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Ministry of Health & Population
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UNAIDS

Egypt National HIV Strategy 2021-2025

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HIV National Strategic Plan 2025-2021

This Updated National Strategic Plan 2025 – 2021 comes to reinsure our national commitment to align with the global AIDS strategy that aims to achieve the sustainable development goals to end the AIDS epidemic as a public health threat by 2030.

The world has taken great steps toward ending the HIV/AIDS epidemic in all strategic areas including prevention , care and treatment and enabling the environment initiatives though after more than 40 years from detecting the first HIV case in 1981 , yet HIV/AIDS still represent a real challenging threat on the public health in the world.

Egypt has been always committed to tackle all initiatives and services that can accelerate the National response , milestones in provision of care and treatment to people living with HIV were achieved and acceleration in the prevention and harm reduction axes are addressed clearly in this national strategic plan.

This plan is a consolidated document that guide all the national efforts gathering the governmental, community-based organizations and international organizations on the same floor with unified national vision to maximize the benefits of the available potentials and resources. This plan is the leading tool to achieve the catalytic HIV response covering the national strategic directions addressing the national priorities.

MoHP developed this strategic plan as part of MoHP role as the Leading and governing body for the national HIV response as to lead the collaboration among the national partners including governmental, non-governmental, international organizations and UN agencies to ensure alignment with the National strategic plan and commitment to the national priorities with clear outcomes that aim finally to enhance the response.

This plan was developed adopting a wide country dialogue including all HIV stakeholders and representatives from people living with HIV as well.

I would like to take this opportunity present my great appreciation to all our partners in the national HIV response with special thanks to UNAIDS country office for their sincere efforts and WHO country office for collaborating in this update.

H.E Minister of Health and Population

Forward

UNAIDS is delighted to support Egypt's commitment towards achieving 'Zero HIV/AIDS in line with the Sustainable Development Goals (SDGs). The National HIV Strategy 2025-2021 aims to ensure that national commitments align with the global targets and expand the equal access of all people to health services as to end the AIDS epidemic by 2030 as a public health threat.

This strategy is considered as a consolidating document to guide the stream, reach and quality of the planned interventions and as a leadership tool to assess the impact of national targets across different dimensions.

This strategy is believed to strengthen the implementation of actions that aim to catalyze the national response to achieve universal HIV control, focusing on increasing the effectiveness of the combined preventive efforts, reaching key affected populations, and providing easy access to quality health services free of stigma and discrimination. The strategy gives special attention to ensure young people and women access to health as part of the comprehensive basic package. In addition, it will ensure high quality management and treatment with continuous streaming of services for all People living with HIV with the equity including refugees, migrants, prisoners and most vulnerable for both women and men.

UNAIDS is keen to strengthen national governance and ownership through full supervision of all activities provided by governmental, non-governmental and international organizations to ensure consistency with the national plan, compliance with the set priorities, clear mapping of actions, comprehensive data collection and analysis and overcoming duplication of efforts.

UNAIDS will continue collaboration with GOE and partners to achieve effective, efficient solutions informed by evidence and work to strengthen the strategic information and data for impact. and will considered an excellent opportunity to engage, integrate and scale up the community-based organizations.

I would like to take this opportunity to express my great appreciation to our partners on the national response for their highly effective efforts and very sincere gratitude to my colleagues in the National AIDS Program at MoHP.

Finally, I would like to appreciate His Excellency Minister of Health and Pop¬ulation 's leadership and guidance to ensure HIV/AIDS services availability under Universal Health Coverage and to recognize the thanks to the national AIDS Program for their support and energy to bring this updated strategy for better health for all leaving no one behind.

Walid Kamal Ibrahim

Walid Kamal

UNAIDS Country Director

Egypt

Forward

WHO is pleased to support Egypt's commitment to achieving "Zero HIV/AIDS" as a national proiority, which will contribute to the attainment of Sustainable Development Goals (SDGs)

The National HIV strategic plan 2025 -2021 is an important foundation for Egypt's HIV response aligned to the commitment to ending the AIDS epidemic as a public health threat by 2030.

The new strategy vision is to end epidemics and advance universal health coverage through primary health care contributing to health security in a world where all people have access to high-quality, evidence-based and people-centred health services.

WHO hails Government of Egypt bold targets in the strategy : the elimination of mother to child transmission by 2025 and by 2030 the achievement of 95-95-95 .This means that it aspires to diagnose %95 of all HIV-positive individuals, provide antiretroviral therapy (ART) for %95 of those diagnosed and achieve viral suppression for %95 of those treated.

Through multisectoral co-operation and collaboration, this strategy focuses on implementation. It includes all stakeholders and different partners at all levels (governmental sectors , civil society and private sector) and as WHO we are pleased to be part of it.

To ensure no one is left behind , the strategy focuses on target groups , and seeks to address human rights related barriers to HIV services, with the aim of improving access to quality services in an equitable manner

Finally , I would like to salute His Excellency Minister of Health and Population's leadership and efforts to ensure expansion of HIV/AIDS services and care in all governorates to achieve better health outcomes for People Living with HIV/ AIDs and Key population towards achieving Universal health coverage for all , leaving no one behind.

Dr. Naeema Al Gasseer

WHO Representative Egypt
& Head of Mission

Forward

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Acronyms

AIDS Acquired Immune Deficiency Syndrome
ANC Antenatal care
ART Antiretroviral therapy
CBO Civil Society Organization
EID Early infant diagnosis
FSW Female sex workers
GBV Gender-based violence
GF Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV Hepatitis B Virus
HCT HIV counselling and testing
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
HMIS Health Management Information System
IBBSS Integrated bio-behavioural Surveillance Survey
IEC Information, Education and Communication
KP Key population
MoHP Ministry of Health and Population
M&E Monitoring and evaluation
MENA Middle East and North Africa
MSM Men who have sex with men
NAP National AIDS Program
NGO Non-governmental organization
NSF National Strategic Framework
NSP National Strategic Plan
PAP Priorities Action Plan
PITC Provider-initiated testing and counselling
PLHIV People living with HIV
PMTCT Prevention of mother-to-child HIV transmission
PWID people who inject drugs
SBG Street boys and girls
SDGs Sustainable Development Goals
SRH Sexual and reproductive health
STI sexually transmitted infection
UN United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDO United Nations Development Program
UNHCR United Nations High Commissioner for Refugees
VCT voluntary counselling and testing
WHO World Health Organization

Executive Summary

The prevalence of HIV among the general population remains low in Egypt. That is supported by data from HIV testing services (HTS) provided to pregnant women. However, Egypt continued to witness an increasing trend of HIV new infection and incidence rate, which is reflecting a rapidly evolving disease spread. The incidence rate has increased by five folds between 2010 and 2019. In 2019, men (mainly young men aged between 15 and 24 years) had the highest HIV new infections compared to women. There was a rapid increase in the estimated number of adults and children living with HIV in the country during the period 2015 and 2020. UNAIDS Estimated around 24,000 People Living with HIV by end of 2020 in Egypt. Programmatic data on HIV testing and surveillance continue to indicate that specific population groups are increasing risks of new HIV infections. People who inject drugs (PWID) and other men who engage in sex with men (MSM) are at higher risk of HIV infection than other population groups. Despite the focus on PWIDs and MSM, data from HIV testing and assessments indicate the significance of other population groups at risk of HIV infection due to specific risk factors.

The rise in new HIV cases and infections has another face, which is the increasing cost for enrolling people on life-long treatment. The number of patients receiving ART (and associated budget) has grown by 50 times between 2008 and 2020. The potential macroeconomic impact of AIDS could be associated with the rise from rising morbidity (rising number of new infection). Given the current epidemiological context, the decision-makers in Egypt should become aware of the potential risks of rapid (uncontrolled) disease incidence in the long term.

Since the country's first AIDS case was discovered in 1986, Egypt's commitment to controlling the HIV epidemic has been demonstrated. The ongoing efforts confirm Egypt's commitment to the international declaration and the achievement of the Millennium Development Goals. The HIV response has witnessed important milestones in the last two decades. During the program review, stakeholders indicated different gaps within the current scope of the national response. The detailed gaps and their contributing factors have been addressed through the strategies and priority actions targeted in this NSP.

The process of developing this National Strategic Plan was highly participatory involving key stakeholders and interest groups including communities of people living with HIV at national and sub- national levels. The process was mainly supported through the programmatic technical groups that met regularly with respective consultant in working sessions to provide their inputs and technical advice. The technical groups were composed of representatives from all groups of stakeholders involved in the national HIV response including all Ministries, departments and agencies, Civil Society Organizations (including PLHIV), private sector partners, different units of government, development partners.

Strategic issues considered by the NSP:

1. This plan will build on previous successes and it will stress the renewed engagement and high-level political leadership spearheading the HIV response, as well as the growing co-operation between government and its partners.
2. This NSP will scale up and strengthen the program to maintain complete elimination of mother-to-child transmission of HIV, the increase in the number of people testing for HIV; to initiate to all HIV positive people antiretroviral treatment (ART).
3. The NSP will enhance the introduction and scale up of prevention services targeting the key populations and other priority populations owing to their vulnerabilities to HIV transmission risks, for being youth, migrants, refugees or persons in closed settings and commit to focus on the drivers of the HIV epidemic and to address the social determinants of health.
4. The new plan will maintain the universal access to key commodities, including antiretroviral drugs (ARVs), and will try to mainstream HIV care and treatment in the overall health care delivery system.

5. The new NSP should strengthen the involvement of the NGO and private sector in service delivery, including the involvement of the PWID and MSM community in delivering services for HIV prevention, diagnosis, linkage to care and treatment and further support to their community members.

Guiding principles and expectations

The NSP 2021-2025 provides strategic guidance for HIV activities for the next 5 years in line with the set vision, goals, and objectives. It focuses on the drivers of the HIV and builds on the achievements of the previous NSP. It is meant to scale up what has been done well, and improves the quality of services, while at the same time integrating new and proven strategies. This NSP is intended to respond to the rapid changes in the epidemic and will, therefore, be reviewed regularly for relevance and effectiveness. It is meant to be in line with the broader development plan of government. It is a multisectoral plan that will inform stakeholders, at various levels, on the strategic directions to be considered when developing implementation plans.

NSP vision for 2025

The strategic plan outlines a national vision aligned with the global vision. The NSP 2021-2025 is driven by a long-term vision for the country with respect to the HIV epidemic. It has adapted the Three Zeros advocated by UNAIDS to suit the local context.

The vision is: Zero new HIV infections; Zero new infections due to vertical transmission; Zero preventable deaths associated with HIV; and Zero discrimination associated with HIV.

NSP goals for 2025

The goals are set taking into consideration to "End the AIDS" epidemic as a public health threat by 2030 within the context of ensuring healthy lives and promoting well-being for all at all ages. Consequently, in line with this five-year vision, the NSP has the following broad goals in:

A. Prevention
- Achieve reduction in new HIV infections, including among key and vulnerable populations
- Validate and maintain zero new mother to child transmission of HIV

B. HIV-related deaths
- Reduce National HIV-related deaths
- Reduce TB deaths among people living with HIV
- Reduce Hepatitis B and C deaths among people co-infected with HIV.

C. Testing and Treatment
- Ensure that 95% of people living with HIV know their virus status
- Ensure that 95% of people diagnosed with HIV are receiving ART
- Ensure that 95% people diagnosed with HIV on treatment achieve viral load suppression.

D. Stigma and Discrimination
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support the implementation of the NSP and
- Have no HIV-related discriminatory laws, regulations and policies, and no HIV-related discrimination in all settings, especially in health settings
- Reduce self-reported stigma and discrimination related to HIV.

NSP Strategic Directions

This NSP draws on three organizing frameworks: universal health coverage; the continuum of HIV services; and the public health approach. Consequently, it was decided to have five strategic directions (SD's) that would cover the whole spectrum of the projected Egypt national NSP for 2021-2025. Each SD has a series of objectives to aim for; in addition to a list of actions or activities that need to be implemented targeting measurable outcomes; interventions that are evidence based with high impact.

- ✓ **Strategic Directions 1: HIV primary prevention among key and vulnerable populations and among young people in the community**
  - **Strategic Objective 1: Scale-up of primary HIV prevention targeting the key populations by 95% of the KPs size estimate**
    - Strategic outcome 1.1. Expansion of comprehensive harm reduction approach
    - Strategic outcome 1.2. Reduction of sexual transmission among key populations
    - Strategic outcome 1.3. Addressing the needs of people in prison and detention
  - **Strategic Objective 2: Enhance HIV prevention related knowledge and skills among Adolescents, young people by 50% of the global targets**
    - Strategic outcome 2.1: Awareness raising and prevention services
    - Strategic outcome 2.2: Addressing the needs of young key populations
    - Strategic outcome 2.3: Addressing the needs of refugees and migrants
    - Strategic outcome 2.4: Enhancing condom programming
- ✓ **Strategic Directions 2: Diagnosis, treatment, care, and support for people living with HIV**
  - **Strategic Objective 3: 95% of estimated HIV-positive persons are diagnosed and started antiretroviral therapy**
    - Strategic outcome 3.1: Enhance HIV Testing Strategy and Policies
    - Strategic outcome 3.2: Increase knowledge of HIV status and reach undiagnosed PLHIV
    - Strategic outcome 3.3: Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment
    - Strategic outcome 3.4: Re-link all of people living with HIV who are lost from treatment
  - **Strategic Objective 4: 95% of HIV-diagnosed individuals started on antiretroviral therapy and are retained on treatment**
    - Strategic outcome 4.1: Enhance enrolment, retention in care, and service quality
  - **Strategic Objective 5: 95% of PLHIV who are currently on treatment have achieved and maintained viral load suppression**
    - Strategic outcome 5.1: Scale-up of viral load testing and monitoring
    - Strategic outcome 5.2: Increase adherence to HIV treatment
    - Strategic outcome 5.3: Identity, engage, or re-engage people with HIV who are not virally suppressed
  - **Strategic Objective 6: Validate and Maintain Zero vertical transmission from mother to child through high-quality care for HIV-diagnosed pregnant women and pediatric service**
    - Strategic outcome 6.1: Increase knowledge of HIV status among pregnant women
    - Strategic outcome 6.2: Early infant diagnosis (EID) and continuous monitoring and treatment

- ✓ **Strategic Directions 3: Strengthening the availability and use of strategic information on HIV**
  - **Strategic objective 7: strengthen HIV surveillance system and invest in strategic information by end of 2022**

- ✓ **Strategic Directions 4: Strengthening access to key HIV services, addressing inequalities and ensure supportive social, legal and policy environments**
  - **Strategic objective 8: National HIV response in Egypt addresses key barriers and inequities**
  - **Strategic outcome 8.1: Reduce disparities and inequalities across the continuum of care and services**
  - **Strategic outcome 8.2: Encourage community participation in HIV response**
  - **Strategic outcome 8.3: Reduce HIV-related stigma and discrimination**
  - **Strategic outcome 8.4: Address sexual and gender-based discrimination**
  - **Strategic outcome 8.5: Relevant Leadership, legal and policy framework**

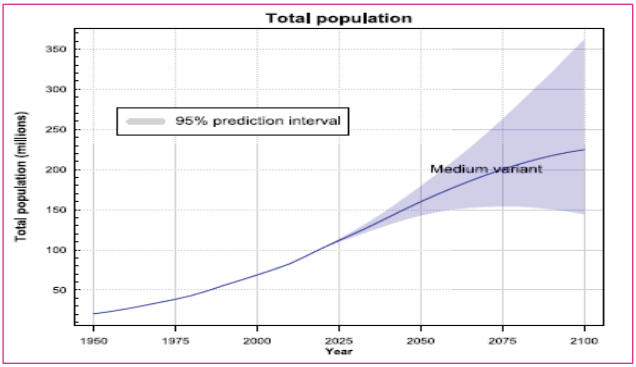
- ✓ **Strategic Directions 5: Strengthening technical, organizational, and institutional capacity of the local implementers**
  - **Strategic objective 9: Strengthen the partnership, CSOs engagement and invest in strengthening NAP capacity**

HIV Epidemic in Egypt: Epidemiological Analysis

Demographic data and trends

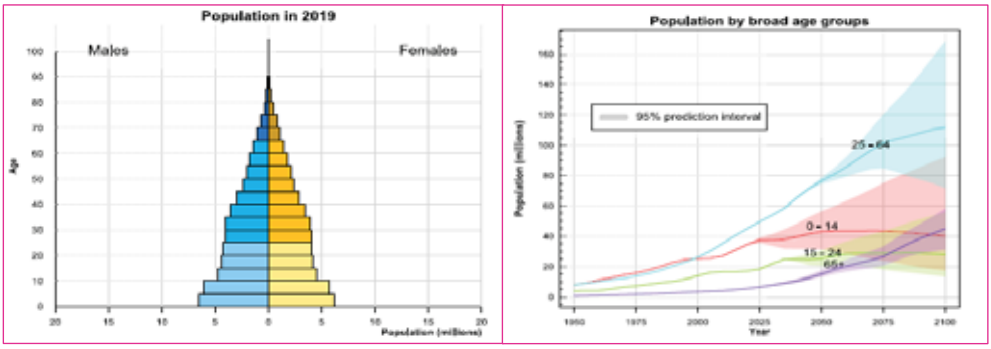
Egypt is the most populous country in the Middle East and the third-most populous on the African continent. Egypt has a population of around 102.3 million by the end of 2020. It is currently estimated that 24,000 people with HIV in Egypt by end of 2020.

The population is currently growing at a rate of 1.94%, which adds about 2 million people to the population every year.



Source: https://population.un.org/wpp/Graphs/1_Demographic%20Profiles/Egypt.pdf

Egypt's population is generally rising at an extremely progressive rate, especially among young populations, causing concerns and an increase in expenditure on family planning policies.



Source: https://population.un.org/wpp/Graphs/1_Demographic%20Profiles/Egypt.pdf

Trends in HIV incidence

It is estimated that 2800 new HIV infections occurred every year in the last five years (i.e., eight new infections every day)

Egypt continued to witness an increasing trend of HIV new infection and incidence rate, which is reflecting a rapidly evolving disease spread. The incidence rate has increased by three folds between 2010 and 2020 . In 2020, men had the highest HIV new infections compared to women.

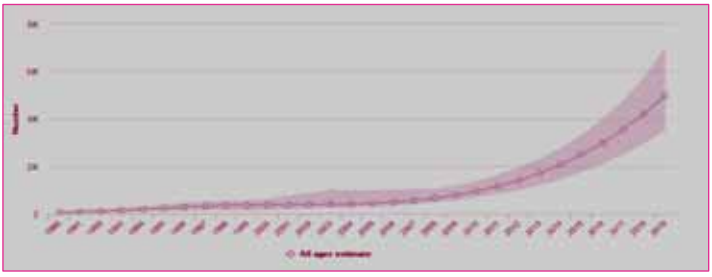


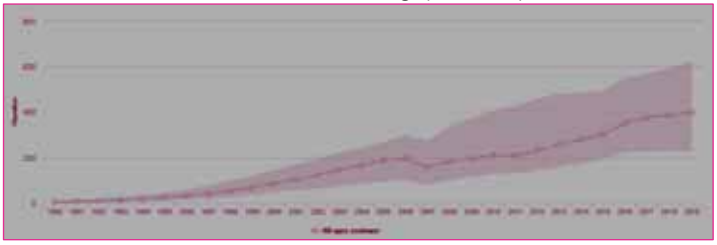
Table (XX): estimated HIV New Infections by gender and key age group, 2016-2020

	2016	2017	2018	2019	2020
All population	2300	2600	2800	3000	3300
Adults, 15+ years	2200	2500	2700	2900	3200
Female, 15+ years	500	520	570	620	690

AIDS-related mortality

While the absolute number of AIDS-related death continued to increase, the relative (percentage) people who died after enrollment in treatment and care steadily dropped, this might reflect efforts in the last years to achieve early detection of patients as well as the improvement in treatment and care process, including treatment adherence and retention on treatment.

AIDS-Related Deaths, all age (1990-2019)



Population groups at the highest risk of HIV infection

Programmatic data on HIV testing and surveillance continue to indicate that specific population groups are at increasing risks of new HIV infections. People who inject drugs (PWID) and other men who engage in sex with men (MSM) are at higher risk of HIV infection than other population groups. As will be discussed later, prevalence data indicate that the HIV epidemic is concentrated among these two population groups.

Despite the focus on PWIDs and MSM, data from HIV testing and assessments indicate the significance of other population groups at risk of HIV infection due to specific risk factors including; people in prisons or in detention , refugees, and migrant communities.

