide HIV services except those who integrate HIV under the umbrella of public health, family health and other related issues as gender.

The only HIV prevention study was conducted in 2015 and counted for some basic data about governmental and non-governmental agencies working on HIV issues in Egypt but without in depth analysis.

Prevention activities targeting key population has been implemented in Greater Cairo, Alexandria, Luxor, Gharbia, and Menya; with varying degrees. There are new initiatives to reach the female partners of men who have sex with men in Alexandria. Although numerous prevention interventions targeting key population were implemented in the country over the past few years, HIV awareness remains insufficient among key populations, as part of the wider population. Un protected sex remains prevailing, and condoms are inadequately used or recognized as an HIV prevention method. This situation calls for a more comprehensive approach in reaching these hidden populations. Linking private to public sector represents a unique outreach model which continue to succeed in Alexandria and Elgharbya.

NAP in collaboration with stakeholders launched an ambitious model to link non-governmental VCTs and outreach programs with governmental VCTs to ensure proper and comprehensive referral to support, care and ART services.

Prevention activities targeting PMTCT had no sufficient access and used to target women already infected with HIV to be provided with the MTCT package, there are only 31 ANC centers that are provided with HIV rapid kits to allow early detection of HIV pregnant women, Unfortunately, there are no mass media awareness material used in a national wide scale.

Stigma and discrimination

Although the huge efforts and mass campaigns delivered to fight stigma and discrimination toward HIV/AIDS PLHA, the overall stigma level is still very high, not only at the community level but appears very clearly at the level of health care providers. This stigma continue to challenge programs and initiatives. PLHIV experienced multifaceted discriminatory attitude, from the general population, their relatives, family, friends and from health care providers at health care settings as well. This remains the most important barrier for HIV prevention and control efforts with urgent need to innovative extraordinary approaches.

Data from recent DHS showed that about 75% of people between (15 - 49) years old replied that they would not buy vegetables from shopkeeper if they knew that this person had HIV, which reflects discrimination among general population towards people living with HIV.(13)

It was found that Stigma and discrimination are significantly lower in fever hospitals compared to other health care facilities. Previous studies indicate that PLHIV in Egypt encounter stigmatizing attitudes in the health care setting, and denial of care is common. Fever hospitals with dedicated clinics for PLHIV offer services, but they are directed mainly toward opportunistic infections. Therefore, PLHIV faced challenges when they need other medical or surgical services.

A small scale study was conducted in 2013 in Giza and Cairo to identify obstacles faced by health care workers face in providing care for PLWHA. Some of them were identified as fear of infection ,fear of secondary stigma and moral judgments as the most recognized leading factors. The study also revealed a relative high level of stigma among doctors rather than nurses

Another national study conducted in 2012 to collect information about the experiences of People Living with HIV (PLHA) related to stigma and discrimination The findings of the research indicated that the negative feelings and internal stigma were faced more by the most at risk population (MARPS), i.e., IDUs, MSM, or vulnerable groups such as prisoners, which pinpoint that the HIV-related stigma and stigma related to certain types of behavior, are interacting and strengthened by each other.

Reducing stigma among health care workers will dramatically improve the access of PLHIV for medical care which will lead to successful and sustainable prevention and control program.

A lot of awareness workshops and training programs were conducted to reduce stigma and discrimination among health care workers, however, the results remained unsatisfactory Most expertise realize the need for more efficient interventions that act on changing not only the knowledge as well as also the attitudes and behaviors.

A national anti- stigma policy was launched to ensure stigma free health care delivery for PLHIV, confidentiality of information and voluntary testing with a formal complaint mechanism to monitor any complain from any HIV positive patient whom deprived from receiving needed medical and health services considering the issue as a human right problem.

Study Rational:

Although various studies in Egypt have already shown the prevalence of HIV among general population, the gaps in testing and treatment and needs assessment among PLHIV, limited researchers address the needs of particularly most at risk population.

Since there is an observed increase in the number of new HIV infections each year, there is an urgent need for scaling up prevention efforts especially among key population, which represent a threat for increasing the prevalence of HIV in the general population. So a basic assessment of the needs of PLHIV and particularly among key population together with assessment of the services available from the perspective of key stakeholders as well as from PLHIV and key population themselves is a pressing issue in order to probe effectively the gaps for more focused, targeted ,robust and sustainable intervention.

This initial work may stimulate interest of policy makers to put HIV as a priority in the upcoming political agenda leading to a more comprehensive supported response.

> ***The human needs of HIV infected people will continue for as long as they live, just like everyone else. Those physical, social and emotional needs must be actively managed for those infected and affected by HIV.***

Legal assessment

Comprehensive HIV services (prevention, treatment, care and support) need to reach out to all populations, with special concern to key populations.

Importantly, a country's legal environment, its laws and policies and how they are implemented and enforced plays a critical role in providing and accessing these services. As shown by the Global Commission on HIV and the Law's 2012 report, 'HIV and the Law: Risks, Rights & Health', protective legal environments improve the lives of people living with HIV and reduce vulnerability to HIV infection. Across the globe, it also found evidence that stigma, discrimination, punitive laws, police violence and lack of access to justice continue to fuel the HIV epidemic.

To analyze the legal and regulatory environment in Egypt, the researcher relied upon an independent legal body who had an experience in the HIV field and legal services since 2009. This process was built mainly on desk review of the available legal and regulatory documents. Moreover, perceptions and insights of PLHIV and key populations on legal issues were recorded during the focus groups and an overview of the legal environment during the key informant interviews was reported as well.

Stigma and discrimination in health care settings

The most important and common legal problem in which PLHIV face is refraining from giving them the necessary medical and surgical services due to stigma and discrimination among health care providers. In accordance to Article (18) in the Egyptian constitution 2014 which stipulates that every citizen has the right in health and the integrated health care according to the quality standards, and that refusal to treat or provide the necessary service to any individual is considered a crime. However, PLHIV is still subjected to many forms of stigma and discrimination during accessing health services which remains a big challenge towards prevention of HIV.

Additionally, article no (53) in the Egyptian constitution 2014 refers to combating stigma and discrimination in general, which can be applied to any situation including HIV. According to the government of Egypt commitments to policies and procedures and to allocate resources to reduce stigma and discrimination, an anti stigma policy was framed in November 2016 to help health care providers to provide quality comprehensive services (medical and surgical) to PLHIV and key population. This policy is aligned with the ethical considerations of the medical syndicate for any physician providing health care service (which states that every physician should provide the necessary service for any person who needs it regardless of his race, gender, religion or any other thing).

The Anti-stigma policy identified the procedures and strategies that should be applied inside any health care facility to provide PLHIV or key population with the services needed, and that refusal of providing service is considered an obvious breech of human rights. Despite the fact that it ensured that no need to isolate HIV patients in health care facilities, this was the main concern of some PLHIV during focus groups in which they complained from the presence of an isolation room specifically designed for them in fever hospitals with an obvious sign in front of the room (Isolation room for HIV patients) which made obtaining any service more complicated and increase stigma and discrimination.

Also the anti-stigma policy ensures to a greater extent the privacy and confidentiality of any information from the patient which is also aligned with the doctors oath and that disclosure of patients information is considered a crime (except for other situations which are stipulated in law).

Moreover, the anti stigma policy design a formal complaint procedure and documentation for monitoring the complain of any patient from being mistreated in any health care facility or didn't get the service needed. This mechanism was deigned to remove barriers and ensure the short pathway to get the patients rights.

Despite the existence of regulations criminalizing the refusal of providing health care services together with disclosure of information among health care providers, during the focus groups most of PLHIV and key populations claimed that some health care providers in different health care facilities refused or even evading from providing them with the needed health service.

While this policy was framed in 2016, however it is not well disseminated in an national wide level with lack of awareness about it among PLHIV and key populations from one side and among the majority of key informants from the other side which represent a major need to increase awareness and dissemination of this policy and the need to apply a punitive mechanism to whom still stigmatize PLHIV, which will in turn enhance the national HIV response.

It is highly important to highlight that all theses procedures apply for PLHIV as well as key populations.

HIV and employment practices

Most of PLHIV and key populations reported that they are facing difficulties in their work places after disclosure of their HIV status either mistreated or dismissed from work.

Although, there are no laws allowing the employers to dismiss any employee from his job after knowing his HIV positive status. However, the employers' practices are against this and many incidents occurred and still occur. One incident case happened in 2016 where an institution worked on strategic litigation, succeeded to ruling an arbitrator for the favor of one person living with HIV who was detached from his work due to his HIV status, this institution defends the legal rights of PLHIV to work without discrimination, then a court law was issued in Feb 2016 stated that employment is a basic human right for all Egyptian citizens regardless of their health condition as long as they can still work.

This seminal court ruling has been applauded by civil society, activists and international development organizations engaged in the AIDS response in Egypt and across the Middle East and North Africa. The ruling sets an important legal precedent for future discrimination cases and is consistent with UNAIDS guidance and the Arab AIDS Strategy (2014 – 2020).

HIV as a notifiable condition by law

As any other infectious disease, according to the law no. 137 of 1985, HIV is a nationally notifiable health condition by law (group A reporting that should be reported on daily basis). This is done for public health surveillance purposes. All health facilities should notify the central HIV office at the MOHP regarding any confirmed case so as to perform further needed interventions such as counselling or referral which is done in a complete private and confidential manner through professional persons.

Its permissible by law that the responsible health authority can disclose the patient's HIV status to his partner and convince him to do the HIV test together with counseling him for methods for prevention of transmission of infection.

