UNAIDS

Operational HIV Prevention Guidance/Tool

UNAIDS - 2023

FOREWORD

The Joint United Nations Programme on HIV/AIDS has the pleasure to present the National HIV Operational Guidance/Tool. This guide aims at supporting the implementation of HIV prevention programs focusing on key populations that are particularly marginalized and exposed to high risk of HIV transmission.

This guidance is specifically oriented towards detailing the various methodologies to provide HIV prevention services. It is people centered and can be adapted for different situations and contexts.

The third chapter contains the key performance indicators to support the unification of data collection tools, definitions, and measurements to facilitate the periodic local, subregional, and national data reporting and data disaggregation.

I would like to take the opportunity to present great thanks to the members of the Joint Team on HIV in Egypt namely: UNDP, UNODC and WHO. With special thanks to the National AIDS program- Ministry of Health and population. I want to highly gratitude the inputs from the civil society organizations and governmental service provision facilities.

Sincerely,
Dr. Walid Kamal Ibrahim

UNAIDS Country Director

This Operational HIV Guidance/Tools comes to provide a unified guidance on implementing HIV self-testing as part of combined prevention interventions and harm reduction packages, the guidance is based on existing working profile and modules and should align with the strategic direction guided by the National HIV Strategy 2021-2025.

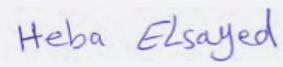
The world has taken great steps toward ending the HIV/AIDS epidemic in all strategic areas including prevention, care and treatment and enabling the environment initiatives though after more than 40 years from detecting the first HIV case in 1981, yet HIV/AIDS still represent a real challenging threat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

Egypt has been always committed to address all initiatives and recommended efforts and services that can accelerate the national prevention response, with a substantial acceleration in the harm reduction progress efforts.

This tool is a consolidated document that adopt quality assurance interventions and indicators specially designed for the service provision level and to support the mid-level data verification and validation guide all the national efforts gathering the governmental, community-based organizations and international organizations on the same floor.

I would like to take this opportunity to express my great appreciation to all our stakeholders who are exerting a great support in the national HIV response with special thanks to UNAIDS country office for their sincere efforts in supporting the development of this important guidance.

National AIDS Program Director
Dr. Heba Elsayed



EXECUTIVE SUMMARY

The operational guidance and tools are designed to address the different HIV service provision modalities especially those provided through the community-based organizations with a specific summary guidance for the harm reduction interventions conducted as per the country context.

The guidance is divided onto the below sections:

First:

Describing the standard service provision modalities (outreach and drop-in center)

Second:

The Harm Reduction package standardized SoPs and flow of work.

Third:

The key performance monitoring indicators.

I.