Prevalence in key and vulnerable populations

Data on the prevalence of HIV among the key and vulnerable population is not up to date. The last integrated biological and behavioral surveillance surveys (IBBSS) among the key populations were conducted by NAP in 2010. Below is a summary of key provenance data from these surveys:

Table ( ):

PWIDs	MSM	SBG	FSW	TG
7.1%	6.1%	0.5%	0.0%	No data

FSW = Female Sex Workers, SBG = Streets Boys, and Girls, TG= Transgender

Programmatic data is useful to understand the level of HIV prevalence among the key population. Interpretation of HIV-reported cases from these populations should be made carefully, however, as it does not provide systematic screening with multiple sources of bias. The table below summarizes data about mode of transmission (MOT) for some of the PLHIV as registered by the national program as part of the surveillance system data.

Table ( ) :

	2020		2019		2018		Average
	PLHIV	% of known MOT	PLHIV	% of known MOT	PLHIV	% of known MOT	% of total 3 years
PWID	725	75.2%	911	69.1%	835	62.6%	**69%**
MSM	175	18.2%	212	16.1%	462	34.6%	**23%**
Prisoners	64	6.6%	193	14.6%	33	2.5%	**2.5%**
FSW	0	0.0%	3	0.2%	4	0.3%	**0.2%**
Known MOT total	**964**		**1,319**		**1,334**		**3,617**

Gaps in strategic epidemiological data:

The availability of strategic epidemiological data is key for robust strategic planning. There are some gaps identified in this area that needs to be prioritized and addressed. The program review identified the following gaps:

- Outdated HIV prevalence data among the key populations (mainly PWID and MSM).
- Unavailability of HIV incidence data among other groups at high risks.
- Unavailability of HIV testing volume data disaggregated by age, gender, and governorates.

Geography

In 2020, greater Cairo and Alexandria reported more than 60% of the total national figure.

Co-infections

Egypt used to be one of the countries reported the highest prevalence rate of Hepatitis C Virus (HCV) infection, before the launching of the presidential initiative of elimination of hepatitis C at national level. Together with the risk of blood-borne hepatitis C infection from using non-sterile injecting equipment. Accordingly, HCV is a common co-infection among HIV patients.

The Egyptian demographic health survey2014 (EDHS) showed a 7% HCV prevalence among the general population (age 15-59 years). Given this context, it is also anticipated that a significant proportion of PLHIV is also infected with HCV.

Although the seroprevalence of hepatitis B among the general population is much lower than that of hepatitis C (1%), hepatitis B is also a co-infection of people who are living with HIV. Hepatitis B is addressed nationally through a routine vaccination program.

Sexually transmitted infections (STIs) can cause considerable morbidity in both adults and newborn infants and many of them amplifying the risk for HIV transmission. The prevalence and incidence of STIs in Egypt have remained mostly unknown. In Egypt, the STIs surveillance is in initiation and transitional phase, information on the status of STIs surveillance and control obtained from focal points in MoPH. The MoPH in Egypt has reported antenatal syphilis rate below 0.01%, while data revealed from studies on the high-risk groups showed higher infection rates, for example, syphilis seroprevalence is 7.5% among MSM (biobehavioral survey 2010).

HIV and TB

Egypt is experiencing a low-level HIV epidemic and is not a high burden country for tuberculosis. Between 2010 and 2017, the estimated prevalence of co-infection with HIV among them was around 0.2%.

HIV Response in Egypt

Since the country's first AIDS case was discovered in 1986, Egypt's commitment to controlling the HIV epidemic has been demonstrated. The ongoing efforts confirm Egypt's commitment to the international declaration and the achievement of the Millennium Development Goals. Since 2004, following the approved three principles, the National Action Plan is considered Egypt's sole coordinating agency for HIV/AIDS.

Given the nature of the HIV epidemic, that is, as a concentrated epidemic, Egypt’s HIV response continues to strive to adopt appropriate interventions to deal with the causes of most new infections and the increase in the burden of cases. Regarding the factors identified in this report. Epidemiological, social, and demographic background. To some extent, people understand the driving factors of the HIV epidemic in Egypt, namely behavioral, socio-economic, and structural factors. As in other situations, in Egypt, gender norms and masculinity, gender relations, and stigma and discrimination against specific social behaviors may also increase the risk of HIV infection among vulnerable people. Risky sexual behaviors, such as early sexual activity and unprotected sex with multiple simultaneous sexual partners. Other high-risk behaviors, such as injecting drugs and unprotected anal sex, are increasing in certain populations, mainly in rapidly growing poor cities and surrounding communities.

The HIV response has witnessed important milestones in the last two decades. The table below highlight some of these remarkable achievements of the response:

1986	First AIDS case reported in the country
1987	The establishment of the National AIDS Program (NAP)
1987	Establishment of multisectoral National AIDS Committee
2006	ARV treatment (ART) has been made available
2007	First HIV National Strategic Plan 2007-2011 was developed
2008	The Country Coordinating Mechanism (CCM) for the Global Fund was established
2008	First Global Fund HIV grant proposal accepted, which has provided
2004	VCT centers were established countrywide
2006	First IBBS study among the key affected population
2008	The first project to target FSW populations with comprehensive HIV services
2008	Establishment of VCT services, PMTCT, and PEP by Refugees Egypt to target refugee populations
2008	First population size estimates among PWID
2009	The first project to target MSM populations with comprehensive HIV services
2010	Second IBBS study among the key affected population.
2011	Movie Asmaa was released as a feature film aimed at giving HIV/AIDS a human face in Egypt
2013	Feasibility Study and Operational Plan for Opioid Substitution Treatment in Egypt
2015	Second HIV National Strategic Plan 2015-2020 was developed
2015	ART centers scaled to cover 14 governorates
2017	The rollout of the 'Test and Treat' approach The government took over 100% of financing or ARVs from national resources (started 2014)
2018	Revision of the Second National HIV Strategic Plan 2018 – 2022
2020	Official introduction of OST as key intervention targeting PWID Establishing National HIV Scientific Committee ART centers scaled up to cover the 27 governorates
2021	Third HIV National Strategic Plan 2021-2025 was developed – Updating National HIV Care and ART Guidelines

Outcomes from the previous NSP:

Egypt has made significant progress to achieve the targeted objectives and outcomes in the previous NSP 2018-2022. While the progress made was considered average at the outcomes level, the national program invested more on establishing and strengthening the needed infrastructure and creation of the enabling environment that could be utilized a s an asset in the fourth coming NSP.

Key achievements:

1. Significant increase in number of people living with HIV know their HIV status in all the governorates and mainly in Cairo, Giza, Alexandria, and Garbia.
2. Scaleup and availability, access and uptake of HIV testing and counselling were significantly increased.
3. Remarkable lowering rates of loss to follow-up for HIV care and treatment of newly confirmed cases of 2017 baseline by 2020.
4. More than 15% increase in number of all people living with HIV who know their HIV status are enrolled in treatment by 2020.
5. Achievement of 96% viral suppression among all people living with HIV enrolled on treatment maintain viral suppression by 2020.
6. Expansion of HIV testing, treatment and care services targeting pregnant women in most of the governorates.

Gaps in the response:

During the program review, stakeholders indicated different gaps within the current scope of the response. The detailed gaps and their contributing factors will be elaborated in detail in the subsequent sections. However, the following were considered as the most significant gaps that need to be addressed by the new NSP:

1. While the national program and stakeholders have identified the targeted population for HIV services, including the key populations and other vulnerable groups, the HIV coverage was short of reaching these populations. That has a significant impact on the ability of the national response to achieve its targets.
2. The coverage gap is associated with the limited availability and accessibility of the services mainly the prevention and outreach services to specific locations (i.e., governorates or cities). That has been shaped by the concentrated nature of the epidemic and the limited availability of financial resources to support the outreach programs.
3. While Egypt has improved its treatment and care significantly, still the expansion of HIV testing to diagnose PLHIV who are unaware of their status is an important area for expansion.
4. Data indicates the importance of giving attention to other population groups who might not have received enough attention in the previous periods. These include people in prisons, refugees, asylum seekers, migrants, and people living in specific locations or communities. While there were continuous efforts to offer the services to these population groups, there was a consensus on the importance of devoting further attention and more focused efforts to provide more services and reach more people among these groups. This was considered important to ensure achieving the principle of “no one is left behind”.
5. Gap in HIV strategic information to guide the national response remain a priority for the next period.

Legal, social, and cultural environment

The legal and social environment for HIV prevention and care is complex but changing on different dimensions. The behaviors of the key populations are criminalized, while street children continued to be marginalized and associated with different vulnerabilities to HIV infection. Many challenges continued to face prisoners, refugees, asylum seekers, and migrants as far as accessibility to preventive services are concerned.

This context contributes to widening the stakeholders' ability to respond to the needs of key and vulnerable populations in a meaningful manner.

Egypt continues to host large numbers of refugees and asylum seekers from more than 50 countries of origin. More than half are from Syria, and most of the rest are from countries in sub-Saharan Africa, Iraq, and Yemen. Most people live in urban areas with the host community in circumstances that might increase their exposure to risk factors associated with transmission of infectious diseases, including HIV.

National HIV prevention road map

UNAIDS and partners have developed the HIV Prevention 2020 Road Map through a consultative process to set the pathway for achieving global HIV prevention goals by 2020. The road map applies to many countries, but it focuses on 25 countries with high numbers of new HIV infections among adolescents and adults. While Egypt does not fall within the targeted group of countries, this section will be guided by the main outlines and pillars set in the Road Map.

The current situation will be discussed against the key actions outlined in the Road Map developed by Global Prevention Coalition:

1. **Strategic assessment of key prevention needs and identify policy and program barriers to progress.**
   There were no formal expanded prevention needs and policy assessments conducted in Egypt in the last years. However, the mid-term program review in 2018 and the end-term program review of 2021 have emphasized understanding the prevention landscape, focusing on measuring progress using available data across the prevention pillars as relevant.

2. **National targets and road maps for HIV prevention 2020**
   The NSP 2018-2022 has set a clear focus on prevention targets and strategies, emphasizing condom programs, combination prevention young population, and combination prevention with the key population (PWID and MSM). As Egypt is a predominantly Muslim society, male medical circumcision was not a target or strategy under the previous strategic plan. In addition, with the lack of adequate local evidence to support the introduction of pre-exposure prophylaxis, together with limited availability of resources, the stakeholder did not include this intervention as part of the previous strategy. The national strategic and operational plans have indicated clear steps for rapid scale-up to meet coverage and output targets.
   As highlighted before, the program achievements in the prevention pillar, especially the service coverage, have been considered one of the main weaknesses and gaps in implementing the national plans in the previous period. Multiple factors have contributed to these gaps; however, adequate financial resources have been the cross-cutting issue across all three pillars. Further details will be provided under each subsequent section.

3. **Institutional changes to enhance HIV prevention leadership, oversight, and management**
   GoE, through the MoHP, has established and designated different national committees that supported the implantation of the NSP in the previous period. These committees played a central role in coordinating and overseeing the implementation of different components of the HIV program, including aspects related to primary

prevention programs across all sectors. This entailed strengthening the national mechanisms for cross-sectoral collaboration on HIV prevention and implementing national policy and associated reviews and guidance. A dedicated national committee was established in March 2021 to focus on the enforcement of harm reduction and opioid substitution therapy (OST) as the main national program to address PWID needs.

4. **Legal and policy changes to create an enabling environment for prevention programs**

Since the introduction of the last NSP, Egypt has taken implementation steps to address key barriers and create an enabling environment for successful prevention programs, focusing on lifting the structural and policy barriers to access services among PWID as a priority population. Further details will be elaborated on below. While there are breakthroughs in addressing policy barriers in the mentioned area, challenges still exist to address some of the structural barriers to address the needs of other key populations like MSM or other vulnerable populations like transgender people.

5. **National guidance, formulate intervention packages, identify service delivery platforms, and update operational plans.**

While the work on enhancing the preventive services in Egypt has a long history with many programs and projects, there is still a gap in national guidelines that identify the intervention packages of services to different targeted populations. NAP and stakeholders are committed to operationalizing more focused and people-centered systems and services in the next period. With the establishment of the dedicated committees that will support the national program, these committees and their taskforces could guide implementors and service providers on operationalizing the prevention policies in specific service packages to achieve the desired objective. While the country has adopted 2016 WHO consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations, these guidelines were not adapted to national guidance on combination prevention packages for key populations yet.

On the other hand, The MoHP has issued the National Guidelines on Clinical Care and ARV Drugs for Treating and Preventing HIV Infection in January 2021. Among the wide range of service pillars, the guidelines provided guidance on HIV prevention based on ARV drugs. The guideline covered aspects related to three interventions, namely (1) Prevention of Mother to Child Transmission (PMTCT), (2) Post-exposure prophylaxis (PEP), and (3) Oral pre-exposure prophylaxis (PrEP). The availability of this guidance will support the service providers to enhance the standardization of services in the next period. Service delivery platforms for various interventions and packages will be identified, promoting the integration of HIV with other services, and standard operating procedures for implementers will be issued for both facility-based and community-based programs. Based on revised national targets and defined program packages and operating procedures, countries will develop or update operational plans, including national and subnational programs and activities.

6. **Prevention capacity-building and technical assistance plan**

Multiple training and/or capacity-building program activities were implemented targeting people living with HIV and key populations to educate them and raise awareness concerning their rights (in the context of HIV). UNAIDS and WHO continued to support the NAP and national stakeholders through multiple activities through expert capacity building workshops in different areas. For instance, gender-sensitive services targeted to enhance the sexual and reproductive health of women living with HIV have been expanded in 2018 through the technical support of UNAIDS and currently cover three Egyptian governorates. While many other build capacities exist, there is no clear plan for technical assistance as part of operational plans.

Planning for technical assistance will form part of the operational planning processes. It will involve mapping existing in-country champions and technical experts, including those currently working on prevention projects led by civil society or funded by international donors rather than the national program. A technical assistance plan may cover mobilizing expertise on high-priority program components and crosscutting and policy issues, facilitating the establishment of implementers' networks for specific pillars and developing communities of practice, identifying gaps, and developing a consolidated request for international assistance where in-country expertise is lacking. The

civil society will play a leading role in establishing and implementing mechanisms for ongoing monitoring of HIV/AIDS policies and performance and other factors relevant to HIV prevention, HIV care and support services, financing of programs, and meeting structural challenges such as stigma and discrimination and gender-based inequalities.

7. **Introduction of social contracting mechanisms for civil society implementers and expand community-based responses.**
   The previous NSP highlighted the potential of expanding health services delivery through piloting and expanding social contracting mechanisms; the current policy environment is not conducive to implementing this intervention. There was no model explored during the previous period. However, with the current attention and focus on prevention services, there are opportunities to explore the willingness of government institutions to provide funding for civil society implementers to provide the targeted services. This will help generate demand for prevention programs and services, facilitate access, and expand community-based programs' coverage. It is also important to enhance these community-based organizations' capacity to participate in the collection of information on key populations.

8. **Availability of resources for prevention and develop a strategy to close financing gaps**
   With the absence of a recent National AIDS Spending Assessment, it is not possible to better understand the availability of resources to support HIV prevention programs. While projects do exist and operate, no formal assessment was conducted to obtain a comprehensive picture of the resources, need availability, and gaps.

9. **Strengthening of prevention program monitoring systems**
   Since 2017 the UN Joint team in Egypt has implemented joint support for the National AIDS Program to build a novel approach to testing and preventing key populations. The focus was on fostering a Government-CSO model in key strategic governorates (Cairo, Alexandria, and Gharbya), where CSOs rolled out outreach services and built a referral pathway to government-led and supported VCTs centers while ensuring they are user friendly to KPs through constant capacity building and monitoring. The approach requires intensive efforts to strengthen the data systems, including capturing, analyzing, and reporting key programmatic indicators.
   Egypt was part of a multi-country grant from the Global Fund, which is implemented through some CSOs, while other CSOs succeeded at securing funding through technical support from the French 5% Initiative. In 2019, multiple workshops were conducted in the field of monitoring and evaluation. The workshops were conducted in partnership with grant recipients, included all sub-recipients, and were designed to increase the technical knowledge of local CSOs in data collection and indicator reporting in their communities. There is a need to continue to strengthen accountability by issuing special prevention reports, regular reporting, and annual joint reviews among stakeholders.

10. **Strengthening of the national and international accountability for prevention**
    The National AIDS Program continued to compile data to develop the Global AIDS Monitoring (GAM) annual reports. The process receives technical assistance from UNAIDS and inputs from national stakeholders, including civil society organizations (CSOs), UN agencies, academia, youth-led organizations, and people living with and affected by HIV. While the GAM is not specifically focusing on prevention, it has been an important accountability framework that serves as a useful tool for a regular review of performance at all levels. The HIV prevention scorecard has not been developed or issued to monitor the combination of coverage. Working with local and international partners to enhancing monitoring and reporting mechanisms is essential. Investment in the data system, especially for key population programs, will remain an important area.

Macroeconomic situation and HIV Impact

According to World Bank and OECD (source), Egypt has experienced growth acceleration since 2015. The growth reached 4.2% in 2016/17, 5.3% in 2017/2018 and is projected to strengthen further in 2021 and beyond, despite the decline during 2020 due to the impact of the COVID-19 pandemic. While the overall disease burden of HIV is not high or significant compared to other health conditions and diseases, it is essential to highlight some of the key features related to the macroeconomic context in Egypt that has a particular relation to HIV as a disease and public health risk.

The potential macroeconomic impact of AIDS in high burden countries is usually associated with two dimensions (1) rise from rising morbidity (rising number of new infection) and (2) rising mortality (higher death rates). Given the current epidemiological context, the decision-makers in Egypt should become aware of the potential risks of rapid (uncontrolled) disease incidence in the long term. Given that the rise in HIV new infections mimics the population growth trend, it is anticipated that HIV might represent a significant economic burden in the medium to long term unless the epidemic reaches a tipping point, where the new infections remain low controlled. The impact will be observed in reduced productivity (patients or their families) and increased expenditure on HIV services (mainly on medicines and patient monitoring tests).

While HIV/AIDS might not affect the country's GDP (Gross domestic product) in the short terms, it is important to conduct economic studies and evaluation to assess this risk in the medium and long terms and to quantify the anticipated economic impact if the trajectory of the epidemic is not changing over the next decade (i.e., by 2030). It is important to understand the implications of the current disease trends on government and national budgets and propose the most likely scenarios given the current context and potential changes if the national response described in this strategic plan is implemented. On the other hand, the analysis should also focus on understanding how the social and economic adjustments and changes (resulting from the current economic context and prospects) are likely to change the future course of the epidemic (in positive or negative manners). Together with sound epidemiological modeling, these types of economics modeling are crucial to informing the decision-makers at strategic levels.

The trend of HIV new infections is alarming as newly diagnosed cases are growing and projected to increase over the next 5 years.

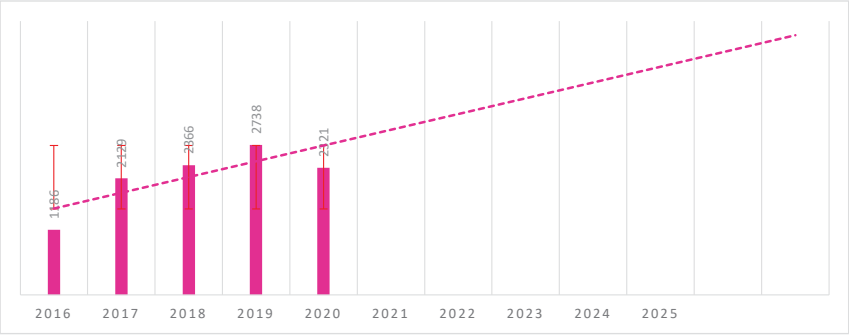
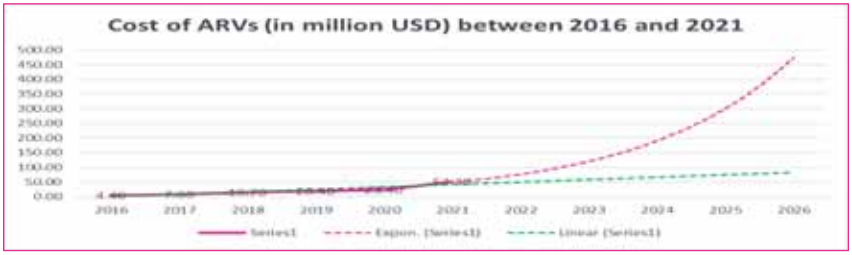


Figure ( ): Registered and projected new HIV cases per year

The rise in new HIV cases and infections has another face, which is the increasing cost for enrolling people on life-long treatment. Between 2008 (following the introduction of ARVs) and 2020, the number of patients receiving ART has grown by more than 50 times.