No doubt that all or some of these measures might include infringement to sanctity of the patient's life. And this is considered to be one of the major challenges identified by some of the key informants during interviews as this might lead to a negative impact on PLHIV or key population undermined their willingness to access the HIV services for fear of reporting constraints.

Key populations &legal issues

Drug use is illegal and can lead to prison though people who admit to drug use can be admitted to drug rehabilitation centers. Female sex work is illegal and prison terms are usually given for women convicted. Men who have sex with men is usually prosecuted as the criminal offense of debauchery

The criminalization of cases of debauchery and prostitution under the law (10) of 1961, especially those with homosexual behavior, represents a challenge to the implementation of health protection and awareness activities. Despite its importance, criminalization is a barrier to access services by those key population. Therefore, collaboration between ministry of health and ministry of interior will improve the accessibility of those key population to the available services and correct information which will eventually enhance prevention and control efforts.

A project which was held in Alexandria to scale up prevention activities among MSM was stopped multiple times due to crack down by police several times which affects ultimately the number of project beneficiaries. Moreover, prevention services among PWIDs are more complicated due to criminalizing drug intake and abuse by law, which makes even distribution of clean syringes among them impossible. Most of them reported during the focus groups that they are continuously threatened to be imprisoned so they fear of accessing many HIV services especially if it requires travel to the central lab in Cairo because of the presence of multiple check points on Cairo Alexandria desert road.

Legal support services for PLHIV and key population

There are many international and national organizations were committed to provide legal services for PLHIV or key populations in the region including Egypt and this involving a variety of interventions for example, law enforcement trainings, training workshops for lawyers, legal counselling services , court defense addressing HIV as well as social determinants of health like personal issues , economic empowerment and right to health .

This was present for several years, however due to limited funding in recent years, all of these services were stopped leaving PLHIV more vulnerable with a minimal legal support and with lack of awareness towards their legal rights, even without necessary knowledge and skills to protect themselves and their families from stigma and discrimination at their homes and work places.

All the above facts represent major barriers made the environment for prevention and control more complex especially among most at risk population and hence added to the HIV epidemic.

Recommendations

- Activate and implement the anti stigma policy with multiple stakeholder's participation.
- Expand legal awareness among PLHIV including raising their awareness on the anti stigma policy.
- Special prevention programs for PWIDs on risk of HIV transmission and different modes of transmission with collaboration of health authorities and law enforcement officials
- Augment collaboration and partnership between NAP and NGOs for supporting outreach activities.
- Legal awareness should be provided through outreach activities to PLHIV and key populations to exercise their health rights.
- Further in-depth analysis of the legal environment in Egypt.

Results

The purpose of this study was to assess the needs for HIV services of people living with HIV in Egypt as well as key population. The needs assessment included primary and secondary data sources. Secondary data sources (desk review) were discussed previously. Primary data, consisting of focus group interviews and key informant interviews.

1. FOCUS GROUPS DISCUSSION ANALYSIS

The project team held a series of 11 focus groups in both Cairo and Alexandria governorate in February and March 2019 involving PLHIV and key populations (MSM, PWIDs and FSWs). Table (3), to gain in-depth information about needs, experiences and perspectives of people living with HIV (PLHIV) and key population towards the available HIV services in Egypt.

Qualitative data analysis revealed 6 overarching themes across the four focus group types (PLHIV, FSWs, MSM and PWIDs):

1. HIV knowledge and Risk
2. HIV testing
3. Linkage to care
4. Access to services
5. HIV risk reduction intervention and prevention
6. Stigma, discrimination and violence

Within each of the major themes, a number of sub-themes were identified. Sub-themes will be discussed within the presentation of each theme.

Type	No. of focus groups	No. of participants
1. FSWs	2	16
2. MSM	2	17
3. PWIDs	2	19
4. PLHIV	5	47
Total	**11**	**99**

Table (3): Total number of focus groups and number of participants

The analysis took place upon the four different types of focus groups

I- Key populations focus groups
  1. FSWs
  2. MSM
  3. PWIDS

II- PLHIV focus groups

KEY POPULATIONS FOCUS GROUPS

FSWS FOCUS GROUP DISCUSSION

- **Participant demographics:**

2 focus groups were held one in Cairo and one in Alexandria with total number of 16 FSWs, aged between 21- 44 years old. The majority of them were not working (9) while (4) of them worked in a beauty center and (3) worked as sales representatives.

- **Participants perceptions:**

1. HIV knowledge and risk

Across the two focus groups held in Cairo and Alexandria, the majority of the participants reported that HIV is a disease that weakens the immune system, with increased chances of getting several infections and frequent ailments. One of them added that “once a person is infected he will necessarily die”. However, one of them never heard about HIV/AIDS.» They agreed that the disease is transmitted mainly through blood and unprotected sexual relationships while only 3 of them knew that HIV can be transmitted from infected mother to her child during pregnancy. A subtheme is identified here which is the source of information about HIV, one of them mentioned that she knew about the disease during searching the internet, the rest of them got all the information related to HIV from Al- Shehab.

2. HIV testing:

All the participants had been tested and the results were negative, with routine follow up every 6-8 months along with taking the necessary precautions. Mostly all of them did it for free through AL-Shehab except one did it on her own expenses in a private lab cost about 75 EGP. They all agreed that no one of them was forced to perform HIV testing. they all suggested that more awareness and knowledge is needed urgently for the public especially for students in schools and universities in order to encourage those at risk to do the test. Additionally, they reiterate that the testing should be free of charge and that there should be announcements for the available testing sites whether governmental or non-governmental.

3. linkage to care:

None of the participants are HIV positive however, they all knew about the availability of medications or treatment within the government, but they didn't experience any communication with any public hospital.

4. Access to services:

About half of the participants reported that all services (Testing, treatment, regular medical monitoring and follow up schedule, prevention methods for ex. Availability of condoms) are easily accessible through Al-Shehab. along with other services such as social, legal and psychological support and capacity building workshops. One participant said that the health information she got was the most important service she had. Others reported that psychological support and empowerment are the most important services they got. Services are provided to them through individual counseling sessions as well as support groups.

5. HIV risk reduction interventions and prevention

All the participants knew about using condoms to prevent HIV transmission, they all agreed that they never faced problems in condom provision (they bought it from pharmacies) however the main challenge is that the condom usage does not only rely on their own decision but their sexual partner should agree on using the condom as well.

One of them said "Sometimes male partner refused to use condoms and if I insisted, he got worried from me ". Two of the participants reported that they don't use condoms with their permanent sexual partner as they believe that no harm will come from this partner. None of them knew about the female condom. Regarding other preventive services, only 3 of them have adequate knowledge about PMTCT package to prevent mother to child transmission.

6. Stigma, Discrimination and Violence

All the participants reported that they fear to disclose their relation with Al-Shehab to avoid stigma and discrimination whether in the community or in any health facilities. Most of the participants even avoid sharing their knowledge about HIV with their surrounding contacts as they believe that this will stigmatize them. One participant who did the test in private lab said that the technician asked her why she is doing the test as he doubts of her behavior which made her feel uncomfortable.

MSM FOCUS GROUP DISCUSSION

- **Participants demographics:**

Two focus groups were conducted, one in Cairo and one in Alexandria with a total of 17 participants, their ages ranged between 17 and 35 years old. Regarding their occupation, the majority of them were un employed (10) while the remaining seven were employed, computer engineer, Human resource manager and Zumba trainer.

- **Participants perceptions:**

1. HIV knowledge and risk

HIV/AIDS was recognized by all participants to be the major health problem facing the gay community today. Other sexually transmitted diseases (STDs) were also mentioned but less than HIV.

Participants agreed that HIV is a disease transmitted through men who have sex with men. This led the majority to practice safer sex and to be tested on a regular basis.

There were high levels of awareness and knowledge of HIV among the participants. They also knew that there are other modes of transmission for HIV such as; Sharing needles, getting blood transfusion and pregnant women to their new born babies.

Participants also identified mosquito bites, hugging, holding hands and drinking from the same glass as misconceptions about modes of transmission of HIV, However, there was two participants who said that a person can acquire HIV by drinking from the same glass. And from unclean personal hygiene

"AIDS is an acquired immunodeficiency syndrome (HIV) and the patient has no symptoms in the early stages of the disease, but when immunity is reduced, the patient is infected with other opportunistic infections such as tuberculosis and gonorrhea"- participant.

"Men who have sex with men are susceptible to HIV/AIDS, gonorrhea and syphilis"- participant.

A subtheme identified was the key sources of information on sexual health and HIV were mainly through the internet and peers. Only one of them had self experience through dealing with HIV positive person.

2. HIV testing

The majority of the participants knew about HIV testing, however, some of them thought that HIV needs no testing, it can be known from the general appearance of the individual, others said that the person needs to develop clinical symptoms to know that he is HIV infected.

Most of the participants got themselves tested for HIV regularly in private labs and NGOs. Most of participants knew that the Fever hospital offers a free HIV testing service, however, none of them used any governmental testing services available for AIDS to test themselves because they feared from being asked any question about their behavior.

They all reported that they do not want to disclose their behavior to anyone for fear of discrimination and social isolation. This fear prevented them from using the available testing services. “I’m afraid of discrimination and stigmatization that I might face in the hospital if I went to do the test”- participant.

They all stressed upon that confidentiality and credibility are the most important factors in accessing information and services relating to HIV. Most participants suggested that if their personal information would not be disclosed, they would like to seek governmental HIV testing.

“I don’t want anyone to know that I went to the hospital to do the test” participant.

“If we have to go to a lab to be tested for HIV, we really hope that the staff will not let other people know that it is an HIV testing”- participant.