PREVENTION SERVICES PROVISION MODALITIES

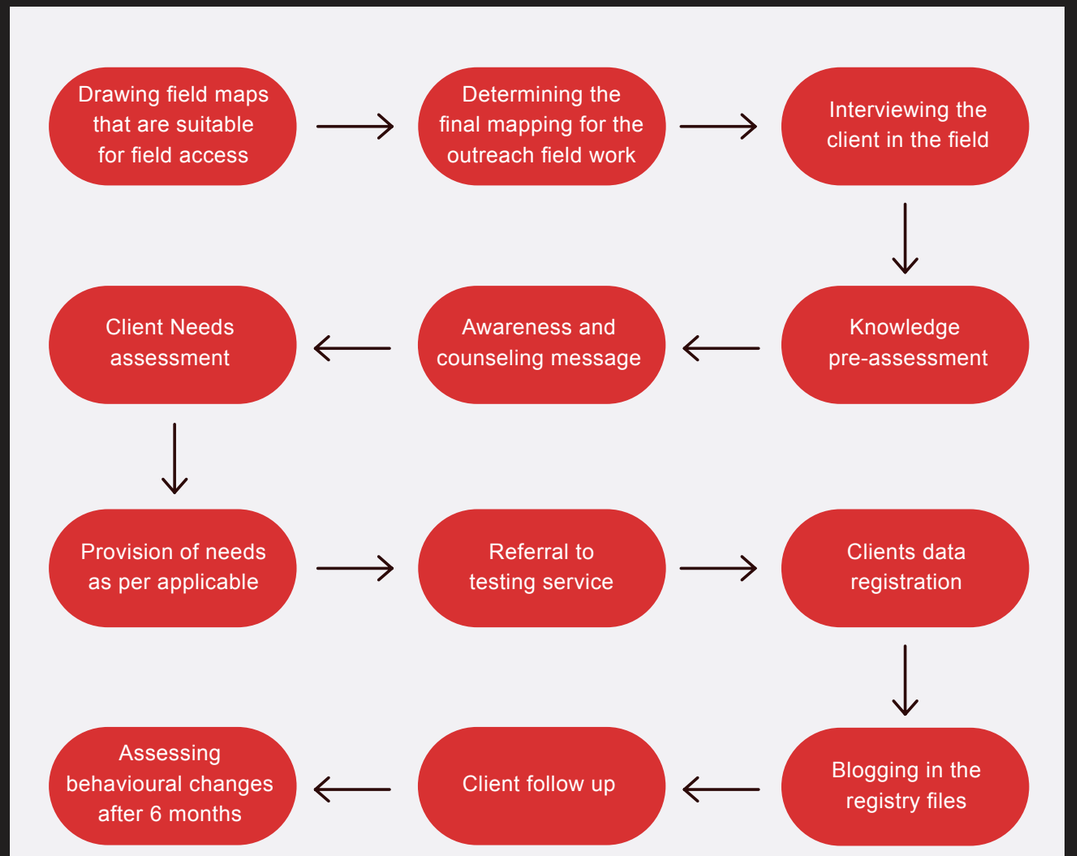
A. OUTREACH SERVICES

Objectives of outreach services

- Disseminating right information about of HIV.
- Introducing the harm reduction concept.
- Providing data about the referral services.
- Referral to testing services.
- Early detection of HIV cases.
- Providing preventive packages based on assessing the clients' needs.

Methodology of field work - outreach:

- The outreach services should be provided through a team - not an individual - and the team consists of at least two members.
- The work areas to be reached shall be studied for its suitability for field work in accordance with the specified criteria.
- Follow the national unified codification system for client's registration.
- The team should also have a supervisor to follow up the team during field work and develop supervisory report.
- The work plan and geographical areas should be reviewed and updated at least quarterly or when necessary.
- Adhere to client data registration frameworks after the end of the interview.
- The outreach team should use special work phone lines for the follow up of the clients to ensure professionalism.
- The team should commit to the standardized messages.
- The message should include info about the available Governmental/ Non-Governmental services and referral methods to receive the required relevant services.



Mapping:

Objectives

- Determine if the target population is present in the place or not.
- Determining the peak times, i.e. determining the best time to reach the target population.
- Determine if the selected place is suitable for field work or not.
- Listing all challenges related to the place (security challenges - environmental challenges - community challenges).

Field mapping methodology

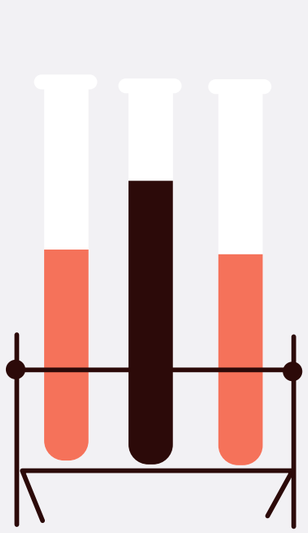
- The team should be trained to explore and draw field maps,
- Regular meetings should be scheduled to determine the areas under study and to determine the disembarkation schedule.
- The disembarkation is done by two teams in the same place and the same days in different weeks (example: Saturday and Sunday for the first week), and the second team makes a map for the same days in the same area of the second week to ensure that the information that will be dealt with for a long time is verified.