Figure ( ): Newly HIV cases enrolled on ART 2008 to 2020 in relation to the cost of ARVs.

As the cohort of PLHIV grow, hence the cost to treat this cohort will grow. The figure below present two scenarios. The first one where the cost will grow significantly over the next five years (to follow the same trend of HIV new cases). The second scenario is to follow a slower and more linear growth if the rates of new HIV infections become slower with more aggressive and well-financed prevention strategy.



The decision makers need to take urgent actions to invest in the prevention as a core priority for the health sector in Egypt.

The broad macroeconomic context and impacts mask a substantial economic burden at disaggregated levels (i.e., individual households or communities). The spread of risk factors associated with HIV transmission in Egypt, according to experts, is changing, different categories and economic categories, and classes of the Egyptian community are now affected by these factors. Because many factors are widening the inequalities within the community, HIV transmission is expected to widen the disparities and inequalities experience in some communities and by certain individuals. In return, we know that AIDS as a disease with a social implication contributes to widening the poverty margins, especially for those affected significantly (i.e., families). This changing epidemiological and economic context in Egypt is a call for a better understanding of how to address the root factors that continue to widen the gaps while addressing the needs of key and vulnerable populations in a meaningful manner.

HIV funding landscape and expenditure:

Domestic government health spending represented almost 28.7% of all health expenditure in 2018. On the other hand, the external health expenditure as % of current health expenditure has been fluctuating substantially in recent years, reflecting a mixture of domestic policy changes and donors' interest in investments in the health sector.

While there were no changes in income classification in recent years, the country faced a decline in external financial assistance for health and increased co-financing responsibilities. By the end of 2018, external health expenditure was 0.7% of the total health expenditure, compared to 1.4% in 2014.
By the time of conducting the program review, there were limited financial support from external donors in the form of earmarked funds allocated to specific tasks.
However, the Global Fund to fight AIDS, TB, and Malaria allocated 4.2 million USD for HIV grant (other services besides ARVs that are fully funded through the MOHP/NAP) from 2022 to 2025. As the country faces a transition in donor financing support, the focus and the challenge is to ensure health programs, including HIV programs are sustained.
That applies to both preventive and curative services with the context of HIV control, as both are important to reduce the overall economic burden of the HIV growing epidemic.

Egypt is classified as lower-middle-income country, with gross national income (GNI) per capita ranging from US$2,690 in 2019. Egypt's economic growth has been strong and resilient since the economic reforms initiated in 2016. It is one of the few African countries that recorded positive growth in 2020 despite the adverse impact of the COVID–19 pandemic. Government of Egypt (GoE) revenue as a percentage of gross domestic product (GDP) was 20.1% in 2019 compared to 24.4% in 2014[1]. That is an important indicator to indicate the country's ability to raise sufficient revenue to fund public programs, including health. Despite this relatively low ratio, the GoE has introduced broad policy responses since 2012 to increase health sector allocations and expand support to the poor and vulnerable population to enhance access to health services. The current health expenditure (CHE) per capita in US$ - per capita in US$ increased from 53.9 in 2004 to 125.6 in 2018, growing at an average annual rate of 7.1%[2]. As % GDP was 4.9 % in 2018, down from 5.6 % in 2017.

On the other hand, there is no recent National AIDS Spending Assessment to provide a comprehensive picture of the HIV spending account in Egypt. The last National AIDS Spending Assessment was conducted by NAP in 2011. The outdated information in the report (2007-2008) does not reflect the current context in the country. However, it is expected that HIV spending accounts for a small proportion of total health expenditure, despite the shift from reliance on external financing to carry out their HIV programs towards more sustained domestic resources, including government budget. Government spending on key commodities, particularly antiretroviral (ARV) drugs, continued to be the major driver of expenditure in HIV services (with 100% financing from the government resources).

The total government spending on ARVs continued to grow with the increasing number of patients enrolled in treatment and care over the last four years. By 2020, the total spending on ARVs was 52.3 million USD compared to 4.4 million USD in 2016.
However, no more data were available to evaluate differences in HIV financing commitments, disbursements, and expenditures by funding source. At the moment, the majority of key population outreach and prevention expenditure is for harm reduction and other programs for people who inject drugs. Few programs are being supported to provide services to other key population groups, mainly the MSM. This focus reflects the match between the prioritization of financial investments and the current epidemiological reality. Programmatic data indicate that people who inject drugs and MSM constitute a relatively large number of people living with HIV.

Further analysis is needed to determine if allocation changes are needed; relatively low spending on key populations could result from small sizes of other key population groups and focus on larger "bridging" populations, such as key population partners. NAP may need to reexamine how they can optimize the use of existing prevention and outreach funding to reduce new infections and increase identification of people living with HIV while considering the limited financial resources for HIV response.

[1] https://www.statista.com/statistics/377974/ratio-of-government-expenditure-to-gross-domestic-product-gdp-in-egypt/
[2] https://knoema.com/WHONHA2021/national-health-accounts?country=1000880-egypt

One of the key assumptions behind this strategic plan is that if the overall health spending increases, government spending on HIV may increase. the GoE continues to express its commitment towards the Abuja declaration on health spending, stakeholders of HIV response will continue to work and advocate to maintain financing for HIV services to ensure the achievement of the desired targets.
the strong political will to invest in HIV and inclusion of HIV in ongoing health reforms presents opportunities to increase domestic resources for HIV and improve the sustainability of the HIV response. Social contracting arrangements, in which the government can directly fund civil society organizations, may be needed to ensure the continuation of civil society-led key population programs, including prevention and outreach, as countries experience transitions in external financing assistance for HIV.

Context of HIV response is changing and evolving

Since the last review of the HIV response in Egypt in 2018 to develop the 2018-2022 NSP, the country has witnessed two major changes that will potentially shape the HIV response in Egypt. These include introducing the Universal Health Coverage (UHC) roadmap and initiating and executing the '100 Million Seha' campaign.

Universal Health Coverage:

The Egyptian health system is undergoing major changes. Until recently, the healthcare system used to raise funds through out-of-pocket payments from households. To solve this problem, Egypt passed the Universal Health Insurance (UHI) law in 2018 to achieve universal health coverage. The government will implement the new system in six phases within 15 years. This major change in the healthcare sector leads to profound changes in systems, functions, and regulations, leading to several technical, legal, and institutional challenges, all of which require extensive technical expertise and process management. The UHI law aims to introduce a new diversified financing mechanism that (1) relies primarily on public resources, (2) reform the financing function, and (3) redefine the cost-sharing arrangement to ensure the financial security of the public.

100 Million Seha campaign:

Egypt used to have the highest rate of hepatitis C infection globally, with an estimated 6 million people suffering from hepatitis C; most do not know who they are. Since 2016, Egypt has been actively working to identify people infected with the hepatitis C virus and help them get treatment. The initial actions led to the diagnosis and treatment of 1 million patients. For this reason, Egypt has adopted a more sustainable CSU approach and implemented the HCV plan with the highest political commitment, so eliminating hepatitis has become a top priority. Egypt has also undergone an epidemiological shift from infectious to non-communicable diseases, focusing on the latest HCV plan. Elimination of hepatitis C and early detection of non-communicable diseases are top priorities on the Egyptian government's health agenda.

These two major initiatives provided many opportunities and lessons learned to advance or reform the country's response to the HIV epidemic. The UHI financing will shape many options to reorganize the financing of HIV services. On the other hand, while the prevalence of HIV is not similar to HCV, lessons from how infectious diseases could become a significant health security issue if not addressed strategically. This report calls for more emphasis on understanding how the HIV response can build on the current opportunities in the current context.

COVID-19 pandemic and lessons learned

The evaluation of HIV response in many countries will be shaped by the COVID-19 pandemic that started in early 2020. The experience of how countries cope with the COVID-19 pandemic has made people place great emphasis on understanding and using the experience of HIV response measures and investing in HIV: using the lessons learned, using the system, and determine the dynamic changes needed to build a new HIV The path to a healthy system. On the other hand, COVID-19 related service interruptions affect global and national efforts to contain the HIV epidemic. In the first 12 months of the COVID-19 pandemic, Egypt has been affected by public health measures, and service interruptions have been evident, especially in secondary and tertiary institutions. In this sense, the role of community-led organizations in governance and planning, direct service delivery, and community surveillance and accountability

are key elements of a resilient AIDS response system infrastructure. Different strategies have been strengthened to mitigate the impact of COVID-19 and avoid disruption of services including ensuring continuous supply of ARVs in a multi-month dispensing approach, monitoring the challenges in procurement and supply, such as delays of shipments.

An important lesson from the response to HIV is that efforts to reduce HIV-related stigma and discrimination have drawn significant strength from the visibility and leadership of people living with HIV, demonstrating that communities in COVID-19 patients play a role in reducing COVID-19 related stigmas, myths, and misunderstandings. In this regard, we have learned much from the HIV response work, which arguably has established the most accurate, timely, and comprehensive health-related strategic data and information. Countries report annually on epidemiological indicators of HIV (such as new HIV infections, AIDS-related deaths), the scope of HIV diagnosis, treatment, and prevention services, and national multisectoral policies on HIV, equality of gender, and human rights.

The 2021 – 2025 National Strategic Plan

The Process for Developing this National HIV and AIDS Strategic Plan

This HIV NSP 2021-2025 is the culmination of extensive consultations and deliberations with a wide range of stakeholders. This process involved a review of achievements against the goals and objectives of the previous NSP 2018-2022 using reports, other documentations as well as interviews and discussions with key informants. The results of such a process constitute the key to determine the strategic priorities and the appropriate way forward in dealing with the HIV epidemic in Egypt for the coming five years.

The process of developing this National Strategic Plan was highly participatory involving key stakeholders (national and international) as well as representatives from people living with HIV at national and sub- national levels. The process was mainly supported through the programmatic technical groups that met regularly with respective consultant in working sessions to provide their inputs and technical advice.

The entire processes included the following steps (among several others that are not listed).

1) Desk review:

Review of secondary data focused on key documents that are relevant to the national HIV and AIDS response. For purposes of alignment with sectoral and national plans, key documents were reviewed, including:

- ✓ Egypt National HIV Strategic Plan 2018-2022.
- ✓ Egypt National HIV Operational Plan 2018-2019.
- ✓ Egypt National HIV M&E framework 2018-2022.
- ✓ Service delivery guidelines (Clinical guidelines 2020 and VCT 2019).
- ✓ HIV testing data and reports – Years 2016, 2017, 2018, 2019 and 2020.
- ✓ ART centers reports – Years 2016, 2017, 2018, 2019 and 2020.
- ✓ Reports on Key population services - Years 2019 and 2020.
- ✓ UNAIDS Global AIDS Monitoring reports - Years 2014, 2015, 2016, 2017, 2018, 2019 and 2020.
- ✓ ARVs procurement reports - Years 2016, 2017, 2018, 2019 and 2020.
- ✓ Integrated Biological and Behavioral Surveillance 2010.
- ✓ Population Size Estimates of Key Populations 2014.
- ✓ Mode-of-transmission - HIV surveillance reports – 2019 and 2020.
- ✓ HIV and Gender assessment 2019.

2) Stakeholders Engagement:

The engagement and consultations involved a wide range of organizations, please refer to annexes, and was organized into the following segmentations:

National-level consultation: At the national level, stakeholders were drawn from key government ministries, departments and agencies, development partners and nationally represented civil society organizations (CSOs), including representatives of people living with HIV and KP.

Governorates level consultations: In liaison with representatives from the Governorates, Focal Persons, NAP mobilized participants for Governorates and service providers meetings. Participants in the consultations included different stakeholders involved in HIV control program at the sub-national level and service delivery levels.

Thematic-level consultation: Technical working discussions (TWDs) were constituted from a wide spectrum of stakeholders and development partners to provide expertise input and review the NSP and related documents.

The TWDs included the following topics: Prevention, Testing, Care and Treatment, systems strengthening focusing on governance, human resource, M&E and HIV Financing.

3) Finalization of the Strategic Plan:

The revised draft NSP document was circulated to the stakeholders for further review. The feedback from stakeholders, during a workshop conducted to ensure a wide consultation with all stakeholders, was used to revise the draft of the NSP. Further feedbacks were received and were used to finalize the draft NSP document.

Strategic issues considered by the new NSP:

1. This plan builds on previous successes and stresses on the **renewed engagement and high-level political leadership spearheading the HIV response,** as well as the growing co-operation between government and its partners.
2. In addition, this NSP focuses on scaling up and strengthening the program to maintain complete **elimination of mother-to-child transmission of HIV,** the increase in the number of people testing for HIV; to initiate to all HIV positive people antiretroviral treatment (ART).
3. Moreover, the NSP enhances **the introduction and scale up of prevention services targeting the key populations** and other priority populations owing to their vulnerabilities to HIV transmission risks, for being youth, migrants, refugees or persons in closed settings and commit to focus on the drivers of the HIV epidemic and to address the social determinants of health.
4. The new plan maintains the **universal access to key commodities**, including antiretroviral drugs (ARVs), and will try to mainstream HIV care and treatment in the overall health care delivery system.
5. The new NSP **strengthens the involvement of the NGOs and private sectors in service delivery,** including HIV prevention, diagnosis, linkage to care and treatment and further support to their community members.

Guiding principles and expectations

The NSP 2021-2025 provides strategic guidance for HIV activities for the next five years in line with the set vision, goals, and objectives. It focuses on the drivers of the HIV and builds on the achievements of the previous NSP. It is meant to scale up what has been done well, and improves the quality of services, while at the same time integrating new and proven strategies.

This NSP is intended to respond to the rapid changes in the epidemic and will, therefore, be reviewed regularly for relevance and effectiveness. It is meant to be in line with the broader development plan of government. It is a multisectoral plan that will inform stakeholders, at various levels, on the strategic directions to be considered when developing implementation plans. It will be also used as the guiding framework for coordinating and monitoring implementation..

NSP vision for 2025

The strategic plan outlines a national vision aligned with the global vision. The NSP 2021-2025 is driven by a long-term vision for the country with respect to the HIV epidemic. It has adapted the Three Zeros advocated by UNAIDS to suit the local context. The vision is:

- Zero new HIV infections.
- Zero new infections due to vertical transmission.
- Zero preventable deaths associated with HIV.
- Zero discrimination associated with HIV.

NSP goals for 2025:

The goals are set taking into consideration to "End the AIDS" epidemic as a public health threat by 2030 within the context of ensuring healthy lives and promoting well-being for all at all ages. Consequently, in line with this five-year vision, the NSP has the following broad goals in:

A. Prevention
- Achieve reduction in new HIV infections, including among key and vulnerable populations.
- Validate and maintain zero new mothers to child transmission of HIV.

B. HIV-related deaths
- Reduce National HIV-related deaths.
- Reduce TB deaths among people living with HIV.
- Reduce Hepatitis B and C deaths among people co-infected with HIV.

C. Testing and Treatment
- Ensure that 95% of people living with HIV know their virus status.
- Ensure that 95% of people diagnosed with HIV are receiving ART.
- Ensure that 95% people diagnosed with HIV on treatment achieve viral load suppression.

D. Stigma and Discrimination
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support the implementation of the NSP and
- Have no HIV-related discriminatory laws, regulations and policies, and no HIV-related discrimination in all settings, especially in health settings.
- Reduce self-reported stigma and discrimination related to HIV.

NSP Strategic Directions

This NSP draws on three organizing frameworks: universal health coverage; the continuum of HIV services; and the public health approach. Consequently, it was decided to have five strategic directions (SD's) that would cover the whole spectrum of the projected Egypt national NSP for 2021-2025. Each SD has a series of objectives to aim for; in addition to a list of actions or activities that need to be implemented targeting measurable outcomes; interventions that are evidence based with high impact.

- ✓ **Strategic Directions 1**: HIV primary prevention among key and vulnerable populations and among young people in the community.
- ✓ **Strategic Directions 2**: Diagnosis, treatment, care, and support for persons living with HIV
- ✓ **Strategic Directions 3**: Strengthening the availability and use of strategic information on HIV
- ✓ **Strategic Directions 4**: Strengthening access to key HIV services, addressing inequalities and ensure supportive social, legal and policy environments
- ✓ **Strategic Directions 5**: Strengthening technical, organizational, and institutional capacity of the local implementers.

Each strategic direction has its own objectives, outcome targets along with respective priority activities and strategies as will be detailed in the next section.

Strategic Directions 1: HIV primary prevention among key and vulnerable populations and among young people in the community

Despite the availability of a widening array of effective HIV prevention tools and methods, there has been insufficient progress in reducing new HIV infections in young people and adults.

The number of adults newly infected with HIV increased by three folds between 2010 and 2020.

This NSP will continue to be guided by the ten priority action points outlined in the Road Map of the Global Prevention Coalition. The operational plans to implement this NSP will include key activities in the roadmap or any new guidance in this area.

Strategic Objective 1: Scale-up of primary HIV prevention targeting the key populations by 95% of the KPs size estimate

Key populations continued to be the primary drivers of the concentrated HIV epidemic in the country. However, available data do not reflect significant changes in HIV prevention or progress towards more ambitious targets. The main challenges remain on the financing side; however, challenges related to a limited number of service providers remain an issue—the previous strategic plan aimed at reaching 90% service coverage for the key populations.
Prevention activities targeting key populations have been implemented in Greater Cairo, Alexandria, Luxor, Gharbia, and Menya, with varying degrees.
Although numerous prevention interventions targeting key populations were implemented in the country over the past few years, HIV awareness remains insufficient among key populations as part of the wider population.

Accountability for results is one of the key areas for successful HIV prevention programs and interventions. Many factors and gaps are hindering meaningful and regular review of progress against key targets. Among these issues is the absence of outcome and outputs-oriented reporting indicators that the service providers use. While there is a national M&E framework linked to the NSP 2018-2022, with multiple indicators at the outputs and coverage levels, the service providers do not use these indicators to report on their operations or progress made. There is more emphasis on input and process indicators to report on people reached, rather the assessing or evaluating coverage and linkages to testing and treatment services. In addition, data systems and tools adopted and used by CSOs service providers need to be revised to align with the selected indicators with appropriate levels of disaggregation to enhance the availability of meaningful programmatic data.

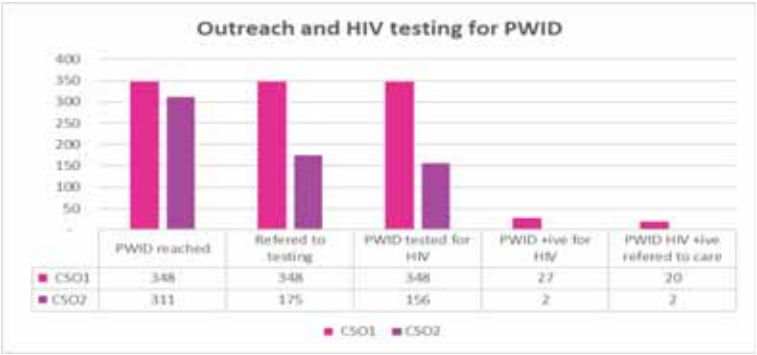
The last population size estimates were conducted in 2014, with no updates to these estimates in the following years. Using these estimates, data indicated that the services reached only around 0.6% of 64,000 MSM and 1% of 93,000 PWID in 2020. For the scope of this NSP, the Key populations terms include MSM, FSW, PWID and People in prisons. The rest of all special population groups are considered as vulnerable populations.

In principle, the core prevention package should ideally include behavioral interventions, condom distribution, and the provision of voluntary counseling and testing. However, not all of the key population will be reached with an integrated package of these services. Working on this area and developing robust monitoring indicators and data systems remains a priority for the next period.

Comprehensive harm reduction approach:

While the incidence of HIV infection globally declined by 25% between 2010 and 2017, HIV infections among people who inject drugs are rising. Outside of sub-Saharan Africa, people who inject drugs and their sexual partners account for roughly one-quarter of all people newly infected with HIV. In the Middle East and North Africa region, people who inject drugs accounted for more than one-third of new infections in 2017. Opioid substitution therapy and NSP have been proven to substantially increase HIV treatment enrollment, treatment adherence, and viral suppression among people living with HIV who inject drugs. Despite that, NSP and OST coverage remains low in most countries, which is caused by low investment in these programs.

The outreach and testing for HIV remain low compared to needs.



As discussed in the previous section, PWID remains the top priority population most at risk for HIV infection in Egypt. Adopting a public health approach to deal with drug use in the country has been an important policy shift contributing to major reforms in services offered to people who inject drugs in the country. The introduction of different harm reduction interventions and services demonstrates the importance of adopting an evidence-based approach to change policies. It also indicates the importance of adopting flexible approaches to utilize the current laws and public policies to achieve better public health outcomes. Clear progress has been achieved regarding better focus and emphasis on the needs of PWID, thanks to attention given to the HCV pandemic through the 100 million Seha initiative.