Participants suggested that increasing awareness and outreach campaigns is an important strategy to improve utilization of HIV testing services.

“There should be national awareness and community-based testing campaigns like HCV campaign”- participant. Also one of them reported that the technicians in the fever hospital are not qualified. I went with my friend who wanted to do the test and the lab technician drew the sample twice which was weird”

When asked about if they are forced to do HIV testing they said no however, there are many workplaces that ask them to conduct a mandatory HIV test before employment.

“Why does the bank ask me to do an HIV test”- participant.and 2 of them reported that they were forced to do the test by their families when they knew about their perverted sexual practice (practicing sex with males).

3. Linkage to care

Most of the participants were aware of the treatment services provided by ministry of health to HIV patients and they knew that there are medications available for HIV patients.

“I knew that there are medications for the disease that the patient gets free of charge from the fever hospital”- participant.

Participants knew from their HIV friends that the long-time interval between diagnosis and receiving the treatment along with the routine paperwork is the main difficulty they faced since engaged in HIV/AIDS related services in Egypt.

One participant said that his HIV friends who work outside Alexandria sometimes can not get the medication on time because their working conditions prevent them from traveling to Alexandria every month to get the medications on a fixed date.

4. Access to services

Except for testing and treatment services, most of the participants were unaware of the other services provided like (counselling, prevention, psychological support, social support, treatment support, therapeutic education or financial support).

There is a lack of trust in services provided by government as there are concerns over their lack of confidentiality.

Two participants said that their HIV friends did not receive any counseling at the fever hospital when they went for either HIV testing, treatment or follow up.

Others knew from their HIV friends that investigation other than HIV like liver function tests are not available in the hospital and expensive.

Four participants attended many awareness raising sessions on the importance of male condom at NGOs.

Participants reported that lack of confidentiality and discrimination remain the most significant challenges to access the services. They also recommended that HIV services had to be linked to all regular services of other diseases such as HCV.

5. HIV risk reduction interventions and prevention

Participants were aware that there are ways in to protect themselves for example the use of condoms and ensuring that any potential partners should be tested before entering a sexual relationship.

In terms of condom use four participants reported to have used condoms all of the time, three participants used condoms some of the time, 1 participant used condoms very rarely.

Participants reported several reasons for not using condoms. Partner-related reasons were the most prevalent, with an about third of them stated that they did not use condoms because they were in a long-term steady relationship with one partner.

The second most prevalent reason was discomfort, difficulty of use, reduced pleasure. When asked about the availability of condoms, two of the participants reported that the fever hospital didn't provide condoms for free. However, they got it easily from pharmacies.

All the participants agreed that there is significant lack in information about HIV/AIDS.

6. Stigma, discrimination and violence

Participants reported that they had difficulties in obtaining medical, dental or surgical services at any health care facility when they disclosed their HIV status. Also, they are exposed to violence when their behavior is discovered or disclosed. Examples of such violence is expelling them from their place of residence, work or facilities.

Only 3 participants have faced stigma from police for their suspected behavior and for their presence in suspected places known for having MSM. 1 of them was prosecuted and arrested for 3 days for that reason.

1 of the participants had experienced behavioral suspicion in general STI hospital and was asked by the doctor to perform HIV testing, he stated that the lab technician deal with him aggressively while she did not refuse to provide him the service.

PWIDS FOCUS GROUP DISCUSSION

- **Participants demographics:**

Two focus groups were conducted, one in Cairo and one in Alexandria, with a total of 19 participants, their ages ranged between 20 and 45 years old. Regarding their occupation, the majority were manual workers (7); some of them (4) not working, 3 were university students, 2 were handicrafts and 3were employees.

- **Participants perceptions:**

1. HIV knowledge and risk

The majority of the participants heard about the disease, only 4 never heard about it. About half of the participants did not know clear information about the nature of the disease and its modes of transmission. Only three participants responded that sharing needles, having unsafe sex and blood transfusion are ways of transmission. While no information exists about the possibility of transmission from the mother to her baby.

"I heard about the disease, but I don't have any information about it"- participant.

"Patients with the disease do not exhibit any symptoms and the disease affects human immunity"- participant.

"I know that the exchange of needles during drug injection can transmit the disease"- participant.

The sources of their information were identified to be either from television or peers or NGOs.

2. HIV testing

None of the participants used any testing services available for HIV. A subtheme was identified which is barriers to utilization of testing services.

Most participants responded that there was a lack of information about HIV testing services.

"Limited information is the barrier. Even if I want to be tested for HIV, I do not know the location of the HIV testing clinics or how they operate."- participant.

"The government pays more and more attention to the HCV now, and devotes more financial resources to prevent HCV but there is no such concern for HIV"- participant.

Only one of the participants knew that the Fever hospital offers a free HIV testing service. However, he did not use the service because he thought he could get infected with HIV in the hospital.

"I heard that I could get infected inside the hospital"- participant.

Stigma associated with drug use and fear of discrimination and disclosure were key issues elicited from the group discussions. Participants reported that they do not want to disclose their drug use status to anyone for fear of discrimination and social isolation. This fear will prevent them from using the available testing services.

“If someone wants to do HIV testing voluntarily, the public will think you are a bad person. Even doctors or nurses may discriminate you”- participant.

“Even if I know I could be infected with HIV, I would not seek HIV testing. People think that all who visit VCT clinics are immoral. They think only those people with bad behavior will be infected with HIV, for example, sex workers or drug users”- participant.

“Education should be provided to the public to reduce the discrimination against drug users and HIV-positive individuals”- participant.

3. Linkage to care

The vast majority of the participants were unaware of the treatment services provided by ministry of health to HIV patients. Most participants do not know that there are medications available for HIV patients.

One of the participants knew that there are free medications for the disease but he didn’t take it.

“I know that there is more than one line of medications to treat the disease and that the State provides these medications for free”- participant.

4. Access to services

Participants were unaware of the different services available for people at risk for or having HIV. (counselling, prevention, testing, psychological support and social support.

Participants said that they need intensive awareness campaigns to familiarize them with these services and how to get them.

Participants ascertained their willingness to stop using drugs. The participants called for the provision of drug cessation services in which they receive psychological support and counseling.

“I need more psychological support services”- participant.

Participants expressed their desire to provide theses services in primary health care centers near their residence.

5. HIV risk reduction interventions and prevention

Although they are injecting drug users, participants had Perception of having low risk for HIV infection. They responded that it is a common practice to share needles and syringes among IDUs. They reported getting their new needles and syringes from pharmacies and friends. Some of them have challenge in having syringes as some pharmacies refuse offering them syringes for suspecting their behavior

“There’s a difficulty in getting needles from pharmacies”- participant.

While all the participants knew the male condom however not all of them knew it’s importance in preventing transmission of infection to the sexual partner.

In terms of condom use, none of the participants reported to have used condoms all of the time, only 2 used condoms very rarely.

“I used condoms once because I didn’t trust the other sexual partner”- participant.

Only one participant said that he received counselling about the importance of the condom in preventing sexual transmission of the disease at one of the NGOs.

“I attended a health education seminar on the importance of condoms in preventing the transmission of sexually transmitted diseases”- participant

6. Stigma, discrimination and violence

Most of the participants responded that the most significant source of stigma and discrimination with the most negative impact on them was family members.

Participants felt that discrimination against people who use drugs is deeply inherited in our society.

Moreover, they responded that health care providers, including hospital and primary care physicians, nurses, and hospital security staff are major source of discrimination. Participants felt that their medical concerns were not taken seriously.

“I was in a hospital and I was treated badly when they knew I was a drug addict”- participant.

The most common impact of stigma and discrimination raised by participants was poor self-esteem and barriers to utilization of HIV testing services. Participants called for more awareness campaigns about the disease and reducing stigma and discrimination associated with drug using and HIV. 3 of them were prosecuted and arrested for days for having drugs.

PLHIV FOCUS GROUPS

- **Participants demographics**

Five focus groups were conducted, two in Cairo (one WLHIV and one mixed) and three in Alexandria (Two mixed and one WLHIV), with a total of 46 participants. Their ages ranged between 14 and 58 years old. Regarding their occupation, most of the WLHIV are housewives, the others were drivers, manual workers and two of them were university students.

- **Participants perceptions:**

1. HIV knowledge

All of them replied that HIV is caused by a virus that attacks the immune system of the affected person with increased chances of getting several infections and frequent ailments especially if not treated early.

They agreed that frequent symptoms of HIV include fever, diarrhea, losing weight and repeated attacks of common cold. They could differentiate between HIV and AIDS.

Additionally, all of them could identify correctly the modes of transmission including blood, unprotected sexual relationships and from mother to child during pregnancy, delivery and through breast feeding. They also knew that some risky behaviors are associated with increased risk of getting the disease like homosexuality, drug use and those involved in unprotected sexual relationships with infected partner(s). While, the majority of the women acquired the disease from their HIV infected husbands, one had the disease since birth from her infected mother and another one acquired the disease after surgical operation in Alexandria University hospital (appendectomy). Three male participants reported that they discovered their HIV status accidentally during treatment from Addiction At Al- Maamoura hospital (Alexandria).

2. HIV testing

Most of the women went for testing after their husbands (most of them were injecting drug users) knew their HIV positive status. Two participants were tested positive in the prison after suffering a health problem. “I was tested positive and isolated in a designated cell in the prison after suffering from multiple abscesses all over my body”- participant.

None of the participants were forced to do the test.

About four of the participants had HIV testing in a private lab costing about (50 – 100 EGP) and tested again in fever hospital to be enrolled in the treatment. The rest of them tested in fever hospital for free.