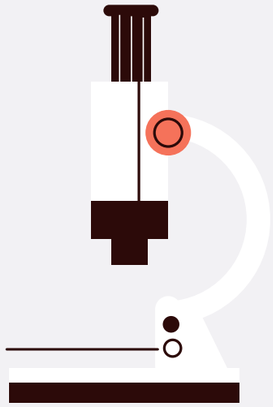
N.B: "After the field map is drawn, a working group meeting is held to decide the number of appropriate areas and determine the schedule." Note: Field maps are reviewed at least every three months or when necessary, in the event of any significant epidemiological updates.

- The non-governmental organization must be aware of the national studies that have been implemented to estimate the size of the most vulnerable groups and the biological behavioral survey of HIV / AIDS among these groups and the geographical distribution included in these studies.
- The work team identifies places where it finds the presence of the most vulnerable groups, according to its geographical area or other areas that are easy to reach and achieves results through it.

Determining the final field maps

- This includes conclusion of the most suitable areas for access.
- Search for solutions to any challenges if any
- Determining the timing to update the work maps based on the areas that have been identified (example: changing the target area according to the seasons of the year in the coastal governorates…etc.)





B. DROP-IN CENTER

What are drop-in centers (DICs)

Drop-in centers (also known as “safe spaces”) are premises that provide key population community members with a comfortable place to get information, receive program services, and interact with each other and with HIV prevention, care and treatment program staff.

- Drop-in centers serve as a place where key population community members:
- Receive information on Health and HIV Prevention, care, treatment.
- Are mobilized to take up services.
- Gather for events and activities.
- Receive psychosocial services and support, and for referral to other services.
- Receive condoms and lubricants.
- Receive HIV self-testing kits.
- Exchange needles and syringes
- And tracking KPs who are lost to follow up from the programs.

In some cases, drop-incentres are co-located with clinics that provide HIV testing and counselling, screening and treatment for sexually transmitted infections (STIs), HIV prevention, care and treatment, family planning, and post-exposure prophylaxis (PEP)and Pre-exposure prophylaxis (PrEP).

DICs are important platforms for program outreach because they provide services, information, and space for community mobilization in locations that are convenient for KPs.

Special considerations for locating of DICs:

- DICs offering needle and syringe exchange should be close to neighborhoods where PWID live.
- DICs for MSM or FSWs should be close to their hotspots.
- DICs should be located just off a main road in order to balance the need for privacy with ease of access (a short walk from a main road) and should be accessible by public transportation at a low cost. However, MSM might prefer a safe and secure areas lightly far from the road, due to issues of stigma.
- DICs should not be close to schools and other locations that the public might consider inappropriate.

Selection of premises for DICs

After the appropriate area and location have been determined and the implementing partner has decided whether the DIC will provide clinical services, a premises for the DIC must be identified.

Considerations for Selecting the DIC premises

The venue should include:

1. A room for rest.
2. A private room for consultations
3. A kitchen with cupboards
4. A bathroom and toilet (separate bathrooms for males and females in case of a PWIDDIC or a DIC that caters to both men and women)
5. An office
6. A large room/hall enclosed space that can accommodate at least 20 people for events/ activities (e.g., trainings, support groups etc.)
7. Space should be available for storing records, consumables, and cleaning supplies.