Similar to experience around introducing the needle and syringe programs (NSP) and OST to serve the needs of PWID, it is important to adopt an evidence-based approach to assess the potential benefits from introducing HIV self-testing (HST) or other innovations to enhance the delivery of the service to key populations.

Reducing sexual transmission among key populations:

Unprotected 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 hidden populations at increased risks of sexual transmission of HIV. Another aspect is linked to integrating a wide range of services that can benefit the key population

in an integrated manner. These gaps for enhancing the availability, accessibility and acceptability of services that are tragting MSM in particular as priority population group.

More attention is needed to the rest of the key population groups, especially the men who have sex with men (MSM). MSM continued to be significantly affected by HIV infection. There were no important changes in service delivery models towards this population group. In addition, some of the evidence-based innovations and new technologies remain under-utilized to accelerate the achievement of specific targets towards MSM. For instance, experience from many countries indicated that adopting HIV self-testing (HST) is an important innovation that can help break the barriers to reach undetected HIV-positive people among the MSM. Transgender people are at high risk of being HIV-positive due to the lack of knowledge and understanding of this community, and because of stigma, this population is often at risk for sexual abuse and is marginalized from accessing prevention, care, and treatment services. It is important to note that this group is normally hard-to-reach populations, and little is known about them. It is important to focus on conducting more studies and assessments to understand the challenges and needs of this population group. There are few activities planned to engage transgender people. These assessments could be a good starting point to establish such engagement to understand further the risks and level of HIV transmission among these groups.

Needs of people in prison and detention:

The country stakeholders agreed on keeping people in prison and detention (i.e., prisoners) as part of the key populations targeted in the national response. This is aligned to internationally adopted categorization and with the national policies that prioritized the needs of this population group.

Data is not available in Egypt on individual risk levels or an estimate of the population size among prisoners, with no information about HIV incidence.

Globally, it is estimated that one in five persons in prison is incarcerated for drug-related offenses; People in detention often have less access to harm reduction services and face a greater risk of HIV, tuberculosis, and viral hepatitis transmission. There is a significant intersection of the prison population with other key or vulnerable populations, including women prisoners.

Moving Forward:

Moving forward, the new strategic plan capitalizes and build on the progress and achievements made in the previous period. The NSP prioritizes primary HIV prevention for key populations, adolescents, and other priority populations, including adolescents and young women, and men in locations with high HIV incidence.

This section provides a snapshot of the key outlines of interventions, targets, and strategies that will be tattered in the next five years.

Strategic outcome 1.1. Expansion of comprehensive harm reduction approach

The strategic plan will focus on defining and developing the appropriate guidance in this area. In particular, the package of services to PWID will include a needle and syringe exchange program comprising injecting equipment packs (needles, syringes, and paraphernalia), overdose prevention, HIV testing and counseling, HIV/ AIDS prevention education, condom distribution, and referral to substance abuse treatment and other medical and social services. Methadone substitution therapy and hepatitis B vaccination for people who inject drugs will be explored. Published guidance on implementing comprehensive HIV and hepatitis C programs for people who inject drugs highlighted the importance of integrating services wherever possible. A ground-breaking opioid substitution treatment and needle and syringe programs will contribute significantly to reducing the burden. The HIV response will continue to utilize the virology clinics that have been established in addiction and rehabilitation centers.

The NSP will be focusing on the following interventions and strategies:

a. Fully implement comprehensive harm reduction and HIV services on a scale that can be easily, voluntarily, and confidentially accessed by all people who use drugs, including within prisons and other closed settings.
b. Encourage stakeholders in Egypt to focus on implementing strong and effective harm reduction programs. While legislative change can take time, harm reduction programs could be effectively implemented and expanded through collaboration between the health and law enforcement sectors.
c. Work with people who inject drugs so that their communities become part of program design through consultations and active participation.
d. Ensure that all PWID, including people in prisons and other closed settings, have access to harm reduction services to prevent HIV infection, including needle–syringe programs, opioid substitution therapy, and antiretroviral therapy.
e. Ensure that all PWID and are living with HIV have access to life-saving antiretroviral therapy and other health services to manage tuberculosis, viral hepatitis, and sexually transmitted infections.
f. Conduct population size estimates, continuous analysis of HIV epidemiology, with disaggregation of behavioral data and HIV prevalence by age groups.
g. Undertake efforts and policies to rebalance the investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction for HIV infection, antiretroviral therapy, drug dependence treatment, and treatment for hepatitis, tuberculosis, and other health conditions.
h. Build consensus on strategic investment from public funds in HIV prevention, treatment and care, and support services for people who inject drugs.
a. Build the capacity of governmental VCT centers to enhance its partnership and support for the outreach programs and strengthen the linkages.

Strategic outcome 1.2. Reduction of sexual transmission among key populations

The NSP will be focusing on the following interventions and strategies:

- Promote innovative approaches to reaching key populations to deliver results. These innovative approaches may include community-based testing, self-testing, and diverse forms of index testing.
- Integrate the prevention service package by offering HIV testing, peer education and psychosocial support through health facilities that distribute medications and have testing kits. Where needed and available, consider offering PEP through peer-led services.
- Adopt risk network approaches “or contact tracing" to reach the key populations in major cities by asking recently diagnosed individuals to refer others in their social networks for HIV testing.
- Promote assisted sexual partner notification among couples to enhance finding new cases.
- The involvement of key population communities in service delivery increases the reach and effectiveness of prevention, testing, treatment, and care. Peer educators or other lay providers shall be key populations who take on important aspects of service delivery to increase accessibility.
- Work with stakeholders to extend and scale up the HIV services to the sex workers and MSM population to reduce sexual transmission of HIV.
- Continue to offer a well-defined package of services for sex workers and men who have sex with men in cities with high HIV infection rates.
- Facilitate access for key populations to sexual and reproductive health and other health services through an integrated, people-centered approach that is gender-responsive and youth-friendly.
- Conduct population size estimates, continuous analysis of HIV epidemiology, with disaggregation of behavioral data and HIV prevalence by age groups.
- Enhancing condoms programming that is targeting young key populations in high priority governorates and large cities.

Strategic outcome 1.3. Addressing the needs of people in prison and detention

The strategy will be focusing on the following interventions and strategies:

- Develop a national policy on HIV and AIDS in prisons.
- Advocate for improving HIV response and service access in prisons.
- Conduct activities to raise awareness of HIV, including peer education and campaigns to promote HIV testing.
- Extend services to prisoners to prevent sexual transmission of HIV, including routine testing and linkage to care.
- Ensure the continuity of care for prisoners on HIV treatment to avoid interruption of treatment when people move between the community and prisons as well as within prisons.
- Conduct population size estimates, continuous analysis of HIV epidemiology, with disaggregation of behavioral data and HIV prevalence by age groups.

Prevention Strategy in Short

The comprehensive package of interventions recommended in the 2016 WHO Consolidated guidelines for HIV prevention, diagnosis, treatment, and care for key populations will be adapted for the local context. It will include both health and structural interventions. As mentioned before, and compared with the WHO comprehensive package and recommendations, there are significant gaps in intended or planned HIV services in the current context.

Highlights of key interventions under this strategic plan

1. Is condom programming targeting key populations will be included?	Yes
2. Is programming for lubricants targeting key populations included?	No
3. Is the offering of oral pre-exposure prophylaxis to key populations will be included?	No
4. Is post-exposure prophylaxis available for eligible key populations will be included?	No
5. Is harm reduction services for people who inject drugs will be included?	Yes
6. Is needle and syringe programming will be included?	Yes
7. Is opioid substitution therapy will be included?	Yes
8. Is community distribution of naloxone will be included?	No
9. Is provider-initiated testing and counseling will be included?	Yes
10. Is community-based HIV testing and counseling will be included?	Yes
11. Is self-testing will be included?	Pilot
12. Is assisted voluntary partner notification will be included?	Yes
13. Is a routine offer of screening of STIs for key populations will be included?	Yes
14. Is sensitization training for healthcare workers on key populations will be included?	Yes
15. Are prevention interventions and activities targeting young people will be included?	Yes
16. Is condom programming to support HIV prevention will be included?	No
17. Is prevention programs, testing and counseling for prisoners will be included?	Yes
18. Is a special program for women and young girls will be included?	Yes
19. Are new innovative outreach approaches and technology-based interventions will be included?	Yes

The mentioned interventions will be operationalized into clear services packages as follow:

Program Area	Intervention/ Target population	PWID	MSM	FSW	TG	Prisoners
Prevention package	Condoms	Y	Y	Y	Y	N
	Lubricants	Y	Y	Y	Y	N
	PrEP	N	N	N	N	N
	PEP	N	N	N	N	N
	IEC	Y	Y	Y	Y	Y
	NSP	Y	N	N	N	N
	OST	Y	N	N	N	N
Testing	Provider-initiated testing	Y	Y	Y	Y	Y
	Community-based testing	Y	Y	Y	Y	N
	Peer educator testing	Y	Y	Y	Y	N
	Self-testing	N	Y	N	Y	N
	Assisted partner notification	Y	Y	Y	Y	N
Management of HIV and other infections	Immediate access	Y	Y	Y	Y	Y
	Adherence monitoring	Y	Y	Y	Y	Y
	STI management	Y	Y	Y	Y	Y
	Tuberculosis co-infection	Y	Y	Y	Y	Y
	Viral hepatitis co-infection	Y	Y	Y	Y	Y

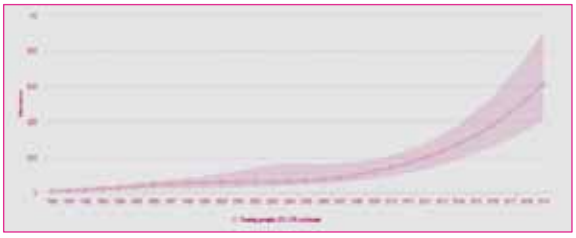
Y = Yes, N = No

Strategic Objective 2: Enhance HIV prevention related knowledge and skills among Adolescents, young people by 50% of the global targets

Awareness raising and prevention services:

The epidemiological data continued to indicate that young people, both women, and men, continued to contribute significantly to the rising trend of the new infections. While the epidemic is still concentrated in specific high-risk groups, the large population of Egypt is an essential factor to think strategically on prevention beyond the high-risk groups. The UNAIDS estimate for HIV prevalence in youth 15-24 years continued to be less than 0.1%. On the contrary, national data revealed that youth contribute around 29.2% of HIV cases, with a female dominance notably in the age group 20-29 years. The previous NSP has highlighted this important aspect of the national response as a key strategic and long-term priority.

New HIV infections among young people (15-24), 1990-2019



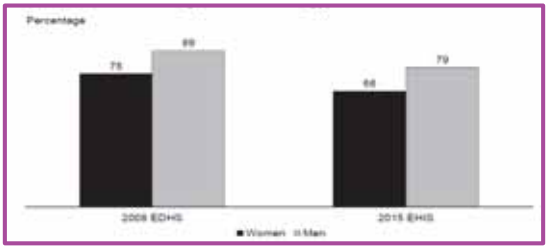
The challenge remains to define what services to be offered and what channels to utilize to deliver a sustained awareness-raising and behavioral change interventions. Different options are available; however, more data is needed to assess each option's effectiveness, acceptability, and feasibility and adopt clear policy supported by the government and society leaders on addressing these needs purposefully. On the other hand, Egypt is also witnessing an awaking movement of young people to participate more in societal priority issues. These movements are welcomed and supported by all stakeholders, including governmental institutions. Building on these momentums can empower young people to participate better in policy formulation through consultations and hold governments and other stakeholders accountable for filling the current gaps in their needs in this area. Continuous engagement of young people, and their communities, in the national prevention response is crucial for the success in changing the trajectory of the HIV growing epidemic in Egypt.

There is a need to continue the dialogue on enhancing the provision of HIV testing and prevention services in youth-friendly facilities and expanding that if feasible. The strategy aimed at capitalizing on the existing Youth Friendly services in Cairo and Upper and Lower Egypt that provide various services. Starting from these facilities can enhance the availability of quantitative data and support making projections and estimates through research and studies in the future. This could be of interest to multiple stakeholders, whether locally or internationally. In addition, the prevention efforts have been focusing on specific governorates that are characterized by a higher number of HIV caseloads. While this is a good approach when focusing on young key populations is needed, accessing many young people at scale requires expansion of the outreach to all governorates without leaving anyone behind without access to the HIV prevention package of services. For instance, drug use among young people is generally more common than among older people, with substance use often peaking at 18 to 25 years[3].

[3] https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_4_YOUTH.pdf

Given the wide gaps incorrect information and knowledge about HIV, educational programs on HIV and AIDS that target youth are urgently needed. Radio and TV shows, social media, and telephone hotlines prove to be valuable alternatives in providing information to youth. Besides that, there are needs to enhance the delivery of curriculum and co-curricular subjects related to HIV education & awareness in school and higher learning institutions.

Trends in the percentage of women and men age 15-49 who have heard of AIDS, 2008-2015



Engagement of the education sector to identify in-school and out-school venues and opportunities is important to ensure wider access of adolescent and youth to information on HIV and AIDS. Finally, the response in this area should consider the gender differences that are also shaping the differences in the needs. However, within the current social context engaging young men in particular as agents of change to achieve better prevention outcomes is crucial.

Access to sex education is limited in the MENA region, including Egypt. Where it does exist, it tends to focus on the biology of reproduction with little or no focus on issues relating to sexuality, gender, sexual violence, consent, or sexually transmitted infections. As a result, school-based education on HIV and subsequent HIV awareness tend to be poor.

Needs of young key populations:

While no data is available, it is expected in the current context that the young key populations continued to be the primary drivers of the concentrated HIV epidemic in the country. In most countries in the Middle East, it is very difficult to distinguish the key populations from their broader community structure in such a cohesive and highly conservative community. That calls for an innovative approach for addressing the population's needs at risk, but at the same time keep the characteristics of this age generation as a critical factor that can influence their beliefs and behaviors. In many cases, young people from key populations are made more vulnerable by policies and laws that demeanor criminalize or penalize them or their behaviors and education and health systems that ignore or reject them and fail to provide the information and treatment they need to keep themselves safe.

Scaling up targeted prevention activities towards KPs while scaling up awareness campaigns, especially social media at low cost, could be a good combination. These combinations, however, should consider the cost implications, and partners should strike the right balance. There is limited availability of adequate funds for research, prevention, treatment, and care for the young key populations. HIV service providers are often poorly equipped to serve young key populations, while the staff of programs for young people may lack the sensitivity, skills, and knowledge to work specifically with members of key populations.

Needs of refugees and migrants:

Egypt's in standing for Refugees and Asylum seekers international protection needs and also within key strategic relations with many Countries of the region including but not limited to Sudan, South Sudan and other Countries of

Africa and Arab states in MENA region facing displacement and migratory movements due to conflicts or within other forced displacement reasons, MOH NAP has always supported UNHCR partner offering clinics based refugee HIV care services and IOM offered medical care for migrants to enjoy equal access to VCT services as is offered for Citizens . Egypt within these vulnerable populations' protection needs, do no ask for any mandatory testing nor any HIV testing screening in standing for this populations right to privacy, liberty and security. Egypt and NAP is giving an example of refugees, asylum seekers and vulnerable migrants inclusion and equal treatment policy as for Citizens.

Data from VCT services for refugees and migrants cannot reflects HIV prevalence, but trends data could be utilized, especially age, gender, and mode of HIV transmission among this vulnerable populations living among their hosting citizens communities. By end of 2020, around 310 refugees have been enrolled into ART. However, no data about level of testing coverage among this group. It is essential to ensure that the current context addresses the needs of these vulnerable populations to ensure sustained access to HIV preventive and testing services.

Egypt and NAP has ensured that the current mixed migration context. The national response strives to addresses the needs of these vulnerable populations to ensure sustained access to HIV prevention , VCT services and Treatment including access to ART for refugees and asylum seekers since 2008 and to date while on a case by case assessment, vulnerable migrants are also offered ART treatment including within IOM Assisted voluntary repatriation programs for migrants and link up to migrants countries of origin National ART programs . NAP under this NSP 2021-2025 and in standing for the SDGs principle of "Leaving no one behind" is foreseeing to foster further all scaling up and inclusion of vulnerable non-national vulnerable populations to include along refugees , asylum seekers and IOM assisted migrants , all what can enhance access to VCT services as a key strategic undertaking for link to treatment , adherence and viral load suppression for all PLHIV toward ending AIDS as a public health threat by 2030 .
The UN joint team continued to support the national response in this area. In 2019, three awareness sessions were conducted targeting migrants in Cairo and Alexandria, reaching more than 500 migrants. The sessions covered HIV mode of transmission, prevention, sexual and reproductive health tips, stigma and discrimination and available services for testing and treatment.

Condom programs:

New HIV infections among young populations are not clear due to gaps in strategic data. However, risky sexual behavior with consistently low condom use, especially as reported among younger age groups. This area needs to be fully understood to generate hypotheses about the new transmission sources and address them. Previous rounds of the demographic health surveys continued to flag the low number of people who are aware that using condoms every time they have sexual intercourse can diminish the chance of HIV infection decreased. In particular, the proportion of youth with correct knowledge continued to decline over time. Studies conducted with support from UNFPA indicated that more than 90.3% of males reported never using a condom with a non-steady partner in the last six months[4]This is not only in Egypt, however. Many HIV prevention services for men strive to achieve national and global goals. In recent years, the benefits of condom use and other risk-reducing behavior changes promoted in the global AIDS response appear to have declined.

No data or studies were identified to indicate the key demand-side barriers to condom use and strategies to address them. In addition, there are gaps regarding the availability of data and information about supplies and distribution of male or female condoms through public facilities or channels. However, in practical terms, the coordination and leadership in this area go beyond the direct scope of NAP and key HIV stakeholders. However, further efforts are needed to better understand the current challenges and gap to enhance the utilization of condoms as a key tool and intervention to reduce HIV transmission. There is a need to understand the issues and barriers from a behavioral perspective to facilitate the development of change communication and condom demand creation, adequate male and female condom supplies, distribution, and social marketing.

[4] https://egypt.unfpa.org/sites/default/files/pub-pdf/f1e01dbc-d54b-4566-aae6-c91c59aea613.pdf

Moving Forward:

Given the nature of the HIV epidemic in Egypt, the prevention strategy will continue to emphasize the targeted prevention to reach more key and vulnerable populations and young people. The current focus of the prevention strategy is built on a better understanding of the evolving epidemiology of HIV and the demographic characteristic of the populations. However, that should not restrict the effort to adopt a more pragmatic approach to enhance HIV awareness-raising, behavioral change, and condom programs targeting the broader population. Data has shown that heterosexual transmission continues to be one of the primary modes of HIV transmission (i.e., at around 45% to 50% of the new cases). Sustained prevention outcomes should be supported by creating a more conducive environment in which awareness and knowledge about HIV and risk factors are part of the general culture.

Strategic outcome 2.1: Awareness raising and prevention services

The NSP will be focusing on the following interventions and strategies:

a. Design adolescent-friendly health services and ensure engagement in its design.
b. Conduct routine assessments to map, assess, plan, set targets, and monitor the progress and quality of these services.
c. Ensure orientation and training of peer counselors, youth trainers, healthcare workers, local and international implementing partners and agencies on adolescent-friendly services, policies to promote and protect adolescents' health.
d. Mentorship and supervision of the peer counselors, implementing partners, and healthcare workers through regular on-the-ground mentorship, including digital and remote mentorship.
e. Continue to utilize mass-social media to reach targeted population groups.
f. Remove barriers to the participation of young people and provide support for their meaningful engagement and leadership in all HIV-related services targeting them.
g. Adopt monitoring and evaluation frameworks with age-disaggregated indicators and integration within national tools.
h. Budgeting and resource mobilization for sustained support for integrated peer-led service delivery and support for the peer supporters.

Strategic outcome 2.2: Addressing the needs of young key populations

The NSP will be focusing on the following interventions and strategies:

- Ensure availability of prevention and reduction of HIV transmission risk among the most at-risk young people and improve the quality of life of people living with HIV.
- Continue to scale up the provision of prevention services targeting the young key population groups, especially young men (especially young MSM and young PWID), in priority governorates based on the standard package of service per guidelines.
- Facilitate and support the existing program for young people with drug use behavior in school and higher learning institutions.
- Conduct population size estimates, continuous demographics, and HIV epidemiology analysis, disaggregating behavioral data and HIV prevalence by age groups.

Strategic outcome 2.3: Addressing the needs of refugees and migrants

The NSP will be focusing on the following interventions and strategies:

- Continue to address the needs of refugees and migrants' populations to ensure sustained access to HIV preventive, testing and treatment services.