The majority of them agreed that the testing service was available however the results sometimes were delayed up in some cases (took about one or two months).

3. Linkage to care

Most of the participants said that they were referred to the fever hospital to receive the treatment after being confirmed HIV positive. Most of them agreed that it took from 3 to 6 months to receive the treatment after being confirmed HIV positive. While there are three participants newly diagnosed from 2 months and didn’t receive the treatment yet.

Most of the participants were receiving HIV treatment and none of them stopped taking their medications for any period of time since the beginning of the treatment. They received their medications on monthly basis and knew that viral load testing should be done every 6 months. However, they all confirmed that they are facing some difficulties in medication provision especially when they are sick, because they should take the medication by their own (which was identified as a big challenge for them to comply with treatment). Moreover, follow up CD4 tests are not available all of the time or with delayed results which might be added to the causes of non adherence to treatment.

“I went to Cairo, and did the investigations, but it has been six months so far and the results did not arrive yet”- participant.

“I live in Alexandria, and I have to go to Cairo to get do follow up tests done, but I cannot afford that, and I cannot take days off from my work”- participant

“Each time I go to the hospital to get my lab result. They once told me that the sample was no more valid, the results did not arrive from Cairo yet and another time I was informed that the device stopped working”- participant.

The majority of the participants replied that they can communicate anytime with the health care provider in fever hospital to ask about anything even before the scheduled follow up visits

4. Access to services

The Majority of the participants experienced some difficulties in accessing testing, follow up, receive their medication either due to time, geographical or financial barriers especially those from Alexandria. For example, one of the participants said

“The fever hospital in Alexandria assigned a single day per week for drawing samples and our working conditions may hinder our ability to attend on that day”- participant

Also, one participant claimed that travelling to Cairo for follow up testing is so difficult

I used to be imprisoned, and I if I pass by a checkpoint on my way to Cairo, I fear policeman may arrest me”- participant

“My sister in law, her son and I are infected. For all of us to go to Cairo, it will cost at least a thousand pound”- participant.

Some of them received information about the Hotline in Cairo from their peers

Half of the participants agreed that they receive counselling with the health care provider when diagnosed and before receiving the treatment during which they had information about the available services including treatment and follow up. as well as information regarding prevention and protection of their sexual partner(s). However, the other half confirmed receiving poor counseling services in fever hospital after getting the test results.

“they told me after knowing my HIV positive status, Don’t marry, don’t get pregnant “participant.

Most of them agreed that services other than testing and treatment are not well established or strengthened (psychological and social support). Although all of them need psychological, social and legal support.

The majority of them receive counselling sessions through informal support groups.

All of the participants from Alexandria recommend that all investigations should be made available at the fever hospitals in order to ensure compliance with treatment. they all confirmed that the routine paper work which makes long time interval between diagnosis and receiving treatment is the main difficulty they faced since engaged in HIV/AIDS related services in Egypt.

All of the participants stated that there is difficulty to receive any medical service dental or surgical health care services either in governmental or private health facilities if they mentioned that they are infected with HIV.

5. HIV reduction interventions and prevention section

When they were asked about how to prevent transmission of infection, they all identified their knowledge about the condom and its importance to practice safer sex. The majority of them reported receiving health education about the importance of condom to prevent transmission to their sexual partner.

“whenever we say that we have got a wife, we get asked to get them tested”- participant.

“I get my wife tested every three months”- participant

Also, most of the women received counselling on how to prevent transmission to their babies and what to do if they want to get pregnant.

Some of them reported that condoms are available at the fever hospital and they received it monthly (despite being unavailable in the previous three months) , others said that they got it from the family planning clinic , others said that if they are not married , they cant receive it.

“condoms are easily offered in the hospital’s pharmacy. I receive nine each month”- participant

All of participants as well as their partners were accepting use of condom and had a general positive attitude regarding this.

6. Stigma, discrimination and violence

All of the participants said that they had been subjected to various forms of discrimination, stigma and violence whether in their residences, workplace or health care facilities once they disclosed their HIV infection.

In health care facilities, the situation is very complex where they can not receive their needs in a normal way , either from the start or HCPs refuses to continue treatment after knowing their status the majority of them said about the isolation room in the fever hospital which is very discriminatory making people as well as health care providers didn’t want to enter the room .

Two participants complained that when they referred to fever hospital their files were labelled as HIV positive.

“I had a broken arm and was supposed to get a plate and screws fixed, and when they knew I had the disease, I was dismissed from the hospital without undergoing the needed surgery"- participant.

"I may be infected by blood transfusion and not by sex or drug use. People should know this"- participant.

Most of them do not know where to complain when they are treated badly. However, one participant said that he wrote down a formal complaint about bad treatment he faced in a health care facility however, no actions were taken.

"I have got a dental problem and am about to lose all my teeth. Upon attending the dental clinic here, I get told (any excuse) the dentist did not come, the apparatus is not functioning, or tools are not sterilized yet"- participant

One participant complained of being highly stigmatized with the certificate not to be in enrolled in military services because being HIV positive written on the front of the certificate.

2. ANALYSIS OF THE IN-DEPTH INTERVIEWS (KEY INFORMANT INTERVIEWS)

The researcher and the research assistant conducted a series of in-depth interviews (24) with key informants helped to inform the needs assessment from the period from 10 March 2019 to 20 March 2019. Eighteen interviews were conducted face to face interview, three were conducted over the phone and two were completed via email.

Relevant stakeholders participated in the interviews were, service providers and policy makers from governmental, non -governmental organizations, UN agencies and experts. (see Annex III b).

The key informant interviews ranged in duration from thirty minutes to slightly over one hour

The in-depth interview composed of a well -structured open and closed ended questionnaire tested for validity and reliability (see Annex IIIa).

This in- depth interviews aimed at assessing and identifying the needs for HIV services available in Egypt.

Our findings cover stakeholder perspectives on the availability and accessibility of quality HIV services available for both PLHIV and key populations. We further assessed opinions on the progress made in integrating FP and HIV services across the components of the health systems, such as trained healthcare workers, availability of commodities, facility structures to ensure integration, and joint monitoring and reporting. Stakeholders also described how FP and HIV services are currently being implemented in the majority of the facilities and shared some successful pilot programs of integration. This report also highlights the role of the private sector in assisting to provide HIV services to the people and also pays special attention to the progress made in reaching youth. Finally, this report will describe how information on HIV is currently being addressed.

The in-depth interview focuses on several themes:

1. Services provided and its quality

Most of the HIV services provided through the governmental facilities offered through VCTs and fever hospitals all over the country providing specialized HIV care and case management (screening, medical care, treatment and follow up).

Some other services provided through Chest hospital as TB, chest and respiratory care, Mother and Child / ANC mainly provide antenatal care services and sometimes HIV testing. The NAP plan, coordinate and supervise all HIV activities.

In the fever hospital, there is a trained team to deal with HIV at risk or infected persons however, more training workshops should be offered along with regular meetings to identify the ongoing arising problems.

Some NGOs provide services to HIV including refugee support, women empowerment, youth awareness on reproductive health specifically for HIV, drop in centers provide free anonymous counselling and testing for HIV along with HBV and HCV. Additionally, they provide support groups for PLHIV, compliance programs for people living enrolled in treatment, home based care for PLHIV and their families. Workshops on self care and living positively with HIV, outreach teams for harm reduction among IDUs. Advocacy for PLHIV rights and telephone helpline services.

NAP support many other services such as hotline for treatment literacy and care follow up in addition to social support groups, NAP also support the above mentioned efforts that are provided by NGOs and provide them with technical and sometimes logistical support.

The UN agencies though offering technical support to the NAP and CSOs to provide services with high quality. UNICEF for example providing services related to mother and child, health education, advocacy hospitals (ex. Al-Zahraa and Al-Hussein hospitals). The UNODC is concerned with the delivery of comprehensive HIV prevention, treatment and care services among people who use drugs and living in closed settings.

All services are provided for PLHIV and most at-risk population by all agencies and also mothers, children and adolescents.

HIV testing

Voluntary and confidential testing is available through VCTs and the fever hospital as well NGOs (Rapid test). The majority of stakeholders are satisfied to a great extent with the HIV testing confidentiality, only we need to ensure that anonymity continued.

The different testing approaches including rapid test, provider initiator, routine in some hospital s, VCTs and outreach.

All stakeholders agreed that HIV counselling is linked to enrollment with care however, it needs to be more strengthen since there are observed gaps between the 2 services.

Some of them replied that it might take from 2 to 6 months for a patient from HIV testing confirmation till linked to care (PCR / CD4 testing)

1st line treatment includes Truvada and Efavirenz is the most common treatment regimen being given to HIV patients. These are being dispensed in 14 integrated centers. Now there is no recommended CD4 threshold for initiating treatment, it is test treat approach. All positive cases are referred to treatment after doing all the monitoring tests.

Routine viral load testing is carried out for monitoring antiretroviral therapy every 6 month and on need. Some of them stated that there are some medicine disruptions especially for the second line. Moreover, they all agreed that ART are not available outside public facilities. Except for some private pharmacies

When asking the governmental service providers about the details of the services provided; they reported that there are 24 VCT centers 16 fixed and 8 mobile. There is a focal point person in each governorate to supervise, follow up all surveillance sites and communicate continuously with NAP through regular reports.

There is a reception area, counseling room, sampling and testing room

Laboratory: Except for VCT located in CPHL all the VCTs are performing rapid test only, when sample is positive the serum is transported to either fever hospital lab or governorate reference lab for ELISA testing then to CPHL for WB.