- Ensure disease status, including HIV status, should not adversely affect their right to access social protection and durable solutions.

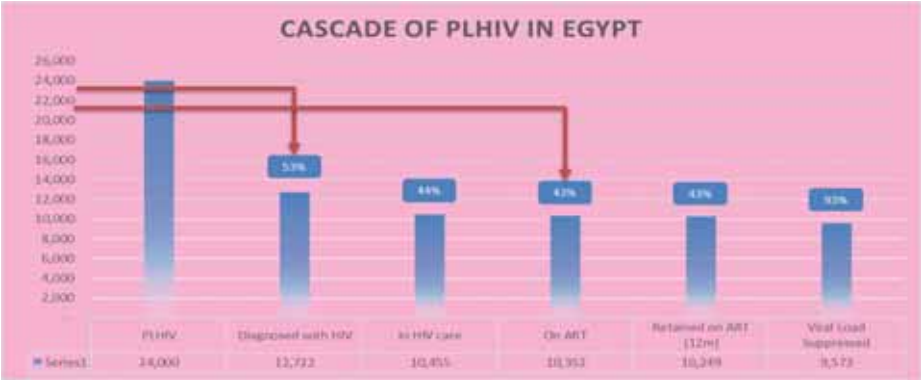
Strategic outcome 2.4: Enhancing condom programming

There is a need for this NSP to build based on analysis of condom needs, current distribution, and current use by priority populations, including key populations, young people, people with non-regular partners, HIV-affected couples, and other couples using condoms for contraception. It will focus efforts to generate strong demand for condoms, rebuild the national condom program, and provide easier access to condoms.

HIV program and stakeholders should intensify efforts to focusing on:

- Identifies key demand-side barriers to condom use and strategies to address them
- Defines condom coordination, government leadership, and market facilitation functions to enhance the utilization of condoms to support HIV prevention efforts.
- Develop behavioral change communication and condom demand creation strategy in coordination with relevant stakeholders and partners.
- Continue to focus on reaching more men with HIV prevention tools, including the promotion of condoms.

Strategic Directions 2: Diagnosis, treatment, care, and support for people living with HIV



Cascade of PLHIV in Egypt: Achievements Gaps and linkages in HIV services by the end of 2020

Strategic Objective 3: 95% of estimated HIV-positive persons are diagnosed and started antiretroviral therapy

While HIV testing, prevention, and treatment services have been scaled up, gaps remain. From the currently estimated 24,000 people living with HIV in Egypt, there are approximately 46% still unaware of their status.
On the other hand, linkage to treatment and care following HTS is essential to programmatic impact. With the offer of immediate ART initiation and improved treatment options, access to and uptake of treatment has increased. Despite that, significant gaps remain to re-link PLHIV, which are lost after their initial diagnosis.

Egypt adopted the recommendations from the 2015 WHO Consolidated guidelines on HIV testing services in a national process on testing guidelines partially. A more proactive, people-centered HIV testing program is needed, and more efforts need to be made to implement high-quality high-temperature superconductors using quality-assured HIV testing strategies recommended by the WHO.

Increase knowledge of HIV status

First: Demand creation
The program review to develop the NSP showed that poor HTS uptake often results from different barriers, including, among others, lack of awareness, fear of a positive test result, lack of confidentiality, fear of stigma, cost, laws, and policies. An evidence-based approach considers incentives to create demand for HIV testing services, including linkages to these services. Previous health household surveys in Egypt indicate that the general knowledge and awareness of HTS vary but generally low. Few people may know where or how to obtain HIV testing outside facilities, such as HIVST.

Within the current concentrated HIV Epidemic in Egypt, general promotion and awareness efforts for HIV testing services are necessary or effective. Rather, there is a need for more efforts to focus on specific populations or settings. The focus should be on crafting strategies to reach people with HIV who do not know their status and those at high ongoing risk. For instance, a new digital, social media, and video or messaging platforms can also be considered. These tools are less costly and readily acceptable, especially to young people. In addition, they can be useful to provide pre-test information and messages.

Second: HTS focus on key populations, young people, women, and high-risk patients
Data from different settings continue to indicate that many of those unreached by HTS are key populations, partners of HIV, people infected with STIs, TB, HBV, HCV, and adolescents and young people. This is valid with the current context in Egypt, with women being historically unreached with HTS at a large scale. Efforts are needed to increase HIV testing among those at risk of acquiring an HIV infection and people with HIV who do not know their status. Focused HTS is needed to reach these specific populations using a range of evidence-based recommended approaches.

On the other hand, demand creation interventions were considered inadequate to reach targeted people or those who cannot access testing easily, and those who may be hesitant to test because of fear of a positive HIV diagnosis.

Third: HIV testing service delivery approaches
There are many approaches to deliver HTS, including facility-based, routine, community-based testing. In addition, other approaches are under consideration as well, including HIV self-testing (HIVST), voluntary HIV partner services, and social network-based approaches. A strategic mix of differentiated testing approaches is needed to match the current disease epidemiology, needs of focus populations, and limited resources.
In the previous period, the national program and stakeholders focused on improving the accessibility and quality of testing services. Expansion of the service delivery sites that offer HIV testing has been shaped mainly by the changes in policies related to HIV testing for pregnant women. These efforts for decentralization aimed at providing HTS at peripheral governorates and health facilities, including through the primary healthcare facilities. However, the

decentralization of HTS should be accompanied by efforts to strengthen linkage and referral systems. Among the main challenges to achieving this is that not all HIV testing channels are considered entry points for HIV services, with some of these being mandatory testing. The stakeholders stressed that more differentiated and innovative testing modalities for reaching people are still missing.

Facility-based testing (PITC):

Facility-based HTS is provided either in stand-alone HTS sites (through VCT - voluntary counseling and testing) or routinely offered at clinical sites (i.e., provider-initiated testing and counseling - PITC).

Voluntary counseling and testing services are performed in both governmental and non-governmental sectors. VCT is provided through government centers located in 16 fixed sites (health facilities or hospitals) across the country and nine mobile units equipped and operated through the NAP. Counselors (mainly nurses) and laboratory technicians support VCT centers. Routinely offered HTS at clinical sites that include:

- ✓ **Tuberculosis centers:** TB patients diagnosed and treated in chest hospitals across the country, and they offered HIV testing in these facilities. While all TB patients will be tested for HIV, not all HIV patients will be screened for TB as routine practice.
- ✓ **Sexually transmitted infection care sites:** Patients with any STIs diagnosed and treated through Dermatology, and Venereal Disease Clinics in hospitals across the country are offered HIV testing by service providers.
- ✓ **ANC and child health centers:** All pregnant women are tested for HIV, syphilis, and hepatitis B surface antigen at least once during their pregnancy. Policy on using dual HIV/syphilis rapid diagnostic tests (RDTs) as the first test in HIV in ANC is under discussion.
- ✓ **Drug rehabilitation centers in mental health centers:** HIV testing is now integrated into the virology clinics in all drug rehabilitation centers and is offered routinely.
- ✓ **Hospital surgery departments:** HIV testing is sometimes applied as part of the routine pre-surgical screening, particularly in major hospitals.

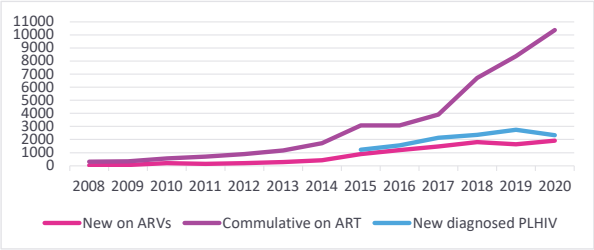
Community-level testing,

Many people with HIV who do not know their status are members of key populations and their partners; that is why strengthening this testing approach will be strategic in the next period. Around seven NGOs were actively engaged in providing HIV services in some areas in Egypt, and this includes the provision of community-based counseling and testing mainly to key populations. HIV testing is offered as part of prevention outreach services for sex workers, MSM and PWID. NGOs also work with other vulnerable populations, including refugees and asylum seekers, and offer HCT as part of their package of interventions. However, the coverage with services is very low; this is worsening by the declined level of resources that hamper the sustainability of the services. Mobile outreach has been used to complement VCT-based HTS in areas of low coverage and poor accessibility.

Link people to care immediately after diagnosis

Despite the gains from expanding HTS in Egypt, the proportion of lost to follow-up (LTFU) individuals between HIV diagnosis and initiating ART remains high. A treatment cascade has been conducted in 2015, 2016, and 2017, and a cohort analysis was performed for newly diagnosed patients for nine months. According to the results, the most significant drop in the cascade was in diagnosed people but did not enter care.

The number of cumulative and new HIV+ enrolled on treatment.



The rollout of the test and treat policy in Egypt in 2017 has contributed to enhancing ART retention. In addition to this policy, many studies from other countries showed that integrating ART services in TB, maternal, newborn, and child health, and rehabilitation services for drug user settings tend to improve treatment initiation in these populations. In 2020 , NAP expanded care and treatment centers to reach 27 ART centers in 27 governorates , also we adopt the MMD (Multi-month dispensing) to mitigate the risk of acquiring COVID infection, this approach enhances patients adherence on ART. NAP has worked jointly with CSOs to ensure continuum of care and linkage to care for detected cases to avoid LTFU. Currently, MoPH has provided point of care machines in 12 main ART centers, expected to be 27 by the end of 2021, we believe that this point of care machines will play crucial role in ensuring comprehensive follow up mechanism and improve linkage to care.

Identify, engage, or re-engage people with HIV who are not in care

Data indicated that NAP has been able to improve linkage for newly diagnosed patients, especially after 2017. However, there still a gap in linking those who have been diagnosed before that. There are people with HIV diagnosed before implementing the "treat all" policy and who were not considered eligible for ART. There are also people with HIV who know their status but are not currently engaged in care for different reasons or discontinued ART. These groups need specific and appropriate post-test messages; they need to be aware of the benefits of HIV prevention and treatment to encourage them to retest to initiate or reinitiate ART.

There is a continuous need to provide community support for people living with HIV to improve retention in HIV care. Poor retention undermines program outcomes, including reducing mortality and achieving sustained population suppression of viral loads. Although NAP has continued to adopt different strategies to support retention, loss to follow-up remains substantial. Efforts have been made by NAP to trace everyone who has missed appointments.

Lessons from HIV programs in similar contexts provide good practices and experience to enhance program performance in this area. Although some individuals who are no longer engaged in care have died, recent data suggest that many successfully traced individuals are alive and many are willing to re-engage in care. It is imperative to adopt patient tracing as a key intervention that could improve the linkage between diagnosis and ART initiation. Approaches to tracing may include remote communication, in-person tracing, and a combination of both approaches. Support for re-engagement in care can include interventions directed towards patients, such as peer- or provider outreach and navigation back to care, and healthcare providers and health facilities, through systems to alert healthcare providers that patients have disengaged. The criteria for tracing and recall should consider seven or more calendar days late for a scheduled appointment.

Moving forward:

Moving forward, the testing strategy and services will focus on people with HIV who remain undiagnosed and on diagnosing and linking them to treatment and care services as early as possible. It will target HIV-negative and ongoing risk and need to be tested and linked to appropriate prevention services. It will also put efforts to re-link who know their HIV status but have not initiated or discontinued treatment.

There is an urgent need to address the significant gap of undiagnosed HIV among key and vulnerable populations through a strategic mix of differentiated and non-stigmatizing HTS approaches. HIV testing will be targeted at least annually, or as appropriate for specific groups, to reach those with undiagnosed HIV as early as possible and engage them in treatment and care. NAP and the service providers will create an enabling environment that removes barriers to increase access to and uptake of HIV testing services, particularly among those at high ongoing risk and key populations. In addition, specific strategies, and interventions to create demand and increase uptake will be implemented to address people at risk of acquiring HIV infection and people with HIV who do not know their status.

Strategic outcome 3.1: Enhance HIV Testing Strategy and Policies

The NSP will be focusing on the following interventions and strategies:

a. Conduct an in-depth HTS situational analysis to evaluate how to optimize HTS – including modifying existing HTS, introducing new HTS approaches, and selecting an optimal combination of HTS approaches to address the needs of different populations.
b. Agree on the operational plan to scale up programs to provide high-quality testing services and support referral to prevention and treatment in an optimal manner.
c. Enhance the integration or decentralization where feasible of HTS with other testing and services, which can maximize the benefits of reaching people at high risks.
d. Continue to seek opportunities to align HIV testing with other health conditions, including TB, SRH and non-communicable diseases.
e. Ensure testing services to the different population groups will be provided according to national testing guidelines.
f. Ensure quality assurance (QA) systems function effectively and expand in parallel with the delivery of HTS.
g. Ensure all providers delivering HTS are appropriately trained and supervised.
h. Ensure HTS sites have standard operating procedures (SOPs) that are aligned with national guidelines and protocols.
i. Improve data on HIV testing access and coverage, post-test referrals, and continue to use data to inform the revision of testing strategy annually.

Strategic outcome 3.2: Increase knowledge of HIV status and reach undiagnosed PLHIV

The NSP focuses on the following interventions and strategies:

a. Focus on prioritized population groups (including key populations, partners of people with HIV, people infected with STIs, TB, and HBV, in addition to pregnant women, young and adolescent key populations) and reaching people with HIV who remain undiagnosed among them.
b. Expand HIV testing service at migrants, refugees, and other vulnerable groups attended at facility based level and enhanced rapid link to treatment within the same strategy of ART treatment access, initiation, re-initiation and adherence as for nationals, toward enhancement of treatment coverage, viral suppression and treatment as prevention for all and advancing toward ending AIDS as a public health threat for all by all.

c. Introduce provider-assisted referral for all people with HIV as part of a voluntary comprehensive package of testing and care, including key populations.
d. Ensure more diverse testing approaches are available and address the different needs of different population groups.
e. Review complimentary packages of services to facilitate linkage to care and create demand for HTS and their effectiveness.
f. Address legal barriers and ethical considerations of testing of adolescents and children in the street and risky situations.
g. Apply evidence-based approaches to demand creation include peer-led and digital platforms focusing on targeted people with low testing uptake and knowledge of status.
h. Design demand creation and mobilization interventions that include: (1) targeted promotions, advertisements, and messaging; (2) educational programs; (3) brief motivational messages and counseling activities; and (4) couples-oriented counseling and partner services.
i. Intensify testing and counseling through community-based rapid testing and prioritizing VCT for people who inject drugs and men who have sex with men through non-governmental organizations and governmental sites.
j. Monitor and evaluate the implementation regularly to optimize the services. That will require developing a monitoring and evaluation plan, selecting key program indicators, collecting relevant data, reviewing progress, and adjusting service delivery accordingly.

Moving ahead, two other HIV testing approaches will be studied and considered/strengthened:

1. Index testing and Assisted partner notification
   As part of its 2016 guidelines, the WHO recommended voluntary partner services to sexual and drug-injecting partners, and voluntary disclosure was beneficial. Partner services, including provider-assisted referral for testing and disclosure with consent of the person, tested. It aims at offering voluntary HTS to sexual and/or drug-injecting partners of people with HIV as part of a comprehensive package of testing and care. Part of this package of services is various options, including: (1) provider assisted referral, in which a trained provider directly assists people who have tested HIV-positive by contacting their partner(s) and offering them HTS and (2) patient referral, in which a trained provider encourages the client to disclose their HIV status to their partner(s). Besides this, experience showed the usefulness of this approach in offering HIV testing for untested biological children of HIV-positive clients. This approach provides the opportunity to offer comprehensive prevention interventions to partners who are HIV-negative.
2. HIV Self-testing (HIVST) with subsequent confirmatory testing
   In 2016 WHO recommended HIVST as a safe, accurate, and effective way to reach people who may not test otherwise. Evidence indicated that HIVST increases the uptake of HIV testing, especially among the key populations, with similar effectiveness in linkages if the right strategies are applied. However, experience from other settings showed the importance of empowering and effectively engaging KPs communities in developing and adapting HIVST delivery and support models. Community engagement should educate the community and providers to raise awareness about HTS and minimize misuse and harm concerning HIVST.

Strategic outcome 3.3: Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment

A combination of interventions is needed to improve linkages to prevention, care, and treatment, particularly to minimize loss to follow-up between HIV testing and care and treatment. Rapid ART initiation will be offered to all people with HIV following a confirmed HIV diagnosis and clinical assessment.

The NSP focuses on the following interventions and strategies:

a. Regular update of the clinical guidelines including testing, post-test counseling, and treatment.
b. Developed and update HIV self-testing counseling guidance and information.
c. Ensure rapid ART initiation.

d. Offer a package of support interventions to all newly diagnosed patients to ensure timely linkage to care for all people with HIV.
e. Integrate VCT with ART treatment sites where it is feasible and align the confirmation of the diagnosis of HIV with enrolment in HIV care.
f. Streamline service delivery by moving away from the use of western blotting and adopt point-of-care diagnostic testing.
g. Pilot and scale-up models for diagnostic integration across programs.
h. Implement peer outreach and support models and/or peer navigators and case management.
i. Train staff to provide multiple services to enhance linkages.
j. Develop the capacity of NAP focal points at the governorate level and VCT staff to ensure proper follow-up and linkages of those testing positive to the continuum of care.
k. Adopt quality improvement approaches using data and monitoring indicators to improve linkages.

Strategic outcome 3.4: Re-link all of people living with HIV who are lost from treatment

The NSP focuses on the following interventions and strategies:

- Prioritize groups of patients, including people initiating treatment in the past six months with advanced HIV disease, people not initiating treatment, and people overdue for clinical consultations or laboratory tests for more than six months.
- Utilize personalized approaches such as personalized text messaging, personal phone call reminders and direct contact through the health workers and peers. This should be linked to the medical records of people who got tested or those who were on ART then got lost.

Strategic Objective 4: 95% of HIV-diagnosed individuals started on antiretroviral therapy and are retained on treatment

There were an estimated 24,000 people to be living with HIV by the end of 2020 in Egypt. By the end of 2020, 12,722 PLHIV have been diagnosed, which translates to around 53% achievements of the first 90 on HIV cascade. Out of these patients, 10,455 are known to be currently on treatment by December 2020, i.e. translating to 44% achievement of the second 90 on HIV cascade (compared to total estimated PLHIV).

The guidelines

NAP Egypt is committed to investing in people-centered practices and communication to enhance the quality of care to PLHIV. Systems are strengthening efforts, including ongoing training, mentoring, supportive supervision, and monitoring health workers, to improve the relationships between patients and healthcare providers.

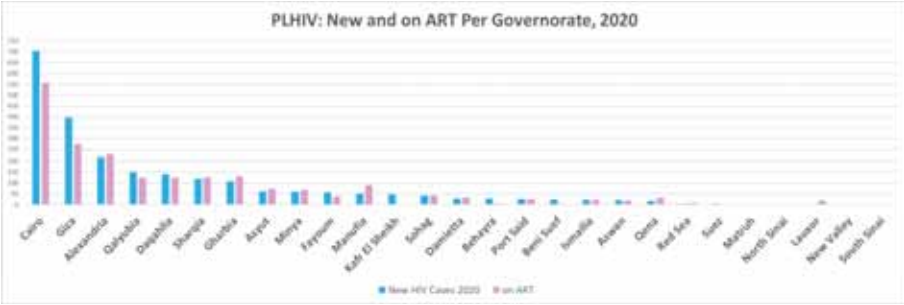
In late 2015 WHO recommended that all people with HIV be offered ART immediately after diagnosis, a strategy dubbed "treat all." Treating all has dual benefits – clinical benefits for those taking ART and a prevention benefit for their partners due to suppressing the ART user's viral load. In 2017, Egypt completely adopted these recommendations without recommended CD4 threshold for initiating ART in adults and adolescents who are asymptomatic. Since 2019, WHO has recommended a fixed-dose combination of tenofovir disoproxil fumarate (TDF), lamivudine, and dolutegravir (DTG) (TLD) as the preferred first-line regimen for people initiating antiretroviral therapy. As a preferred alternative option, low dose efavirenz is being offered as an alternative to dolutegravir. DTG is also recommended in second-line antiretroviral therapy for treating individuals with treatment failure.
The HIV Scientific Committee in Egypt has supported the national program to develop the new National Guidelines, released in January 2021. The new guidelines are aligned with WHIO recommendations, including the transition to DTG based therapy. This progress calls for intensifying efforts to scale antiretroviral therapy with DTG and assess the impact of such changes on achieving the transition smoothly. This is especially important to monitor the transition among women with HIV closely. Women with childbearing potential or any pregnancy or breastfeeding should be provided with information about benefits and risks to make an informed choice regarding the use of DTG or other ART.