All labs are provided with centrifuges for samples preparation and refrigerators for storage of samples and kits (special attention for equipment maintenance is needed).

Laboratory technicians are dealing with samples using their previous experience but they did not receive periodic training on HIV sample management after joining VCT.

In most of the places cold chain is available and effective. Transportation using official governorate car.

They added that the national testing protocol follows the 2015 WHO guidelines on HIV testing.

VCT centers provide pre-test and post-test counseling-partner counseling–condom distribution, materials for knowledge and referral system.

They also convince the HIV positive patient to notify his/her partner and invite him for testing. NAP in collaboration with stakeholders has launched an ambitious model to link non-governmental VCTs and outreach programs with governmental VCTs to ensure proper and comprehensive referral to support, care and ART services.

HIV testing is not mandatory before marriage or for key population or to work or residence except for foreigners however, some work places require HIV testing as a pre requisite for work.

Some NGOS perform HCV testing as well with HIV testing however, this is not routine

Central lab: doing all tests responsible for diagnosis (and follow up the adherence and effectiveness of the treatment. and all analysis needed to identify the lines of treatment and the side effects changing.

All governmental services are provided all days of the week except Friday from 8 am to 2 pm However , NGOS continued to provide the services all over the day from 8;30 am to 9 pm except or the drop in center in one NGO (Caritas) which is available all days from 6pm to 9 pm except Friday and Sunday

The vast majority of the respondents agreed that there is limited geographical distribution of HIV testing centers in relation to the population density in Egypt. Additionally in terms of time, Most of them agreed on there may be some time limitations due to routine paper work for the follow up test and treatment.

As regards, referral, it is done mainly from NGOs to the NAP for treatment or from the MCH to the NAP. Also NGOs sometimes refer PLHIV to their specialized team in different hospitals for medical services. They all reported that PLHIV sometimes follow on through care /or service referrals.

NGOs representatives agreed that most of the patients didn't follow through on referrals might be due to less trust of the referral place especially when it is governmental place where they fear of breech of their privacy.

Additionally, they confirmed that counselling sessions are available however not systematically or on regular basis

Some of the stakeholders suggested that peer education and support groups are the most effective and efficient approach for PLHIV to receive education, others suggested to be provided as a part of service provision. The most common suggested topics are; literacy sessions, nutrition, being able to live positively, psychosocial , compliance to treatment and mother to child transmission.

Prevention

Some of the stakeholders especially NGOS and governmental service providers replied that condoms are available for free for PLHIV and key population however others reported that is available for PLHIV not for key population, or not systematically provided.

They all agreed that post exposure prophylaxis is available for only occupational exposures however facing some routine issues which might delay the provision of post exposure prophylactic drugs

Prevention activities targeting PMTCT has no sufficient access and used to target women already infected with HIV to be provided with the MTCT package, there only 31 ANC centers that provided with HIV rapid kits to allow early detection of HIV pregnant women, no mass media awareness material were used in a national wide scale. Routine testing in selected sites in 8 governorates with service provision to prevent vertical transmission.

NGOS provide counselling programs to explain how to prevent mother to child transmission and provide support to pregnant females to get access to their medicines providing prenatal, natal and post natal services.

Barriers

Most of the stakeholders reported that there are some barriers preventing PLHIV /Key population from having full access to the services related to limited resources, other health priorities and beneficiaries are not aware of the available services. It is important to highlight that most of the stakeholders confirmed that legal barriers exist for key population to access the services provided for fear of being prosecuted.

All of them reported no specific barriers that prevent or make the place uncomfortable for the beneficiaries.

2. Service integration and partnership

All stakeholders are aware of the HIV national strategic plan and the NAP provided continuous consultative process and participation in the country dialogue made on regular basis to share data and information. They all believed that it is to a great extent comprehensive and based on realistic situational analysis except for the urgent need of an updated IBBS.

NAP used to conduct a transparent country dialogue to all stakeholder and HIV player to discuss all vital issues for example GF proposal, NSP, annual indicators.

There is also a great need to enhance the linkage between NAP and Ministry of social solidarity to allow transparent work and prevent duplications and proper use of allocated funds in line with the NSP, this will facilitate the national governance and accountability.

Some of the stakeholders stated other suggestions to be considered in the NSP as a clear strategic intervention for stigma and discrimination. Also a multisectorial collaboration is needed for example other ministries like ministry of social solidarity, higher education, ministry of interior and mass media.

Most of the UN agencies and NGOS have direct collaboration with the NAP either through offering technical support, sharing supplies, information, mutual flow of information, reporting and working together with pharmaceutical sector

They all reported that there is a joint planning between HIV and SRH programmes however it is not strong enough (partially). Its undertaken through CSOs and Ministry of health (there is a proposal for the global fund for PMTCT and integration of HI into ANC clinic (above allocation).

There is a unified monitoring framework between NAP and MCH. They also replied that there are regular joint collaboration meeting on the national level not on the local or district level.

They all agreed that the major development partners for HIV are CSOs, UN agencies and the government through different ministries. (some of them issued that there are an ongoing proposal between ministry of social solidarity to provide treatment and rehabilitation services

The role of CSOs mainly outreach activities and referral especially for key population to get their treatment and follow up care. There are minimal networks for PLHIV however no networks for Key populations.

The main funding agents for HIV response and activities are the government of Egypt and the global fund. Due to limited fund in recent years, the burden of the GOE increased while a lot of NGOs stopped providing their services.

3. Monitoring and evaluation

Most of the stakeholders are aware of patient profile system and the automated health care management (HMIS). All NGOs shared their data with the NAP annually as apart of GAM.

Although NAP collect data from governmental and non governmental organizations and CSOs in regular basis (monthly, quarterly and annually), GAM/GARPR is considered the only reporting tool that is widely disseminated in addition to some workshops and round table to discuss definite issues such as NSP and National Guidelines .

Not all national partner are committed to properly and timely sharing of their data and NAP is now establishing a national electronic data collection tool gathering all entities in a systematic database.

4. Staffing and workforce

In fever hospitals, there are pharmacists, counsellors, laboratory staff, information management staff. One NGO replied that it had about 12 health care providers (Physicians, counselors, and lab technician)

Capacity building workshops and training sessions for healthcare providers are available but not systematically developed with regular follow up.

5. Stigma and discriminations

Among service providers, all of them stated that they don't have any negative attitude towards HIV positive patients and no additional infection control practices are done when dealing with HIV positive patient. No limitations of service provision.

The majority of them suggested to design programs to change attitude not increasing knowledge along with intensive mass public awareness campaigns and targeted educational messages for health care providers.

There are anti- stigma programs but no direct programs for violence.

Policy and decision makers agreed that most of PLHIV experienced discriminatory attitude from their micro community (their families) than the external community (work, health care providers)

Most of them suggested that streaming of HIV services along with other health care services is the way to reduce stigma and discrimination

Legal part

Most of the interview respondents did not have full correct information on legal aspects related to HIV, which represent an important point for intervention.

All of stakeholders agreed that HIV is a nationally notifiable condition through a governmental reporting system only. Other private labs might not report. They believe that this is one of the challenges for prevention efforts.

Laws are present requiring parenteral consent for adolescents to access HIV testing as well as treatment however, there are some exceptions. Also these are one of the important barriers to improve adolescent's health as they might find difficulties in accessing services without disclose their status to their parents. So they preferred to remain silent taking all information from their peers and internet. While there are no laws directly criminalize homosexuality, they refuse to access services for fear of being prosecuted.

Moreover, Laws for criminalizing drug users are present and this added an important barrier for prevention strategies among PWIDs.

AIDS is not criminalized by law anyway however, the legal environment is very complex and challenging. There are no laws preventing PLHIV (national residents) from working or studying; only laws exist for foreigners.

No laws obligating PLHIV to disclose their HIV status however, there are laws obligating health care providers to provide high quality services for all people regardless their disease status or behavior

SWOT Analysis

SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. It was originally designed by the Boston Consulting Group (BCG) in Massachusetts, USA, where Strategic Managers devised the strategy to undermine their competitors and achieved competitive advantage.

SWOT analysis can be adapted to scientific research to help us as scientists and policy makers in formulating strategies that augment our research and enable us to understand and devise holistic strategies to combat emerging epidemic. When the characteristic capacities and the gaps have been identified, we can then devise means of achieving our goals.

An analysis of collected data revealed the following strengths, weaknesses, opportunities and threats in regard to the available HIV services in Egypt.

Strengths

- Very well developed comprehensive national strategic plan
- Policies developed in collaborative manner involving all stakeholders.
- Continuous country dialogue process between relevant stakeholders and the NAP in the field
- The presence of wide range of experiences capable of assisting, training and advising others

Weaknesses

- Cultural beliefs (conservative and religious community)
- Understaffing (and under-skilled staff) in the public health system
- Inadequate infrastructure
- lack of awareness
- Poor information management
- Poor Government/CSOs sector collaboration

Opportunities

- The epidemic still concentrated among most at risk population
- Access to educational opportunities
- Management support and commitment
- Management interest
- Access to management
- Improved access to information and drugs
- Linking HIV services with other health care services

Threats

- Limited funds
- Overwhelmed government of Egypt
- Alarming increase in new HIV cases
- Poor multi sectorial collaboration
- Media ignorance and stereotyping
- High cost of drugs
- Phobia among health care workersand fear of HIV/AIDS
- Complex legal environment

Conclusions

Policy level

- Universal access to HIV prevention, treatment, and care is an aspiration, although the programming, resources allocated and health professionals do not provide universal access to the services.
- There is a complex legal framework for key population specifically making it difficult to address problems adequately
- A good cooperation between different stakeholders is well established

Service delivery level

- Several challenges were identified in the present study with regards to provision of services especially counselling and psychological support.
- lack of integration and linkage between HIV prevention and treatment services
- lack of well trained health professionals capable of dealing with HIV comprehensive case management.
- Key populations declare that confidentiality and privacy issues remain the most significant barrier for them to access the services

HIV awareness

- FGD results demonstrated that PLHIV in general and specifically key population had lack of information about where and how to apply for an HIV test and where and how to access treatment.
- Most of the interview respondents did not have correct information on legal issues related to HIV

Strategic partnership

- Strategic partnership and country comprehensive dialogue is in place and coordinated by NAP, however, there is a need to develop a clear national thematic groups for Policy, prevention and care, etc.
- Participation of affected or most at risk groups in these mechanisms is limited as there is no organized groups for PLHIV or key populations.
- Updated M&E system is not disseminated systematically on a nation wide scale.