While the current general guidance is to treat all regardless of the CD4 count, CD4 cell count testing at baseline for all people living with HIV remains important. Identifying people with advanced HIV disease who are eligible for elements of a package of care requires CD4 cell count testing.

Treat all, Rapid Initiation, and same-day offer.

The introduction of the "treat all" recommendation (ART for all people living with HIV regardless of CD4 cell count) supports the rapid initiation of ART, including the offer of same-day initiation where there is no clinical contraindication. Adopting these policies is critical but might create many operational challenges. The WHO is also recommending that rapid ART initiation be offered to people living with HIV following confirmed diagnosis and clinical assessment. Rapid initiation of ART is defined as within seven days of HIV diagnosis. ART initiation on the same day upon HIV diagnosis is a strategic decision, but it should be based on the person's willingness and readiness to start ART immediately unless there are clinical reasons to delay treatment. 2016 WHO consolidated ARV guidelines made recommendations on decentralizing ART initiation to peripheral health centers. In addition, there is evidence that establishing good adherence in the initial period following ART initiation is important for long-term treatment success. The guidance stressed the need for quality counseling to support treatment literacy, including lifelong optimal adherence, how ART is monitored, and options for future differentiation of care. Besides that, experience has shown that both clinical and public health approaches to ART service management are important; by using simplified and standardized ART that supports the decentralization of care.

Analyzing the available data on enrollment of new cases on ART is important. All Governorates, except Cairo and Giza, have succeeded in enrolling and maintaining the vast majority of PLHIV on treatment. This data may indicate the need to start the approach of same-day treatment in Cairo and Giza.



PLHIV: New and on ART Per Governorate, 2020

As national guidelines in Egypt have evolved towards initiating ART for all people with HIV regardless of clinical and immune status, the HIV program has been challenged to manage an increasingly diverse set of people's needs. There is a diverse mix of patient groups that need differentiated care, including PLHIV presenting or returning to care with advanced HIV disease; those who are clinically well; those newly established on ART; and those receiving an ART regimen that fails. There is a need to understand how the 2021 new guidelines will be applied in clinical sites to achieve better-differentiated care to these groups. Of particular importance to continue to simplify the service delivery for those who are clinically stable. Currently, people who are established on ART are offered clinical visits every 3–6 months, preferably every six months. They are also offered refills of ART for three months.

Service delivery models should also be designed to address the needs of children and adolescents, pregnant and breastfeeding women, and key populations. While the number of children on HIV treatment is not large, there is a need for more differentiated services to address their needs. That is essential as HIV diagnosis among children and pediatric HIV treatment coverage are stagnating

Quality of services

The results of several studies have indicated that rapid ART initiation, including same-day start, can improve program outcomes, especially by reducing loss to care in the pre-ART period. Rapid initiation is defined as within seven days from the day of HIV diagnosis; people with advanced HIV disease should be given priority for assessment and initiation. However, some evidence from program settings indicates that rapid initiation could lead to increased loss to follow-up after initiating ART because of insufficient time to accept and disclose HIV status and prepare for lifelong treatment. The offer of same-day ART initiation should include approaches to improve uptake, treatment adherence, and retention, such as tailored patient education, counseling, and support. This more rapid approach to ART initiation is particularly relevant to people with advanced HIV disease, considering the specific clinical benefits.

On the other hand, there is a need for intensified adherence support to be provided at the time of diagnosis and initiation of ART and the patient journey. Chronic care requires integrating and linking related services to ensure comprehensive and consistent care provision over time. Integrated services will enhance adherence support and optimize retention in care.

Moving forward:

Moving forward, the NSP will focus on ensuring that ART initiation follows the overarching principles of providing people-centered care. People-centered care will be organized around people's health needs, preferences, and expectations, especially for vulnerable populations. The program will promote engaging and supporting people and families to play an active role in their care by informed decision-making. The focus will be on offering safe, acceptable, and appropriate clinical and non-clinical services in a timely fashion to improve health outcomes and the quality of life of PLHIV.

Strategic outcome 4.1: Enhance enrolment, retention in care, and service quality

The NSP focuses on the following interventions and strategies:

a. Ensure 95% of all new cases are enrolled on ART in a short period through continuous monitoring and data analysis.
b. Review the current set of indicator frameworks used to monitor the availability, access, and uptake of treatment service, and ensure proper clinical monitoring of ART effectiveness and outcomes.
c. Based on the clinical guidelines, develop a package of operational guidance to healthcare workers to support rapid ART initiation and intensified adherence interventions, including guidance on the same day to people who are ready to start.
d. Improve facility-based adherence counseling and tracking mechanisms for PLHIV, build local capacities at Fever Hospitals to manage these mechanisms, and link that with support from PLHIV and CSOs.
e. Offer individualized adherence counseling and client-centered communication.
f. Ensure that PLHIV in special settings like detention centers, prison settings, refugees, and migrants have uninterrupted access to treatment and clinical follow-up.
g. Enhance mechanisms for adequate monitoring, including pharmacovigilance and surveillance for drug-drug interactions.
h. Enhance the culture of providing feedback to healthcare workers on client concerns and evaluation of service quality.
i. Conduct sensitization training for clinical and non-clinical healthcare providers to improve linkage, treatment, and care for key populations.
j. Conduct research activities to identify strategies that support the access of PLHIV to HIV treatment services and adherence to ART.
k. Conduct a cohort audit to identify some of the lost cases and implement re-link activities with them through a strong partnership with CSOs, PLHIV groups, and other partners.
l. Implement interventions to trace people who have disengaged from care and provide support for re-engagement.

Strategic Objective 5: 95% of PLHIV who are currently on treatment have achieved and maintained viral load suppression

Scale-up comprehensive responses, including testing, access to quality treatment, and retention in care, are a strategic objective for the HIV response in Egypt. The is a need to increase efforts to ensure accessible, affordable, and stigma-free and better access to treatment and viral load testing for all people living with HIV.

On the other hand, approximately 3300 adults became newly infected with HIV in Egypt in 2020. Many of those new infections were transmitted by people who did not know their HIV status, were not on treatment, or had started antiretroviral therapy but had not yet become virally suppressed or had poor adherence to their treatment. While the focus on prevention remains a public health priority, achieving better treatment adherence to ensure viral suppression is critical to breaking the current chain of HIV transmission. Data also indicates that approximately less than 500 people died of AIDS-related illnesses annually. Many of those deaths occurred among people who did not seek or continue their medical attention until they became very ill.

To maintain an undetectable viral load, it is very important for a person living with HIV to stay on treatment and have regular viral load tests. Regular viral load testing helps people living with HIV and their healthcare providers monitor the success of a treatment regimen. It is important to raise awareness and promote the knowledge that undetectable viral load means untransmittable infection, an important message to motivate adherence. On the other hand, within the current program context in Egypt, there needs to be better access to viral load testing at affordable prices, combined with effective laboratory systems and vital health services.

Strategic outcome 5.1: Scale-up of viral load testing and monitoring

By 2013, WHO guidelines recommended routine viral load testing for all HIV-infected children and adults on ART. Measurement and understanding progress towards the viral suppression target among people receiving ART and as a proportion of all PLHIV has proven challenging in many countries, where the coverage and reporting of VL testing have been suboptimal. Besides challenges in providing the testing services, these same challenges are facing HIV programs in Egypt. The definition of viral suppression in National Clinical is aligned with the 2016 consolidated WHO ARV guidelines. The guidelines indicate that viral suppression refers to the aim of ART to maintain viral load below the level of detection of available assays, generally less than 50 copies per ml. The current WHO virological criterion for treatment failure is 1000 copies per ml or more.

The importance of viral load testing and achieving the targeted viral suppression rates at the population level is important to inform national targets and provide targeted programmatic quality improvement efforts. It is also an important measure at the patient level to provide enhanced care and support to people living with HIV. Clinically stable people with undetectable viral loads can be provided with differentiated service delivery options that reduce clinic visits and allow for three- or six-monthly drug prescriptions. Further, viral load testing is critical to ensure that those with detectable viral loads greater than 1000 copies/mL are provided enhanced adherence counseling and more closely monitored to determine whether they need to switch to second-line treatment.

Scaling up laboratory capacity in Egypt will facilitate increased access to HIV diagnostics in general and for HIV viral load. However, challenges remain, with inadequate patients' access (as confirmed during the program review), human resource shortages, long test turnaround times, and proper clinical utilization of results (which requires further training and supervision). The addition of point-of-care viral load testing is an important step towards improving the use of viral load in different governorates. While decentralization (through point-of-care technologies) is important to enhance access to high-quality testing, it should be combed by laboratory-based services in an integrated laboratory network. With the expected increase in viral load testing coverage and enhanced viral suppression proportions because of better linkages, retention, and adherence, it is important to focus on how people with an elevated first viral load will be monitored and supported (including through clinical interventions, e.g., switching to a second-line regimen).

Progress on Viral Suppression by age and gender among people tested for viral load 2020

	Number tested for viral suppression.	People tested who are virally suppressed.	Proportion
Children 0-14	**183**	**164**	**89.6%**
Male 15+	**3275**	**3046**	**93.0%**
Female 15+	**856**	**822**	**96.0%**
Total	**4314**	**4032**	**93.4%**
% of all PLHIV	**18%**	**17%**	

Data from NAP indicated that 18% of the patients on treatment had received viral load testing in 2020. Of these patients, 93.4% had achieved viral suppression. However, several bottlenecks limit the availability and use of data about viral load testing. Routine viral load testing is not being offered at all treatment facilities, and not all patients attend for their testing on time. As a result, interpreting the current data may lead to biased or skewed representativeness of estimates of viral suppression based on those accessing testing. It is important to continue assessing the completeness of viral load monitoring data at the treatment centers and laboratory level and determining the coverage of VL testing in terms of the proportion of eligible PLHIV. They should receive a test and have their results documented in their patient records and used. In addition, timely transmission, receipt, and use of viral load test results remain a challenge. That is affecting both the completeness of data and the quality of care. Bottlenecks in reporting or returning VL results should be identified to support remedial actions, improve data flow, and ensure the clinical utility of results for improved patient care and service delivery.

Strategic outcome 5.2: Increase adherence to HIV treatment

The primary purpose of antiretroviral therapy is to keep people living with HIV in good health. For most people living with HIV, antiretroviral medicines can reduce HIV in the blood to levels that are undetectable by standard laboratory tests. Efforts to reduce a person's viral load to undetectable levels, and prevent onward transmission of the virus, need to be tailored to the individual, considering adherence to the antiretroviral medicines.
Adherence-support interventions are strongly recommended to be provided to people receiving ART and use the viral load monitoring for monitoring adherence and confirming treatment response. Approaches to monitoring adherence should provide additional information about the risk of failure to suppress viral loads or to support daily tablet-taking behavior in settings where viral load testing is not available. On the other hand, health care workers should assess the level of adherence and decide to simplify service delivery models if patient's outcomes are favorable or to switch treatment regimens when viral load is unsuppressed.

The national program sensitizes the service providers to use simple adherence monitoring tools. Effective monitoring of adherence requires a combination of approaches. These may include using the pharmacy refill records on when people pick up their antiretroviral drugs. The use of self-reported feedback can be a useful adjunct to estimating non-adherence. However, counseling on the importance of remembering ART doses and an environment that promotes and enables honest reporting of non-adherence are critical components.

Strategic outcome 5.3: Identity, engage, or re-engage people with HIV who are not virally suppressed

As mentioned before, multiple factors are contributing to the prolonged time to repeat testing, including patient factors that prevent them from returning for counseling and/or repeat viral load testing. It is critical to ensure that the program

collects and analyzes data on people who are lost to follow-up regarding who, why, where, and when they have dropped from the care and treatment program.
Besides, detecting earlier treatment failure resulting from pretreatment drug resistance would be beneficial. The 2021 national guideline recommends that the first viral load test be performed six months after initiating ART; however, experience has shown that for many people living with HIV, sample collection, testing, and result delivery occur beyond that period. These factors may aggravate further the chance to follow up patients at regular intervals. A defined and more precise time for the repeat viral load test may create more consistency and compliance and emphasize the importance of timely repeat viral load testing.

Interventions that target people living with HIV with advanced HIV disease initiating treatment, including the central role of CD4 for clinical staging, are important. Since CD4 testing is critical for assessing immune status, access to CD4 cell count is an essential component of high-quality services for people living with HIV. The changing indications for CD4 testing have led to giving lower priority to CD4 access. This decrease in perceived value may threaten access to timely CD4 testing if CD4 testing networks are not adapted to the needs of advanced HIV disease screening. Given the high risk of short-term morbidity and mortality among people with advanced HIV disease, rapid and simple CD4 testing is essential. The national program should assess how to maintain this testing either as centralized testing networks or point-of-care devices. In addition, experience has shown that point-of-care CD4 testing has a role in improving retention in care, which is an important opportunity.

Moving forward:

This NSP will create effective health services that provide optimal care and treatment to people living with HIV and continue to revitalize and invest in laboratory testing and clinical services to support HIV care services. It also aims to ensure that the right training, tools, and environment are available to promptly improve the uptake and use of all diagnostic results. The program will work closely with all healthcare providers to reinforce and support adherence to antiretroviral medicines, ensure regular returns for health checks and provide personalized advice.

The NSP focuses on the following interventions and strategies:

a. Ensure adequate training on ART for clinicians, healthcare providers, including the transition to optimal regimens, treatment failure, switching therapy, and adherence support.
b. Ensure accurate and timely viral load data, with the results available for use, by enhancing data collection systems and records.
c. Map out all of the referral needs, links, and pathways for viral load specimen type, based on testing algorithms and capacity, between each relevant level of the health system—building quality improvement based on this analysis.

Strategic Objective 6: Validate and Maintain Zero vertical transmission from mother to child through high-quality care for HIV-diagnosed pregnant women and pediatric service

Globally, there are 1.4 million new maternal HIV infections and 988,000 new maternal syphilis infections each year, and 65 million women of childbearing age with chronic HBV infection. Elimination of mother-to-child transmission (EMTCT) of HIV, syphilis, and HBV remains a global health priority. HIV and syphilis testing as early as possible in pregnancy enables pregnant women to benefit from prevention, treatment, and care and reduces the risk of transmission to their infants and sexual partners. Early treatment for HIV and syphilis and use of PMTCT interventions (antivirals and birth dose with infant HBV vaccine) and identifying those women in need of long-term treatment for chronic HBV will lead to the best health outcomes for mothers and children.

Through the decades of experience, ART has been proven as the most effective in preventing HIV transmission from mothers to infants when begun before or early in pregnancy. These services can be delivered at ANC or post-natal (PN) services. Linkage to the full package of RMNCH services is essential for all women and HIV-exposed infants regardless of HIV status.

Data from 2020 HIV program records indicated that 76 women out of an estimated less than 500 HIV-positive pregnant women had received ARVs to reduce the risk of infection to their infants. However, the program has managed to ensure that all newborn infants born to known infected mothers or exposed to HIV risk factors received a timely early infant diagnosis in 2016.

With gap in data, it is not easy to affirm whether or not Egypt is on track to eliminate vertical transmission of HIV from pregnant mothers with HIV to their children. According to WHO, a country is deemed to have eliminated MTCT of HIV when the HIV MTCT rate is ≤ 2% and when the rate of pediatric HIV infection is ≤ 0.3 per 1,000 live births, supported by indicators of access to prenatal care, screening for HIV in pregnant women, and treatment of pregnant women with HIV.

Since 2018, the program has maintained a protocol as all HIV-positive children born to mothers known to be living with HIV should be provided with ART as part of the government-supported program. All mothers known to be living with HIV can access PMTCT services through the treatment centers. NAP implements guidelines for treating all children irrespective of their age and CD4 count, irrespective of symptoms, with an age cut-off to treat all <5 years.

Strategic outcome 6.1: Increase knowledge of HIV status among pregnant women

Despite the massive expansion of HIV testing among pregnant women, the current coverage of services to prevent mother-to-child transmission of HIV is low in Egypt. Meaning that fewer than estimated pregnant mothers tested and know their status during pregnancy. Only 76 in 2020 were diagnosed with HIV out of estimated less than 500 cases. Most children and adolescents are tested for HIV either because their parents have been tested and diagnosed or because they have become symptomatic of advancing HIV disease.

The proportion of pregnant women in 2020 who received HIV testing

The goal of this NSP is to expand umbrella of coverage to include all encountered pregnant women.

Given that Egypt has a low prevalence of HIV, it is essential to balance all of the options regarding the testing policies related to ANC and PN services. As the county aims to achieve the global target in this area and learn from the initiative of 100 million Seha, it is imperative to devote resources to sustain the testing. In addition, the testing protocol of women at high risk during pregnancy and postpartum period will also be defined e.g., who are in serodiscordant relationships where the partner is not virally suppressed on ART or have other known ongoing HIV risk.

Improve linkage, initiation, retention, and adherence of HIV-diagnosed pregnant women to HIV treatment

There is a need for a diverse mix of differentiated care models for pregnant women in the next period. The stakeholders around this area should adopt new and innovative modalities for reaching and linking pregnant women who are newly diagnosed and missing. In addition to strategies highlighted in relevant sections of this NSP, additional strategies, such as differentiated ART delivery models and peer support and adherence counseling, should be implemented to make it easier to stay in care and prevent treatment drop-out more focus on pregnant women. There is a need to adopt certain policies and service delivery models to eliminate mother-to-child transmissions, such as the role of associated paramed has to be enhanced to encourage enrollment in treatment and sustaining the link with health care facility.

Strategic outcome 6.2: Early infant diagnosis (EID) and continuous monitoring and treatment

The overarching goals of providing HIV testing to infants born to a mother with HIV are to deliver an early diagnosis and effectively facilitate access to and uptake HIV prevention, treatment, and care. For HIV-exposed infants, virological testing for HIV as early as possible is recommended so that ART can be started immediately, and morbidity and mortality prevented. HIV and syphilis testing as early as possible in pregnancy enables affected pregnant women to benefit most from prevention, treatment, and care and reduces the risk of transmission to their infants and sexual partners. Similarly, early treatment will lead to the best health outcomes for mothers and children. ART is most effective in preventing HIV transmission from mothers to infants when started before or early in pregnancy.

As stated before, all infants born to HIV+ mothers are screened for HIV infection according to the national protocol. Most infants and young children are tested and diagnosed as HIV positive following confirmation of the parents' diagnosis.

As per the national testing guidelines, Infants perform PCR test after 2 weeks of prophylaxis cessation (i.e.: after 2 months of birth). Then if PCR result is undetectable, the test is repeated every 3 months till 18 months age, then antibody test is performed to confirm negativity. At any point the PCR result is positive, the infant is immediately linked to care and ART services. Screening and diagnosis may also occur by PITC through hospital services, but such cases are extremely rare in the last few years. In addition to birth and after birth care, assessing the risk of infection through breastfeeding should be maintained, and those infants at risk should be linked to services for prevention and offered a broader package of appropriate services according to guidelines.

Cascade of EID monitoring for new pregnancies of HIV positive pregnant mothers, 2020

In 2020 100% of all HIV-exposed infants were tested by the second month of age, and none of them was detected HIV positive.

Moving forward:

Moving forward, the NSP will focus on validating and maintaining zero cases of HIV vertical transmission by implementing tailored, integrated, and differentiated service delivery for women and children. It will also focus on implementing innovative tools and strategies to find and diagnose all pregnant women living with HIV and HIV-exposed infants. Appropriate care will be provided to those confirmed to be HIV positive and those who are found negative but at higher risks of HIV infection.

The NSP focuses on the following interventions and strategies:

a. Cross cutting between the five identified strategic areas should be utilized towards achieving eMTCT
b. Ensure, through policies and relevant plans, all pregnant women are tested for HIV and syphilis at least once and as early as possible.
c. Work towards integrating services to match the needs of pregnant women who are HIV positive or at higher risk of HIV positive.
d. Provide women with HIV, including those who may become pregnant, information about the benefits and risks of ART, and medical guidance appropriate to their situation.
e. Ensure timely HIV testing (with two months of birth) of HIV-exposed infants (born to HIV-positive mothers), with prompt return of test results and immediate treatment for those with confirmed for HIV with a second sample.
f. Ensure all infants who born to a women LHIV, who tested negative for HIV, are enrolled immediately on preventive care as appropriate, and link infant who at high risk of infection through breastfeeding to services prevention.

Strategic Directions 3: Strengthening the availability and use of strategic information on HIV

Strategic objective 7: strengthen HIV surveillance system and invest in strategic information by end of 2022

Egypt's HIV surveillance system has been robust since establishing the national program. The system provided rich data on the level and trends of the HIV epidemic over the years, which has been used to monitor the evolution of the HIV epidemic. Besides the routine data collection, one round of Integrated Biological and Behavioral Surveillance (IBBS) was undertaken. The 2006 and 2010 IBBS have improved surveillance among MSM, PWID, and sex workers to better understand the epidemic within these groups.