Recommendations

Policy level

- Establish common policy on universal access to HIV treatment and HIV related services to cover more geographical areas.
- Establish a clear probing strategic intervention for stigma free health care facilities
- Implement an effective national information system and tracking records
- Establish organized networks for PLHIV to be able to participate in policy processes

Service delivery level

- Assess the costs and benefits of ensuring universal access to HIV related services and mobilize additional resources from donor funds to establish more testing services universal access in action.
- Unifying and simplifying the linkage system to ensure closing the second 90% gap.
- Improve integration and linkage between HIV testing and treatment services.
- Strengthen national and subnational prevention campaigns and interventions (establish network of pre-defined organizations which refer and receive referrals, agree on common information activities, set up regular format for review of progress and discussion of challenges, etc)
- Work on eliminating administrative and legal barriers to access the services.
- More Training of health professionals in provision of prevention, treatment and care services. (build a wide network of competent professional health care providers capable of dealing with profound HIV clinical care, ART and opportunistic infections.
- Stimulate the cross-country dialogue to share best practices and experience, to identify mutual benefit in improving access to the services.

HIV awareness

- Design a well-organized programs aimed at awareness or outreach of mobile groups, providing full information on HIV, transmission routes, prevention, treatment and care, HIV rights, using all means of information delivery appropriate for mobile groups.

Strategic partnership

- Development of multi sectorial collaboration mechanisms between different ministries for example ministry of interior and ministry of health in outreach prevention programs
- Official mainstreaming HIV services to other health care services is essential to improve accessibility to services

Appendices

1. ANNEX I

List of resources used for literature review

1. National strategic plan 2018
2. GAM report 2018
3. Monitoring and evaluation national framework
4. STI national framework
5. Global fund Concept note
6. Health strategy
7. IBBS 2010
8. Gender assessment 2015
9. PSE 2015
10. TTR 2018
11. VCT assessment
12. Stigma policy
13. National Guidelines for care and treatment
14. Guidelines for key populations (WHO)
15. Guidelines for testing
16. SOPs and patient follow up procedure
17. Case reporting
18. Further studies

Along with catalytic responses from UNAIDS and SDGs

2. ANNEX II

Focus Group Discussion Guide
PLHIV and Key risk population

Total Time Required:	2 hour
Total focus group time:	1 hour 45 minutes
Break:	15 minutes

Equipment needed:

Paper and pens for everyone
An easel
Markers
Cards for names
Recording equipment
A moderator and recorder

Aim

Identification of needs, experiences and perspectives of people living with HIV (PLHIV) and key population towards the available HIV services in Egypt

Specific objectives

1. Identify gaps in knowledge about HIV and HIV services in Egypt.
2. Assess awareness and knowledge of HIV services in Egypt.
3 Identify challenges and barriers to accessing HIV services in Egypt.
4. Determine models for improving HIV services in Egypt.
5. Understand the patient perspectives of health care along with satisfaction to services.

Participants

- Since people living with HIV/AIDS from different transmission routes may have different needs and experiences it is necessary to recruit participants representing most prevalent groups.
- A total of ten focus groups will be conducted for PLHA and Key population groups of average 8 participants for each ,as follows:

	Number of Focus groups			
Governorate	**PLHA**	**PWID**	**MSM**	**FSW**
Cairo	2	1	1	1
Alex	3	1	1	1

- Each focus group composed of :
  - A moderator (facilitates the discussion)
  - A recorder (observe and document the discussion)
  - 8 participants (PLHIV or key population)

Tips for the moderator:

1. Explain to the group the purpose of the meeting and that it is not an educational lecture however, we are here to gather your opinions, sharing experiences and learning from you.
2. Try to address participants by name or use name tags or cards.
3. Starts by asking each participant in turn a general question not related to the topic so as to make them get used to speaking for example what's your favorite food? then go to the questions suggested below.
4. Emphasize the fact that their ideas and opinions are very important for the planning of services and everyone should express his opinion freely.
5. Encourage everyone to participate, don't allow a few to monopolize the group.
6. Redirect the discussion to the right track, don't allow side talks.
7. Be flexible in letting the group talk, but move them on to the next question before the discussion loses energy or becomes repetitive.

Tips for the recorder:

1. He/she should write down the number of people present, where the discussion takes place, the sex and approximate ages of the participants, and how long the group discussion takes. The participant's names should not be recorded.
2. He/she should also note down the atmosphere of the group lively or bored, anxious or relaxed, etc.
3. For each question, he/she should write down the main opinions expressed, and the areas of particular sensitivity or strong feeling.
4. It is important to write down the terms and expressions people actually use when talking.

Running Focus group discussion

- INTRODUCTION: (10 MIN)

- Welcome participants

Good morning. My name is Dr. __________, and I am a public health expert in Alexandria and I am here to get your opinions about some topics related to HIV/AIDS in Egypt. First, I want to thank you all for taking the time to be with us today.

- Explain the purpose of the FGD

Its our pleasure to discuss with you your thoughts and ideas about HIV-care, services, sexual health protection, testing and treatment.

Our discussion will provide guidance needed for us to design attractive programs for HIV.

- Explain the focus group process

Before we begin, I'd like to explain what a focus group is and then give you some information about this specific focus group. As some of you probably already know, a focus group is like a discussion group. In a focus group, people are asked to discuss their thoughts and ideas about a subject. I'll introduce a subject by asking the group a question. There are no right or wrong answers to the questions. What I am looking for is an informal discussion about how people think or feel. I encourage you to just jump into the conversation with how you feel about the subject I bring up or about other people's responses. Just like there is no right or wrong response, there is also no single opinion for any subject. I am interested in hearing what each of you think and feel about each topic. The more points of view, the better.

- Establish ground rules

In order for this group to be as engaging as possible for everyone, there are a few "ground rules" I am hoping we can all agree to before getting starting.

(1) Turn off you cell phones during the discussion.

(2) Please try to protect each other's confidentiality

(3) Please respect each other and each other's opinions.

(4) Finally, please try to speak one at a time, so we can listen what other colleagues have to say. This will also make it easier to transcribe our discussions accurately.

Are there any questions or concerns about these ground-rules? {take the time for each participant to confirm that they agree to these group rules}

- Consent

- We will be tape recording the discussion today, because we don't want to miss any of your valuable comments.
- These recordings will be written out into text and those will be read by the study team to get the most out of what you are sharing today.
- In those documents, the text is de-identified- which means that names or anything that would lead to someone being able to guess a group member's identity.
- All of the material from our groups is kept confidential, only reviewed by professionals on the research team, and any presentation of results based on these groups would never identify anyone here today by name or anything else that would give someone's identity.

Does anyone have any questions?

Ask them to introduce themselves

- WARM-UP [10 MINUTES]

Okay, let's begin by getting to know a little about each other. A. On the paper in front of you, please write your age, education, residence B. Now let's begin. First, introduce yourself (first names only, or nickname) and your hobbies; C: How long you've been living in Alex or Cairo? Do you like living here? What do you like about the city? Not like about the city?

Great. Let's begin recording.

- [TURN ON TAPE RECORDER]

- BEGIN.

I- For PLHIV

It is recommended to initiate a discussion with a question on experiences with health services in general, in a context of HIV/AIDS. It is good opening for further questions

- Introductory questions: 10 min

Q1: From your observations and experiences, what are the major problems in the community?

Q2: Is HIV viewed as a major problem in the community? How does HIV infection compare to other problems?

- Key questions:

[HIV Knowledge and Risk] [15 minutes]

Q3: How much do you know about HIV/AIDS?

Q4: How do people get infected? OR Why do you think people in the community are becoming infected with HIV?

Q5: What activities, behaviors, or conditions put individuals at risk? OR Who is at risk of getting infected with HIV, the virus that causes AIDS? and Who is not at risk?

- [HIV testing] 15 min

Q6: How do you know if someone has the virus that causes AIDS?

Q7: What do you think about testing services available and how they might be improved?

Q8: What were your experiences with HIV testing? If tested , where did you get tested? How much did the test cost? Discuss details, If not ,why do you think that was?

Q9: Have you received enough information about HIV testing and available testing options?

Q10: Did you feel obliged to be tested for HIV / AIDS? If so, can you describe.

Q11: What help do people need to go for HIV testing? Does location of testing services matter? What would make it attractive for people? OR what would make it easier to get tested?

- [Linkage to care] 15 min

I would like to discuss your experiences with getting enrolled in HIV care.

Q12: When you received the positive HIV-test results, how did getting into care get presented to you? Did anyone talk to you about getting into care or help you to do it?

Q13: As a person living with HIV, have you had access to treatment following your testing? After how long?

Q14: How many of you are currently taking ART- the medications used to control or manage HIV?

Q15: For those of you in care, how often are you asked to come in for HIV-care visits?

Q16: Have you had to stop your treatment? If so, for how long? Why?

Q17: For those of you who did get into care, what kinds of things made it easy or easier; and what kinds of things made it difficult for you to stay in care and go into appointments in the recommended intervals?

- Access TO SERVICES

Q18: Are you aware of the different services available in your country?

Q19: Do you have access to the following services: information on HIV / AIDS prevention, all prevention methods (planned and available at national level), testing , regular medical monitoring, psychological support, social support, treatment support (compliance) , therapeutic education, biological tests? If yes, do you have difficulty accessing these services?

Q20: What are the needed services that you would like to have access to ?

Q21: How could services in each of these areas best meet your needs

- [HIV risk reduction interventions and prevention] 15 min

Q22: What kinds of things do you do, or have you heard about other people doing, to protect you and your partner's sexual health?
Condom use? Avoidance of certain partners or venues? Minimizing number of partners? Minimizing drug and alcohol use? Discussing HIV status

Q23: Of the things we have listed here, which would you say are the ones that are (1) easiest for you to use? (2) most effective at preventing transmission of HIV?

Q24: Lets talk more about condoms: What do people think about condom use? Do people even think about using condoms? Why or why not? What do you think are the advantages and disadvantages of using condoms? Are condoms easy to get in your community? OR Where would be the best places for people to get condoms? What would make condoms easier to get?

Q25: What about counseling around the prevention of giving partner(s) HIV from local public health programs? Has anyone engaged in any kind of counseling like that? What were your impressions?

- [STIGMA, DISCRIMINATION AND VIOLENCE] 10 min

Q26: Have you suffered discrimination and / or violence when your serological status was announced??

Q27: Have you been poorly received by a health facility (testing or care))?? If yes, can you describe your experience

Q28: What program or service do you think could help solve these problems?

Q29: Did you ever complain about bad treatment in health care facilities? And what was the flow of the complain?

- WIND DOWN/WRAP UP] [5 minutes]

Q30. What recommendations do you have for developing a program that tries to help PLHIV that have not yet been discussed? Is there anything you might want to add?

- [ACKNOWLEDGEMENTS]

Thank you very much for coming here today. We appreciate your thoughts and ideas.
They will be very helpful.

II- For key population (MSM/FSWs/PWIDs) not having HIV

- Introductory questions:

Q1: From your observations and experiences, what are the major problems in the community?

- [HIV Knowledge and Risk]

Q2: How much do you know about HIV/AIDS?

Q3: what do you think about modes of transmission of HIV?

- [HIV testing]

Q4: How do you know if someone has the virus that causes AIDS?

Q5: what do you think about testing services available and how they might be improved?

Q6: What were your experiences with HIV testing? If tested , where did you get tested? Discuss details, If not ,why do you think that was?

Q7: Have you received enough information about HIV testing and available testing options?

Q8: Did you feel obliged to be tested for HIV / AIDS? If so, can you describe.

Q9: What help do people need to go for HIV testing? Does location of testing services matter? What would make it attractive for people? OR what would make it easier to get tested?

Q10: After testing ,how often are you asked to come to HIV care for retest?

- Access TO SERVICES

Q11: Are you aware of the different services available in your country?

Q12: Do you have access to the following services: information on HIV / AIDS prevention, all prevention methods (planned and available at national level), testing , regular medical monitoring, psychological support, social support, treatment support (compliance) , therapeutic education, biological tests? If yes, do you have difficulty accessing these services?

Q13: What are the needed services that you would like to have access to?

Q14: How could services in each of these areas best meet your needs

- [HIV risk reduction interventions and prevention]

Q15: How do you feel about your partner? (afraid – suspicious)

Q16: What kinds of things do you do, or have you heard about other people doing, to protect you and your partner’s sexual health?
Condom use? Avoidance of certain partners or venues? Minimizing number of partners? Minimizing drug and alcohol use?

Q17: Of the things we have listed here, which would you say are the ones that are (1) easiest for you to use? (2) most effective at preventing transmission of HIV?

18: lets talk more about condoms: What do people think about condom use? Do people even think about using condoms? Why or why not? What do you think are the advantages and disadvantages of using condoms? Are condoms easy to get in your community? OR Where would be the best places for people to get condoms? What would make condoms easier to get?

Q19: What about counseling around the prevention of giving partner(s) HIV from local public health programs? Has anyone engaged in any kind of counseling like that? What were your impressions?

- STIGMA, DISCRIMINATION AND VIOLENCE

Q20: Have you suffered discrimination and / or violence when you disclose your behavior?

Q21: Have you been poorly received by a health facility (testing or care)? If yes, can you describe your experience

Q22: What program or service do you think could help solve these problems?

Q23: Did you ever complain about bad treatment in health care facilities? And what was the flow of the complain?

3. ANNEX III-A

List of potential stakeholders for In-depth interviews

NGOs	
1.CARITAS Alexandria	
2.Freedom	
3.Al Shehab Association	
4.Abnaa El Dahrya	
5.Support for development	
6.Sehaty men beyaty	
7.National foundation for family and society development	
Governmental	
8.Dr Walid Kamal	National AIDS program
9. Dr. Amal Naguib	Director of virology directorate
10.Faten Mohamed	Counselor
11.Dr.Shaymaa Shawky	Technical manager
12. Mrs. Rania Mohamed	
Ibrahim Galal	Supervisor of the hotline for rehabilitation and social integration
13.Dr. Shaimaa Abd El wahed	Giza Focal Point
14.Dr. Radwa Khayri	Pharmacist
15.Dr. Mahmood El Askalany	Immunology Department Director
16.Dr.Abdel Salam	Head of impact assessment unite
17. Dr Ghada el gameel	Director of Addiction Management
18.Dr. Ashraf Nasr	Nephrology
19.Dr Wagdy	Chest
20.Dr. Fawzy	MCH
21.Dr. Eman abbas	Communicable diseases
22.Dr. Zeinab mounir	Monitoring office
23.Dr. Abdelbaset	AIDS responsible in Cairo
24.Dr. Ahmed elkordy	Al qasr el3einy
UN agencies	
25. Dr Ahmed Khamis	UNAIDS country manger
26. Dr. Alaa Hashish	WHO
27. Dr. Tareq sonnan	UNODC
28. Dr. Maged Ragie	UNICEF
Others	
29. Dr. Ibrahim Elkabbash	Expert
30. Dr. Adel Malek	Expert
31. Dr. Doaa Oraby	Population council

4. ANNEX III B

List of stakeholders responded to the In-depth interviews

NGOs	
1.CARITAS Alexandria	
2.Sehaty men beyaty	
Governmental	
3.Dr Walid Kamal	National AIDS program
4. Dr. Amal Naguib	Director of virology directorate
5.Faten Mohamed	Counselor
6.Dr.Shaymaa Shawky	Technical manager
7. Mrs. Rania Mohamed	
Ibrahim Galal	Supervisor of the hotline for rehabilitation and social integration
8.Dr. Shaimaa Abd El wahed	Giza Focal Point
9.Dr. Radwa Khayri	Pharmacist
10.Dr. Mahmood El Askalany	Immunology Department Director
11.Dr.Abdel Salam	Head of impact assessment unite
12.Dr Ghada el gameel	Director of Addiction Management
13.Dr. Ashraf Nasr	Nephrology
14.Dr Wagdy	Chest
15.Dr. Fawzy	MCH
16.Dr. Eman abbas	Communicable diseases
17.Dr. Zeinab mounir	Monitoring office
18.Dr. Abdelbaset	AIDS responsible in Cairo
19.Dr. Ahmed elkordy	Al qasr el3einy
UN agencies	
20. Dr Ahmed Khamis	UNAIDS country manger
21. Dr. Tareq sonnan	UNODC
22. Dr. Maged Ragie	UNICEF
Others	
23. Dr. Adel Malek	Expert
24. Dr. Doaa Oraby	Population council

5. ANNEX IV

Key informant interview questionnaire guide

Purpose:

To assess the available HIV services in Egypt as well as to identify the challenges and recommendations to improve HIV services in Egypt.

Prepare for the interview

- Make sure you have clarity about the purpose of the interview and the type of information you're looking for.
- Review the interview questions , Be aware of questions that are relevant to the type of stakeholder you'll be interviewing .
- Print a copy of the questions to bring to the interview and make sure you have what you need to record the answers (e.g., a notepad and pen, recording device, etc.)
- Familiarize yourself with the questions you plan to ask.

Conduct the interview

- Explain that the purpose of the interview is to learn as much as you can about the interviewee's experience in order to gain insight into how to improve HIV services and program.
- Assure the interviewee that you welcome detailed feedback, whether positive or negative, about a full range of topics, including how involvement has helped move the research agenda forward; where engagement efforts have been successful and where they have fall en short; where obstacles have been encountered and how they were dealt with ; and what changes might be made to help strengthen engagement and improvement efforts .
- Clarify whether the interviewee will be answering questions from his or her own perspective; as a representative of an organization, institution, or group; or both.
- Conduct the interview, making sure to ask follow - up questions when more information would be helpful.

Document the recommendations

- Compile a master list of recommendations gathered from each interview.
- Review the recommendations, evaluating them for feasibility and importance.

Informed Consent

Interviewer: Read the consent statement below to the interviewee prior to conducting the interview.

Good morning ! My name is____________________

In coordination with the national AIDS program.