The broader national health information system in Egypt suffers from some challenges. Developing and strengthening the national health information system and monitoring framework is a priority for the government in the current period. That will become particularly crucial as the renewed focus on robust national health policies and plans will need to be supported by a reliable health information system that can provide policy-relevant data and information to monitor and evaluate the progress. Steps are underway in MoHP to institutionalize the health information system by establishing a multispectral health information steering committee for sound health information governance, establishing a "data warehouse" for the sector, strengthening HIV related civil registration and vital statistics, developing a national research strategy, and through other strategies to enhance information and evidence.

On the other hand, HIV routine information system remains vertical in Egypt, mainly due to the nature of service delivery models currently used to provide testing and treatment services. World Health Organization supports MoHP in establishing a stronger routine health management information system (HMIS) on HIV-related services. This will change to a great extent the completeness and quality of routine data. The new system can help identify and remove duplicate health information for patients within and between clinics, such as linking records using unique identifiers. No unified adopted reporting system from NGOs, involved in HIV prevention , care and support services. A system for monitoring the health care outcomes of all people tested and entered care needs development so that care cascade diagrams can be used as a management tool. Annual reports against the national strategic framework should be published.

Egypt has a window of opportunity to stop HIV from becoming a generalized epidemic and reverse the number of new HIV infections. However, this can only be achieved if appropriate and timely surveillance systems are put in place. HIV/AIDS is a notifiable disease in Egypt, with standardized data reporting forms and procedures are in place at sentinel and service delivery sites. Data forms and reports are built to enhance HIV case-based surveillance. These data are reported as part of the routine information system described above. The MoHP is currently implementing a National Epidemiological Disease Surveillance System (NEDSS). Surveillance is limited to the leading public STD hospitals. There was a recommendation during the mid-term program review of 2018 and the end-term program review of 2021 to re-assess HIV surveillance to understand the gaps and develop appropriate actions. However, some gaps exist in the current surveillance system, despite efforts by the NAP and other national and international organizations. Gaps include lack of biological surveillance among at-risk groups, weak sentinel surveillance among women, and lack of systematic and representative behavioral

surveillance data (especially for the general population). Some key challenges explain many of these gaps in Egypt's surveillance system. First, at-risk groups are difficult to access due to their social marginalization. Secondly, a severe lack of knowledge among health workers and the general population makes it less likely that people will seek a potential HIV diagnosis. Thirdly, the conservative nature of Egyptian society, including general reluctance to discuss sexuality, limits the ability to conduct representative behavioral surveillance. Besides, structural factors within the NAP itself and the wider health system, ranging from understaffing, bureaucracy, limited budget allocation, and fragmentation of efforts, maybe constraining surveillance efforts. Further research and practical strategies are urgently needed to overcome these challenges so that appropriate surveillance can ensure a timely and proper response to this emerging epidemic.

The health-facility-based surveillance system is limited to positive case-finding, and uptake of HIV-testing-and-counseling services is very low in this high-risk approach. Furthermore, monitoring and evaluating HIV services and interventions are limited to basic information on the number and coverage of services provided. However, in the absence of operational research, it is impossible to assess these programs' quality and the impact they have on their beneficiaries. The previous NSP called for operational research to be part and parcel of new interventions to identify what works and improve programs and services (cost) effectiveness. There is no clear guidance or policy on approaching and using patient identifiers (name, date of birth) and individual-level identification methods. For example, there are no national-level identification numbers, no clinic-assigned patient numbers, or biometrics. Similarly, there are no existing policies on HIV reporting regulations in general. Accordingly, there is a lack of clarity around the roles and responsibilities of the testing/diagnosing facility to provide complete patient data and the treatment sites. However, and as in many countries, these sources of data are not harmonized and integrated. For example, registers (for C&T, HTS, PMTCT, pharmacies, and laboratories) are all available and used, but they are not patient-centered and do not correlate directly at the program level. Variables collected in these registers need to be simplified and revised to correlate and focus on achieving completed patient files at the program level.

Data flow on cases reported remains mainly as a clinical function rather than a surveillance function, in which all cases that have been screened positive should be confirmed through the central laboratories. Upon confirmation, the cases will be reported officially to NAP. There is no direct link between the national program and the reporting facilities, neither can the national program access the data from the reporting facilities directly. Accordingly, the notification remains interrupted (only from the laboratory). There was no formal data quality assessment or review that has been conducted in the last ten years and no evidence that the surveillance system itself was a subject of a major review or changes. While supervision is often done from the central to governorate levels; however, this surveillance normally does not receive much attention compared to other program areas.

Moving Forward:

Strategic information is a critical piece that shapes the national response to the HIV/AIDS epidemic. Strategic information management to support the decision-making through strong monitoring, evaluation, and surveillance (MES) framework have been fundamental to HIV response. It started with the setting up surveillance systems in the early days of the HIV/AIDS epidemic that guided the initial response under NAP. Strategic information is a major challenge to be addressed under this NSP. Surveillance and M&E systems do not provide the information needed to assess the key population numbers or the locations. The baselines are largely missing, and the information on the indicators established is not available. The quality of the information collected and its analysis and use for program monitoring and development need to be

strengthened. Surveillance systems need to be re-built and restructured to address all of the current gaps and be aligned better on the objectives of the national response.

This NSP will have a strong in-built component to measure its impact and guide the program in evaluating and achieving a fast track and sustainable development goal of ending the HIV/AIDS epidemic. A joint participatory mid-term and end-term review engaging all stakeholders will also be implemented to review the achievements, identify the opportunities and challenges, and advise and offer recommendations for planning the program's next steps.

The objective is to develop the national surveillance system to generate periodic estimates in the general population and key population. In addition, it is important to institutionalize Case-based HIV surveillance within the MOH and governorates and support routine surveillance activities.
One cohesive M&E framework will be the core strategy of strategic information management. The information system will be capacitated and maintained as a comprehensive system for data management and data analysis in the next period. This will help avoid multiple data reporting and parallel data management systems and ensure linkages and individual patient tracking across program components. It will ensure that all the data personnel collaboratively work with the Surveillance Unit to avoid duplication and increase efficiency. Knowledge transfer through training, update of latest systems, data definitions, development of guidelines, changes in formats must be done to achieve better Surveillance capacity.

A Core Surveillance Committee of HIV and M&E experts could be proposed to establish the Core Surveillance Committee. The committee will meet every quarter to discuss and review the progress at NAP. A team of key M&E officers will be identified for sharing knowledge and building capacity to enhance the monitoring, quality, and use of data.
The NSP aims to address the weaknesses in the surveillance system and systematically identify and prioritize more on which surveillance and surveys are necessary to update its decision-making.

To achieve this, the following interventions and strategies are targeted:

1. Standards will be revised, disseminated, and monitored. It will be made widely available to all concerned parties.
1. The electronic registry will be continually enhanced to promote the sharing of patient information across HIV service delivery points and various programs. The national database would usually use unique identifiers instead of names to enhance information privacy and security. Clinical documents typically retain names that require the utmost consistency to sustain the continuity of patient experiences.
2. Assess the possibility of establishing a comprehensive patient monitoring system, including a provision of database to follow the cohort of pregnant women over a long time, especially that of women's plan for multiple pregnancies. For infant outcomes, it is important to document the use of ART until the infant is weaned, while for maternal health, it is important to document continued use of ART past infant weaning.
3. HIV case surveillance will be used to measure its progress against several of the strategic indicators for the monitoring and evaluation of the 95–95–95 targets. Sentinel events for HIV case surveillance correspond to several of the priority strategic indicators for HIV in the health sector.
4. Thenationalprogramwillworkwithallofthepersonnelwhodiagnoseand/orcareforpatientswithHIV, or the records clerks to ensure real-time quality and complete case reports.
5. The national program will (at the Ministry of Health level) visit all the reporting sites regularly to review data sources to complete the case report.

6. Conduct population size estimates, continuous analysis of HIV epidemiology, with disaggregation of behavioral data and HIV prevalence by age groups.

The HIV and STIs surveillance will be strengthened at the priority governorate levels, which will provide support for enhancing the surveillance at service delivery levels to enable front-line workers to understand the epidemic. This will be done using simple tools that will draw and triangulate data from both surveillance and program systems that will enable the governorate workers to identify the geographical areas and population groups that require attention.

Strategic Directions 4: Strengthening access to key HIV services, addressing inequalities and ensure supportive social, legal and policy environments

Strategic objective 8: National HIV response in Egypt addresses key barriers and inequities

The mid-term program review in 2018 and the end-term program review of 2021 have emphasized critical understanding of policy, programmatic and structural gaps, and barriers to increasing service coverage and reducing HIV incidence.

The key issues include:

- The urgent needs to reduce disparities in risk factors, in new HIV infections, knowledge of HIV status, and along the HIV treatment and care continuum
- The need to strengthen the legal and policy framework on HIV and AIDS ensures that it is inclusive of all persons living with HIV, key populations, and other vulnerable groups.
- Persistent stigma and discrimination with a need to implement interventions aiming at reducing it.
- Pay attention to unaddressed sexual and gender-based discrimination and violence.
- Fill the policy gaps to address issues related to the gap in HIV prevention financing, lack of systematic program implementation of current interventions at an adequate scale.

A fundamental principle to approach the mentioned challenges is to apply the principle of people-centered services to provide the targeted populations with their needs. The fundamental idea that this new strategic plan will adopt is better tailor the services to match the needs of the targeted people, instead of more emphasis on changing the general environment or the culture. This was a key lesson learned from the HIV response during the previous period. Good people-centered systems and services are more controllable and achievable than emphasizing extreme legal, social, and cultural environments. Addressing the needs and rights of key and vulnerable populations to access and receive the right mix of services will remain a strategic principle and goal for HIV stakeholders in Egypt.

On the other side, adopting the people-centered approach does not contradict the importance of continuing the advocacy work to address the systemic barriers that hinder people living with and affected by HIV from accessing the services. Exitance of multiple barriers is not unique to Egypt, as many countries in the Middle East and North Africa region (and beyond) continued to face similar challenges. With more evidence and analysis, the stakeholder will be able to develop and tailor effective solutions and interventions to remove these barriers. The stakeholders agreed on the importance of a continued focus on this area through advocacy work and open dialogue at different policy and community leaders' levels.

NAP should continue to conduct assessments and reviews of structural barriers for key populations to access the services and identify critical enablers to address them.

Strategic outcome 8.1: Reduce disparities and inequalities across the continuum of care and services

Barriers and challenges still exist that affect the progress to achieve the desired results on HIV prevention and testing.

Key populations continued to experience the fear of stigma, discrimination, and lack of confidentiality.
Adolescents still experience barriers to access HIV prevention and testing services. Policies around age-of-consent may affect the rights of this group to make choices about their health and well-being.
In addition to the spread of health-related risk behaviors among key populations, increased risk of HIV among these populations could be attributed to the impact of stigma and discrimination on their vulnerability. Men who have sex with men are criminalized, and FSW remains marginalized and subject to significant legal penalties under existing regulations. Stigmatizing attitudes and discriminatory behaviors serve as a significant disincentive to access necessary services for the prevention, care, and treatment of HIV. Working with the key populations has a long history in Egypt since 2007 with the first project that has targeted FSW. Despite that, social and legal challenges and barriers continued to shape the prevention response in this area. On the other hand, significant progress has been made on breaking some important policy barriers.
Experience has shown that strong and bold political leadership and plans are required at all levels to address sensitive issues and defend progressive public health, social policies, laws, and ambitious prevention targets for key populations. Since the introduction of the last NSP, Egypt has taken implementation steps to address key barriers and create an enabling environment for successful prevention programs, focusing on lifting the structural and policy barriers to access services among PWID as priority populations. While there are breakthroughs in addressing policy barriers in the mentioned area, challenges still exist to address some of the structural barriers to address the needs of other key populations like MSM or other vulnerable populations like transgender people.
The social and legal situation directly or indirectly increases transmission risk for men who have sex with men. Data continued to indicate the significant number of new infections among MSM, and anecdotal evidence shows that the social and legal situation affects their health-seeking behavior and acts as a barrier in several ways. The marginalization of MSM in the societies continued to have its consequences on risks of HIV infection. In addition, due to legal implications, MSMs may not be expected to attend public behavior change communication talks or receive specific types of condoms and other commodities in public spaces outside of their network. Specific civil society actors and strategies are therefore required to provide HIV prevention and treatment services to MSM.

As emphasized through this NSP, the HIV response to words young key populations is crucial. Egypt is characterized by many young people (around 40 million) with special needs for preventive services that should be designed and delivered innovatively to attract them. According to experts, the current service delivery models, where preventive services are promoted as part of primary care facilities, are not attractive to most young people. This population group's risk perceptions and awareness are usually low, combined with some misconception or inadequate knowledge. A 2014 survey of young men and women ages 15 to 29 in Egypt revealed that less than 10 percent knew all possible modes of HIV transmission. More-educated youth were only slightly more likely to know all the modes of HIV transmission, reaching 15 percent for women and 19 percent for men who had 16 years of schooling or more. HIV epidemiology in Egypt indicating that men are more affected by HIV than women. Many studies clearly show that, compared to women, men's lifestyle and health behaviors generally make them more prone to ill health problems and dying prematurely. Despite many social and economic advantages, men are less likely than women to seek preventive services, medical care, or initiate and adhere to HIV treatment.

Stakeholders should continue to develop strategies that address the needs of young men and their meaningful contributions towards achieving the prevention objectives. Learning from experiences of other countries and similar societies is essential. The persistent escalating situation on HIV transmission calls for different and innovative approaches for enhancing the correct knowledge about HIV and AIDS among the general population. These approaches will build on existing platforms and entry points to access the targeted populations with an appropriate and comprehensive package of knowledge that is sensitive to their needs and context. That is a vital strategic component as it emphasizes primary prevention as a key from a public health perspective.

Unlike the previous decade, the MENA region started to witness more stability in ongoing armed conflicts and wars. The instability in the region is a key determinant of the humanitarian context and situation in Egypt. Egypt continues to host large numbers of refugees and asylum seekers from more than 50 countries of origin. More than half are from Syria, and most of the rest are from countries in sub-Saharan Africa, Iraq, and Yemen. Most people live in urban areas with the host community. Refugees and asylum seekers enjoy the same public health services and educational opportunities as Egyptian citizens. According to the UN refugee agency, Egypt hosts refugees and asylum seekers from 56 different countries. As of October 2019, the refugee population registered with United Nations High Commissioner for Refugees (UNHCR) includes around 260,000 refugees from 8 countries. More and more people of concern are trapped in the poorest and most populated communities in big cities like Cairo and Alexandria[5]. Other reports indicate that the unlisted numbers might exceed six million. Some of these populations may expose to different conditions that expose them to many vulnerabilities that might increase their exposure to risk factors associated with transmission of infectious diseases, including HIV. Population instability, movement, and migration can place people in situations of heightened vulnerability to HIV and have been identified in certain regions as an independent risk factor for HIV. In most countries, refugees, asylum seekers, and undocumented migrants face complex obstacles, such as a lack of access to healthcare services or social protection. This increased HIV risk and vulnerability is exacerbated by inadequate access to HIV prevention, treatment, and care services and the fear of being stigmatized for seeking HIV-related information or support.

Strategic outcome 8.2: Encourage community participation in HIV response

It is essential to continue to look at the community involvement is critical for successful advocacy and accountability. It is important to engage and build capacities of the community activists in advocacy at the community leadership level against sociocultural prejudgments harmful to the rights of individuals to access healthcare services. That can help in creating a favorable legal environment for people living with HIV and key populations.

The critical role of civil society organizations in HIV prevention response towards the key populations will continue to be a fundamental success factor. Many civil society organizations were working to prevent HIV services among people who inject drugs and other key populations. Combination prevention services implemented in Egypt through these organizations include raising awareness, condoms, HTC services, but no pre-exposure prophylaxis is included in the part service package. The NSP development process ensured that civil society organizations and representatives of people living with HIV and of key populations actively participate in framing the HIV response priorities and strategies. That included the mobilization of community organizations and networks so that key and vulnerable populations have increased representation in the process.
This NSP should aim to support and empower the community and civil society organizations, including organizations and networks of PWID, MSM, and other key populations, to design and deliver HIV, health, and

[5] https://www.unocha.org/middle-east-and-north-africa-romena/egypt

social protection services. Besides, it will continue to build the capacity of CSOs working with the targeted populations to enhance their capacity to deliver the services.

(3) Many of the CSOs are not working directly in HIV-related fields. However, many are engaged in offering sexual and reproductive health services, especially women and young people. This represents an important opportunity in which HIV should continue to be integrated into the scope of services offered through these organizations. Scale-up of interventions is feasible if joint activities, partnerships, and integration among NGOs/CBOs, governmental and international agencies are considered for all initiatives. The government should ensure the use of social contracting modalities for engaging allied nongovernmental organizations to deliver community-led and community-based services.

Strategic outcome 8.3: Reduce HIV-related stigma and discrimination

Stigma and discrimination continued to shape and negatively affect the national response to HIV in Egypt. It takes different shapes, including:

(1) There are significant challenges associated with stigma and discrimination towards the key population groups, affecting their safe access to prevention services at inadequate levels. On the other hand, other policy changes continued to be refined and implemented to enable better access to services among other populations, including prisoners, refugees, and others. Moving ahead, there is a need to focus on the need for sensitization training of healthcare workers to address stigma and discrimination in the health sector.
(2) While the strategy calls for enhancing demand creation to increase the adoption of HTS and attract the target population, the increased demand is also an important tool to ease the stigma and discrimination associated with HIV testing.
(3) Many people living with HIV remain undiagnosed. The main reasons include fear of stigma and discrimination, challenges in referral linkages, poor health-seeking behavior among patients, and other factors.

The NAP will seek technical support to establish interventions and training targeting healthcare workers to reduce stigma and discrimination toward key populations in the health sector. Many PLHIV continued to face discriminatory attitudes towards people living with HIV. Misconceptions and misinformation continued to shape this negative culture.

Strategic outcome 8.4: Address sexual and gender-based discrimination

Gender inequalities and harmful norms, which promote unsafe sex and reduce access to HIV and sexual reproductive health services, continue to drive the transmission of HIV. Within this context, addressing the needs of transgender women and men is essential. Designing the services towards key populations should consider the broad spectrum of gender identity to offer appropriate HIV counseling and other services to different population groups. Stigma and discrimination against transgender people frequently cause them to be rejected by their families and denied healthcare services, including access to HIV testing, counseling, and treatment. There is limited understanding of the global burden of HIV and other STIs among transgender populations, and transgender people are rarely identifiable in national surveillance systems. Egypt is not an exception.

The stakeholders should continue to promote access to services as a basic right, as no person should be denied access to prevention knowledge, skills and services or treatment, care and support services based on their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location or level of literacy. There is a need to develop innovative strategies to address challenges in delivering an appropriate package of HIV services, improve linkages to these services, and continue to utilize data to inform the programming. Stakeholders should ensure an enabling legal environment for civil society organizations of and key population so they can operate without fear of intimidation, threat, harassment, or reprisal.

Strategic outcome 8.5: Relevant Leadership, legal and policy framework

The legal and social environment for HIV prevention and care is complex; but changing on different dimensions. At higher levels, Article 18 of Egypt's constitution preserves the right to health for all, which is the critical entry point to protect the rights of individuals to access health protection and prevention services. On the other hand, the behaviors of the key populations are criminalized, while street children continued to be marginalized and associated with different vulnerabilities to HIV infection. Many challenges continued to face prisoners, refugees, asylum seekers, and migrants as far as accessibility to preventive services are concerned. This context contributes to widening the stakeholders' ability to respond to the needs of key and vulnerable populations in a meaningful manner. Historically, the drug policy remains focused on demand reduction and penalties for drug use. However, the shift towards sustained health-related risk and harm reduction policies and services will contribute towards the sustained reduction of HIV transmission in the next period. In addition to efforts by service providers, drug users, their families, and the communities in which they live are critical partners in the HIV response, especially in emerging epidemics. This holistic approach should guide the response in the next period.

The growing interest of government entities in establishing programs to enhance HIV prevention services. This will create future opportunities for changes in policies to provide mechanisms for social contracting for HIV prevention. This mechanism will help the CSOs access funding and better position to participate in policy formulation—agreeing on mutual advocacy agenda, where stakeholders work together to advocate enhancing the supportive environment to deliver services both for key populations and their service providers. There is a need to establish a coordination task force among service providers to ensure that sustained models of services were initiated based on an agreed mechanism for reaching the targeted beneficiaries and how sustained financing arrangements for these models can be established. In addition, there is a need to conduct national reviews of laws and regulations that impede an effective public health response to HIV to enhance the accessibility of key populations to services.