We are conducting an assessment on the services provided to people living with HIV (PLHIV) and key populationtogether with the system and policies linked to HIV. This information may help to improve services ,policies and programmes . We would appreciate it if you could answer some questions. However, your participation in this study is voluntary and if you choose not to participate, its up to you. You can also ask me to stop the interview whenever you want. Your participation may result in improved future HIV policies and services. Your opinions and the information you give during the interview will remain confidential. The questionnaire will not have your name. This way, no one will be able to know that I interviewed you or what you said. Finally, if you have any questions about this study at a later time, you can call this phone number …………………

May I continue with the questions?________________________ No __________________

Preliminary Questionnaire Information

1. Interviewer name	
2. Date of the interview	
3. Interviewee name	
4. Interviewee title (position)	
5. Interviewee institution	

I-Services provided and its quality

1.What type of services do you provide in your organization? (please select all that apply)

Primary Health Care Mental Health Care
Maternal/Child Health Care Laboratory
Radiology Alcohol/Substance Abuse
Treatment Pharmacy Services
Family Planning Services Dental Care
Patient Education HIV/STD/Hepatitis C screening
HIV/AIDS Care and Treatment Other (please identify)
Not applicable

2. Can you please describe the service(s) do you provide in details and where do you provide it ?
3. Can you specify which population do you serve?
4. Is the package of services provided (prevention, testing, care) easily accessible? (in terms of time and location)
5. Are there any specific barriers that prevent or make the place uncomfortable for clients (specifically for key population)?
6. How many PLHIV/Key populations have received care here within the past month?
7. What are the working hours or days in which you provide the service(s)?
8. What are the most important barriers preventing PLHIV/key population from having full access to services?
9. What barriers do you experience in providing care to HIV-infected patients/clients?(Probe; Limited Resources, Inadequate Access to HIV Medications ,Lack of Provider Expertise, other Health Priorities, Lack of Provider Interest, Patients/Clients Not Aware of Services, Issues of Confidentiality, Issues of Cultural Competency
10. Under what circumstances, and to whom, do you refer HIV positive patients?
11. To the best of your knowledge, how often do patients follow through on care and/or service referrals? Always/ Almost always/ Sometimes/ Never
12. What is the most common reason(s) patients cite for lack of follow through on referrals?
13. How often do you provide counselling sessions for HIV positive patients or key population and their partners?
14. From your point of view, what is the most effective and efficient manner for patients to receive HIV/AIDS education and training? On what topics?
15. Are condoms available for free for all HIV positive patients and for key population?
16. What are the circumstances where post exposure prophylaxis available? please describe in details the process
    Service integration and partnership (ONLY for policy and decision makers)
17. Do your career allow you to meet directly with PLHA/Key pop?
18. Are you aware of the HIV national strategic framework or plan?
19. Do you participate in the country dialogue process? and what was your role?

20. Do you believe that the national strategic plan (NSP) is comprehensive and rely on realistic situation analysis?
21. Do you have another suggestions or alternative priorities to be considered in the NSP? Open comments
22. Do you or your organization have direct collaboration with the NAP or any other organization? Please describe in details
23. Is there joint planning of HIV and sexual reproductive health (SRH) programmes?

23a. (If yes) How is joint planning of SRH and HIV programmes undertaken?
(For example, dual protection in condom programming, the HIV National Strategic Plan, proposals for the Global Fund, integration of HIV into poverty reduction strategy papers).

23b. Is there any collaboration between SRH and HIV for programme implementation?
(If yes) Provide examples.
Probe;Coordination of activities? i.e how do SRH and HIV coordinatorscollaborate? Monitoring activities? How is the data integrated?Integrated supervision of activities?Integratedbudgets? Do they itemize tools/equipment that can be used for both services?

23c. What institutions are providing integrated services for HIV and SRH?
Probe; Government facilities? NGOs? Faith-based organizations? Community-based organizations? Private sector?

24. What is the government interaction with the CSOs / private sector. Regulation? Collaboration? Sharing supplies? Referral? Probes for types of private sector include NGOs, for - profit facilities, pharmaceuticals, social marketing, etc.
25. Are there regular joint coordination meetings at the national, district, and local level for HIV prevention?
26. Who are the major development partners for the HIV programme?
27. What is the role of civil society in HIV programming (in particular networks of PLHIV)?
28. What is the capacity of PLHIV organizations and networks? i.e. do they have proper structures and/or skills?
29. Are Networks or associations of key populations, (e.g. SWs, IDUs, MSM) involved in HIV responses and programming?
30. What are the main funding agents for HIV activities in Egypt?

II- Testing ,Treatment and Laboratory support:

31.Is voluntary and confidential HIV / AIDS testing widely available?
32. What are the different testing approaches available?
33. To the best of your knowledge, Are the 2015 WHO Consolidated guidelines on HIV testing services adapted on testing?
34. Is HIV testing available for free? Are voluntary and confidential counseling and testing services equally accessible to all PLHIV, including key populations (MSM, SW, IDU)?
35. Do you notify the partner of the HIV postive patient and offered testing for him?
36. Is HIV testing a) Is mandatory before marriage ? b) Is mandatory to obtain a work or residence permit? c) Is mandatory for key population?
37. Do HIV counselling and enrollment with care linked with HIV testing?
38. Do you perform hepatitis C testing as well with HIV testing?
39. Are you satisfied with the level of confidentiality through HIV testing process? If no , kindly clarify
40. How long does it usually take for a patient from HIV testing confirmation till linked to care (PCR / CD4 testing)?
41. If more than 4 weeks, what is/are the probable cause(s) and what are your suggestions to shorten this time?

42. Are you aware about the National testing protocol?
43. Are VCTs and testing facilities easily accessible?
44. Are there any barriers or stigma in the testing settings?
45. Have actions taken by global agencies on testing or treatment had an impact (positive or negative) on service delivery? If yes, for which populations?
46. What is the most common treatment regimen being given to HIV patients?
47. Where are these being dispensed?
48. Are you aware of any medicines disruptions? If so, how often? For How long?
49. What is the recommended CD4 threshold for initiating treatment?
50. Did Egypt adopt the 2016 WHO guidelines (treat for all policy)?
51. Is antiretroviral therapy provided outside public health-facilities?
52. Does routine viral load testing is carried out for monitoring antiretroviral therapy?
53. In accordance with Ministry of Health guidelines, What is the recommended package for preventing the mother-to-child-transmission of HIV?

III- Monitoring and Evaluation

54. Are you aware of patient profile system and the automated healthcare management information system(HMIS) for HIV?
55. Do you have (HMIS) electronic or paper based?
56. Who is responsible for HMIS? How is the data shared and to whom? Who is using these data for programming?
57. what are the different sources for data available?
58. Do you/your organization share data with the NAP? How often? through Paper/email/automated?

IV- Staffing and workforce

59. What are the qualifications and numbers of health care providers for HIV services in your organization?
60. Is there capacity building for health care providers in your organization?
If yes on what topics and how often?

V- Impact of violence and stigma (questions from 61 to 70 for service providers only)

61. What is the first thing come to your mind when you think about HIV positive patient?
62. Are there additional infection control practices you follow when dealing with HIV positive patients?
63. What’s your opinion towards doctors and nurses who provide services for PLHIV?
64. What’s your opinion towards doctors and nurses who refuse to provide services for PLHIV?
65. In your organization, do some providers limit the services they provide? If so, for which population?
66. In your organization, how often do you notice or was reported that health care providers refuse to provide service for PLHIV or referred him to another health care facility?
67. What do you think the reasons behind limiting health care services for PLHIV/key population?
68. What’s your suggestions to build a health care system in Egypt that can provide efficient and effective services for PLHIV/Key population?
69. What’s your suggestions to change health care provider’s negative attitude towards PLHIV?
70. Have you got training(s)to deal with PLHIV anytime in your organization or outside? If yes, how often and on what topics?

Remark: Questions from 71 to 74 only for policy and decision makers

71. How do you assess the role of violence and stigma in accessing services available for PLHIV / and for key population?
72. To the best of your knowledge, where do PLHIV experience discriminatory attitude?
73. Are there programs to fight against violence and / discrimination, especially for key populations? If so, how are they implemented in relation to the offer of testing, care and treatment?
74. Thinking out of the box, what are your suggestions to end stigma and discrimination towards PLHIV in the Egyptian context?

VII- Legal assessment

75. Is HIV a nationally notifiable condition by law?

76.Are there laws requiring parental consent for adolescents to access HIV testing?

77. Are there laws requiring parental consent for adolescents to access HIV treatment?
78. Are there laws that criminalize homosexuality / drug abuse / addiction prostitution?
79. Are there laws that criminalize AIDS?
80. Are there laws that distinguish PLHIV and prevent them from working, studying or travelling abroad?
90. Are there laws that distinguish Key population and prevent them from working, studying or travelling abroad?
91. Are there any laws obligating PLHIV to disclose their status to health care providers?
92. Are there any laws obligating key population to disclose their behavior to health care providers?
93. Are there any laws obligating healthcare settings to provide timely and quality health care regardless of the behavior or HIV status?
94. Are there laws criminalizing health care providers who refuse to provide services for PLHIV?
95. Are there laws criminalizing employers who refused to appoint PLHIV or Key population or even separated them from their work after knowing their status?
96. Are there any laws criminalizing the intended transmission of or exposure to HIV partners?
97. Are there any laws or policies restricting the entry, stay and residence of people living with HIV to Egypt? In which cases.

Finally, thank you so much for taking the time for conducting the interview, we really appreciate your great input and added value to improve HIV services in Egypt.

FORSS

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AL-SHEHAB INSTITUTION FOR PROMOTION AND COMPREHENSIVE DEVELOPMENT

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