Strategic Directions 5: Strengthening technical, organizational, and institutional capacity of the local implementers.

Strategic objective 9: Strengthen the partnership, CSOs engagement and invest in strengthening NAP capacity

This strategic plan adopts the same implementation arrangements approved to implement the previous strategic plans. No major changes have been proposed in the next phase of the national response.

A) Governance Framework

There is a need for stronger governance arrangements to coordinate, enable and lead HIV control program beyond government response. This section is providing an overview comprehensive governance framework of this strategic framework. It also linked to an expansion of engagement of additional key actors in the national response part of the national task force and coordination committees.

B) National AIDS Program

NAP is one of the early AIDS programs in the region, and it has been established since 1986. Since then it continues to play a central role in the implementation of different AIDS control plans and strategies. NAP continues to manage and coordinate the responsibilities of MoHP as defined in the previous governance framework. NAP has gone through a restructuring phase since late 2013 and early 2014. Following its restructuring, a more transparent and inclusive approach was sought, encouraging the meaningful involvement of civil society, people living with HIV and key populations. NAP has coordinated the process of program assessment and strategic planning while ensuring transparent sharing of information, inclusiveness to all partners including key and vulnerable populations and strategic guidance in line with global guidelines and targets.

Moving forward, there is a critical need to empower and strengthen the capacities of the national program to have a strong structure to perform its essential functions. That can be achieved through the deployment of additional adequate and highly qualified human resources to the program. This is an essential expansion needed to strengthen the stewardship role of MoHP within the national response at this critical stage.

C) Partnership and Coordination

There are already existing structures in Egypt that support the coordination of some components of HIV response in the country. These vary between government coordinating bodies, UN Joint Team and CSOs in some program areas. The forums will continue to play an important role in coordinating the national response, and

ensuring different stakeholders are fulfilling their roles and responsibilities. However, it is critical at this stage to restructure a national body that can enhance the partnership and coordination among all of the stakeholders to achieve mutual goals highlighted by this strategic plan. This body; which is proposed to be the '*HIV Partnership and Coordination Committee*' will be composed of all stakeholders concerned by the implementation of this strategic plan highlighted in the above table.

It is essential to maintain National AIDS Program as the Secretariat for this national committee considered the critical role it can play to mobilize policy-makers level to support the implementation of this strategic plan.

D) Operational Plans

To operationalize this NSP, the NAP will develop the operational plan concerned with priority activities in collaboration with relevant stakeholders in accordance with the present NSP . Priority action plans (PAPs) are detailed operational plan and were developed as an integral part of this strategic plan. PAPs will cover two phases, i.e., the period 2021 to 2023 and 2024 to 2025. Each PAP is a results-based plan; that defines objectives, outcomes, outputs, and activities to achieve the desired goals and targets under this strategic plan. It also articulates the required financial resources, timelines, and responsibilities to accomplish the specific milestones of the results chain. The primary responsibility for developing these plans should be led with MoHP efforts, with technical support from UNAIDS, WHO and other partners.

Monitoring and Evaluation Framework

World Health Organization and partners recommended monitoring and evaluation (M&E) framework that enables the governments to monitor the progress continuously. This M&E framework considered an integral part of the strategic plan to control HIV. Part of the strategic framework below will provide more information about the selected indicators that will be used for regular reporting, based on the current context in Egypt. Given the wide range of stakeholder participating in the national response, it will be essential to continue reviewing, harmonizing, and standardizing the collection of data that will be used on these selected indicators, and in the preparation of global and regional reports.

The goal of this M&E framework support to clarification of the NSP objectives and targets, by providing an efficient mechanism to track and demonstrate the achievements by the end of the plan period. All stakeholders need to agree on an appropriate M&E framework that meets the different information needs and is suited to the capacity and context realities in each setting.

The M&E indicators framework for this plan as presented in Annex A is based on the NSP high-level impact and outcome results; and the detailed coverage/ output indicators that will be monitored at the program level. The output indicators will be further refined alongside the priorities action plan to include other process and inputs indicators as needed.

The M&E framework relay on the following components of data and information system:

1. Routine notification and reporting:

In Egypt, healthcare providers around the country send their electronic data to NAP on nationally notifiable diseases, usually communicable diseases of public health significance, and other health conditions as well. While HIV is notifiable conditions, however not all of the health facilities are reporting suspected cases (based on initial screening). That is very critical, as HIV surveillance requires tracking individual patients over time and processing a significant amount of information for every case, i.e., patients were followed throughout the continuum of care. That seems to contribute to a substantial extent to cases that are lost in the health system after diagnosis. However, for Egypt to reach the global targets, and to bridge the gap between diagnosis and treatment, the enforcement of HIV case notification should be high on the agenda for the next period.

2. Disease burden:

Estimating HIV burden still rely on modelling of an estimated number of PLHIV, namely through the spectrum. There was no study in Egypt conducted to inform the assessment of actual disease burden, e.g., DHS. Given the low prevalence in the country, it is not perceived that such studies will be conducted. On the short term, the HIV program in Egypt will rely on targeted bio-behavioral studies to generate evidence about the disease burden among specific population groups, as well as defining the key affected populations and associated risk factors.

3. Assess disease outcomes:

Another important component of data system is to different AIDS outcomes, including coverage with 95-95-95 targets, treatment outcomes including patient level cure, viral suppression, and deaths.

4. Monitoring service coverage:

Indicators in this area cover prevention and outreach coverage, testing, diagnosis, and treatment services. This area covers also other service delivery components, including interventions targeting reduction of stigma.

Monitoring and Evaluation framework

Egypt National HIV Strategic Plan 2021 - 2025
Monitoring and Evaluation Framework

#	Indicator level	Program Area	Target Population	Indicators	Level of reporting	Reporting entities
1	Impact	Not applicable	All people living with HIV	Number of people living with HIV	National	NAP
2	Impact	Not applicable	All population	HIV incidence among 15-49 age group	National	NAP
3	Impact	Not applicable	Men who have sex with men	Percentage of men who have sex with men who are living with HIV	Sub-National	NAP
4	Impact	Not applicable	Sex workers	Percentage of sex workers who are living with HIV	Sub-National	NAP
5	Impact	Not applicable	People who inject drugs	Percentage of people who inject drugs who are living with HIV	Sub-National	NAP
6	Outcome	Not applicable	All people living with HIV	Proportion of people living with HIV who know their status	National	NAP
7	Outcome	All program	All people living with HIV	Percentage of adults and children living with HIV currently receiving antiretroviral therapy	National	NAP
8	Outcome	All program	All people living with HIV	Percentage of people living with HIV and on ART who are virologically suppressed	National	NAP
9	Outcome	All program	All people living with HIV	Percentage of people in prisons and other closed settings who are living with HIV	National	NAP
10	Outcome	Trearment and care	All population	Percentage of newly diagnosed adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	National	NAP
11	Outcome	Prevention / KPs	Men who have sex with men	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Sub-National	NAP

12	Outcome	Prevention / KPs	Sex workers	Percentage of sex workers reporting the use of a condom with their most recent client	Sub-National	NAP
13	Outcome	Prevention / KPs	People who inject drugs	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	Sub-National	NAP
14	Outcome	Trearment and care	All people living with HIV	Percent of people living with HIV who experienced recent discrimination at health care facilities	National	NAP
15	Coverage/ output	HIV Testing	All population	Number of women and men aged 18+ who received an HIV test and know their results	National	NAP
16	Coverage/ output	Prevention / others	All population	Number of individuals from targeted populations reached through community outreach with standardized HIV prevention interventions	National	NAP
17	Coverage/ output	All program	All population	Percentage of newly diagnosed adults linked to HIV care (individual linkage)	National	NAP
18	Coverage/ output	Prevention / KPs	Men who have sex with men	Percentage of MSM reached with HIV prevention programs- defined package of services	Sub-National	CSOs
19	Coverage/ output	Prevention / KPs	Sex workers	Percentage of sex workers reached with HIV prevention programs- defined package of services	Sub-National	CSOs
20	Coverage/ output	Prevention / KPs	People who inject drugs	Percentage of PWID reached with HIV prevention programs- defined package of services	Sub-National	CSOs

21	Coverage/ output	Prevention / KPs	People in prisons	Percentage of people in prisons reached with HIV prevention programs- defined package of services.	National	NAP
22	Coverage/ output	HIV Testing	Men who have sex with men	Percentage of MSM that have received an HIV test during the reporting period and (know their results)	Sub-National	CSOs
23	Coverage/ output	HIV Testing	Men who have sex with men	HIV testing positivity rate among MSM tested for HIV	Sub-National	CSOs
24	Coverage/ output	Linkages	Men who have sex with men	Percentage of MSM who tested positive linked to care within 7 days of test results	Sub-National	CSOs
25	Coverage/ output	HIV Testing	Sex workers	Percentage of sex workers that have received an HIV test during the reporting period and (know their results)	Sub-National	CSOs
26	Coverage/ output	HIV Testing	Sex workers	HIV testing positivity rate among MSM tested for HIV	Sub-National	CSOs
27	Coverage/ output	Linkages	Sex workers	Percentage of Sex workers who tested positive linked to care within 7 days of test results	Sub-National	CSOs
28	Coverage/ output	HIV Testing	People who inject drugs	Percentage of PWID that have received an HIV test during the reporting period and (know their results)	Sub-National	CSOs
29	Coverage/ output	HIV Testing	Sex workers	HIV testing positivity rate among PWID tested for HIV	Sub-National	CSOs
30	Coverage/ output	Linkages	People who inject drugs	Percentage of PWID who tested positive linked to care within 7 days of test results	Sub-National	CSOs

31	Coverage/ output	HIV Testing	People in prisons	Percentage of people in prisons that have received an HIV test during the reporting period and know their results	National	NAP
32	Coverage/ output	Prevention / KPs	People who inject drugs	Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	Sub-National	CSOs
33	Coverage/ output	Prevention / others	Young population	Number of of young people aged 10–24 years reached by life skills–based HIV education	National	NAP
34	Coverage/ output	eMTCT	Women with HIV	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission	National	NAP
35	Coverage/ output	eMTCT	Infants born to HIV+iv mother	Percentage of infants who received an HIV test within two months of birth, during the reporting period	National	NAP
36	Coverage/ output	Trearment and care	TB patients	Percentage of TB patients who had an HIV test result recorded in the TB register	National	NTP

Egypt National HIV Strategic Plan 2021 - 2025 Monitoring and Evaluation Framework				
#	Target Population	Indicators	Numerator	Denominator
1	All people living with HIV	Number of people living with HIV	estimated number of people living with HIV (modelling)	Not applicable
2	All population	HIV incidence among 15-49 age group	Number of new HIV infections among 15-49 age group	Adult population aged 15-49 years
3	Men who have sex with men	Percentage of men who have sex with men who are living with HIV	Number of MSM who tested positive for HIV	Number of MSM tested for HIV
4	Sex workers	Percentage of sex workers who are living with HIV	Number of sex workers who test positive for HIV	Number of sex workers tested for HIV
5	People who inject drugs	Percentage of people who inject drugs who are living with HIV	Number of people who inject drugs who test positive for HIV	Number of people who inject drugs tested for HIV
6	All people living with HIV	Proportion of people living with HIV who know their status	Number of people living on HIV who are diagnosed	Estimated number of all adults and children living with HIV
7	All people living with HIV	Percentage of adults and children living with HIV currently receiving antiretroviral therapy	Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period	Number of people living on HIV who are diagnosed
8	All people living with HIV	Percentage of people living with HIV and on ART who are virologically suppressed	Number of PLHIV received viral load testing with an undetectable viral load <1,000 copies/ml during the last 12 months	Number of PLHIV received viral load testing during the last 12 months (among all those currently on treatment who received a VL measurement regardless of when they started ART)

9	All people living with HIV	Percentage of people in prisons and other closed settings who are living with HIV	Number of people in prisonswho test positive for HIV	Number of people in prisons tested for HIV
10	All population	Percentage of newly diagnosed adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	Number of newly diagnosed adults adults and children who are still alive on antiretroviral therapy at 12 months after initiating treatment	Total number of newly diagnosed adults adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period
11	Men who have sex with men	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Number of MSM who reported that a condom was used the last time they had anal sex	Number of MSM who reported having had anal sex with a male partner in the last 12 months
12	Sex workers	Percentage of sex workers reporting the use of a condom with their most recent client	Number of sex workers who reported that a condom was used with their last client	Number of sex workers who reported having sex in the last 12 months
13	People who inject drugs	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	Number of PWID who report using sterile injecting equipment the last time they injected drugs	Number of PWID who report injecting drugs in the last month
14	All people living with HIV	Percent of people living with HIV who experienced recent discrimination at health care facilities	number of people living with HIV reported recent incident or discrimination at health care facilities (e.g. denial to access services)	number of people living with HIV surveyed
15	All population	Number of women and men aged 18+ who received an HIV test and know their results	Number of women and men aged 15+ who have been tested for HIV during the reporting period and who know their results	Not applicable

16	All population	Number of individuals from targeted populations reached through community outreach with standardized HIV prevention interventions	Number of individuals from the targeted population reached through community outreach with standardized HIV prevention intervention	Not applicable
17	All population	Percentage of newly diagnosed adults linked to HIV care (individual linkage)	Number of adults who newly enrolled in HIV care and received clinical HIV care services with in the past 12 months	Number of adults newly diagnosed with HIV with in the past 12 months
18	Men who have sex with men	Percentage of MSM reached with HIV prevention programs- defined package of services	Number of MSM who have received a defined package of HIV prevention services	Estimated number of MSM in the targeted area
19	Sex workers	Percentage of sex workers reached with HIV prevention programs- defined package of services	Number of sex workers who have received a defined package of HIV prevention services	Estimated number of sex workers in the targeted area
20	People who inject drugs	Percentage of PWID reached with HIV prevention programs- defined package of services	Number of PWID who have received a defined package of HIV prevention services	Estimated number of PWID in the targeted area
21	People in prisons	Percentage of people in prisons reached with HIV prevention programs- defined package of services.	Number of people in prisons who have received a defined package of HIV prevention services	Estimated number of people in prisons
22	Men who have sex with men	Percentage of MSM that have received an HIV test during the reporting period and (know their results)	Number of MSM who have been tested for HIV during the reporting period and who know their results	Estimated number of MSM in the targeted areas
23	Men who have sex with men	HIV testing positivity rate among MSM tested for HIV	Number of MSM who tested positive for HIV during the reportin period	Number of MSM who have been tested for HIV during the reporting period and who know their results

24	Men who have sex with men	Percentage of MSM who tested positive linked to care within 7 days of test results	Number of MSM who tested positive for HIV and linked to treament centers within 7 days during the reportin period	Number of MSM who tested positive for HIV during the reportin period
25	Sex workers	Percentage of sex workers that have received an HIV test during the reporting period and (know their results)	Number of sex workers who have been tested for HIV during the reporting period and who know their results	Estimated number of sex workers in the targeted areas
26	Sex workers	HIV testing positivity rate among MSM tested for HIV	Number of Sex workers who tested positive for HIV during the reportin period	Number of Sex workers who have been tested for HIV during the reporting period and who know their results
27	Sex workers	Percentage of Sex workers who tested positive linked to care within 7 days of test results	Number of Sex workers who tested positive for HIV and linked to treament centers within 7 days during the reportin period	Number of Sex workers who tested positive for HIV during the reportin period
28	People who inject drugs	Percentage of PWID that have received an HIV test during the reporting period and (know their results)	Number of PWID who have been tested for HIV during the reporting period and who know their results	Estimated number of PWID in the targeted areas
29	Sex workers	HIV testing positivity rate among PWID tested for HIV	Number of PWID who tested positive for HIV during the reportin period	Number of PWID who have been tested for HIV during the reporting period and who know their results
30	People who inject drugs	Percentage of PWID who tested positive linked to care within 7 days of test results	Number of PWID who tested positive for HIV and linked to treament centers within 7 days during the reportin period	Number of PWID who tested positive for HIV during the reportin period
31	People in prisons	Percentage of people in prisons that have received an HIV test during the reporting period and know their results	Number ofpeople in prisons who have been tested for HIV during the reporting period and who know their results	Estimated number of people in prisons

32	People who inject drugs	Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	Number of needles and syringes distributed in the past 12 months by NSPs	Number of people who inject drugs in the country
33	Young population	Number of of young people aged 10–24 years reached by life skills–based HIV education	Number of young people reached through any effort to affect change, including peer education, classroom, small group, and/or one-on-one information, education and communication or behavior change communication to promote change in behavior	
34	Women with HIV	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission	Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery	Actual number of HIV-positive women who delivered within the past 12 months.
35	Infants born to HIV+iv mother	Percentage of infants who received an HIV test within two months of birth, during the reporting period	Number of infants who received an HIV test within two months of birth, during the reporting period	Number of HIV-positive pregnant women giving birth in the last 12 months
36	TB patients	Percentage of TB patients who had an HIV test result recorded in the TB register	Number of TB patients registered during the reporting period who had an HIV test result recorded in the TB register at the time of TB diagnosis	Total Number of TB patients registered during the same period

Egypt National HIV Strategic Plan 2021 - 2025
Monitoring and Evaluation Framework

#	Indicator level	Indicators	Baseline	Baseline year	Target 2023	Target 2025
1	Impact	Number of people living with HIV	24,000	2020	17,000	14,000
2	Impact	HIV incidence among 15-49 age group	0.04	2017	0.03	0.03
3	Impact	Percentage of men who have sex with men who are living with HIV	6.10%	2010	4.90%	3.90%
4	Impact	Percentage of sex workers who are living with HIV	-	-	4.90%	3.90%
5	Impact	Percentage of people who inject drugs who are living with HIV	7.10%	2010	5.70%	4.60%
6	Outcome	Proportion of people living with HIV who know their status	54%	2020	60%	90%
7	Outcome	Percentage of adults and children living with HIV currently receiving antiretroviral therapy	24%	2017	60%	90%
8	Outcome	Percentage of people living with HIV and on ART who are virologically suppressed	93%	2020	84%	95%
9	Outcome	Percentage of people in prisons and other closed settings who are living with HIV	No national baseline		50.00%	90.00%
10	Outcome	Percentage of newly diagnosed adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	98.00%	2020	99.00%	100.00%
11	Outcome	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	24%	2010	48%	80%

12	Outcome	Percentage of sex workers reporting the use of a condom with their most recent client	11%	2010	22%	50%
13	Outcome	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	19.40%	2010	40%	80%
14	Outcome	Percent of people living with HIV who experienced recent discrimination at health care facilities	52%	2013	41.50%	33.00%
15	Coverage/ output	Number of women and men aged 18+ who received an HIV test and know their results	793,921	2020	1,500,000	2,500,000
16	Coverage/ output	Number of individuals from targeted populations reached through community outreach with standardized HIV prevention interventions	No baseline		200,000	400,000
17	Coverage/ output	Percentage of newly diagnosed adults linked to HIV care (individual linkage)	82%	2020	100%	100%
18	Coverage/ output	Percentage of MSM reached with HIV prevention programs- defined package of services	0.60%	2020	50%	90%
19	Coverage/ output	Percentage of sex workers reached with HIV prevention programs- defined package of services	No national baseline		50%	90%
20	Coverage/ output	Percentage of PWID reached with HIV prevention programs- defined package of services	1%	2020	50%	90%

21	Coverage/ output	Percentage of people in prisons reached with HIV prevention programs- defined package of services.	No national baseline		50%	90%
22	Coverage/ output	Percentage of MSM that have received an HIV test during the reporting period and (know their results)	No national baseline		50%	90%
23	Coverage/ output	HIV testing positivity rate among MSM tested for HIV	9%	2020	15%	20%
24	Coverage/ output	Percentage of MSM who tested positive linked to care within 7 days of test results	No national baseline		100%	100%
25	Coverage/ output	Percentage of sex workers that have received an HIV test during the reporting period and (know their results)	No national baseline		50%	90%
26	Coverage/ output	HIV testing positivity rate among MSM tested for HIV	8%	2020	15%	20%
27	Coverage/ output	Percentage of Sex workers who tested positive linked to care within 7 days of test results	No national baseline		50%	90%
28	Coverage/ output	Percentage of PWID that have received an HIV test during the reporting period and (know their results)	No national baseline		50%	90%
29	Coverage/ output	HIV testing positivity rate among PWID tested for HIV	10.30%	2020	15%	20%
30	Coverage/ output	Percentage of PWID who tested positive linked to care within 7 days of test results	No national baseline		100%	100%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