Services that DICs should ideally provide

- **Safe space:** The DIC should be a place where KPs can meet and receive their services and discuss issues. Information: KPs should receive information on HIV, STIs, counseling, clinical services, violence response services, condoms, needles/ syringes, HIV self-testing kits among others.
- **Registration with the program:** The demographic details of each KP are recorded in the KP Enrolment Form. If such information has already been collected during outreach, the form need not be filled again. Group discussions: KPs should be involved in group discussions in which issues pertaining to drugs, HIV, hepatitis, STIs, and other related information are discussed. The group discussion should be organized and moderated by the outreach worker or the counsellor, Training on various issues can be provided to the KPs and the peer educators in the DIC.
- **Referral to HIV-related services:** KPs should be referred to the nearest HTS for HIV testing after proper pre-test counseling. If a KP is HIV positive, referral to an ART centre should be made.
- **Referral to other services:** Based on the KP's need, the KP may be referred to a TB center, a KP clinic for counseling and STI screening and management, centers providing nutritional support, shelter/home, mental health care, reproductive health services.
- **Harm reduction:** KPs should be given condoms, new needles and syringes.
- **Behavioral change communication:** KPs should receive risk reduction information through one - to-one and one-to-group interactions and through IEC materials.

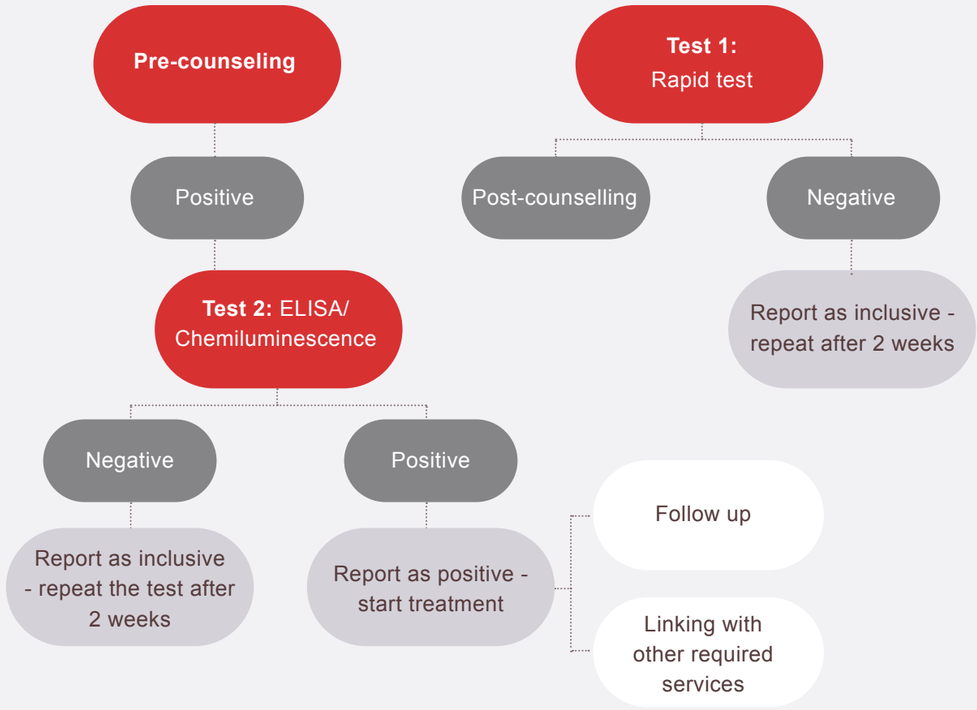
- **Integration into the community:** the DIC should also integrate the KP back into the community.
- **Outreach:** Outreach workers and peer educators should extend many of the DIC's services into the community.
- **Other services:** Some DICs also provide fresh clothes, a feeding program, laundry services, hygiene kits (tooth paste, brush, sanitary napkins).
- **Family day:** Some DICs also invite families and children of KPs to spend time together in the DIC, and also provide them food, psychosocial support, and clinical services.

Program Challenges/Gaps

Testing

The testing algorithm is standard and included clearly in the National care and treatment guidelines, there has been a significant update in the phasing out from using the western blot in the HIV case confirmation to minimize the time needed to enrol positive cases in care and treatment. The confirmation is done using advanced fourth generation ELISA (HIV Chemiluminescence)

The national HIV testing algorithm is as follows:



However, the main challenge is in the coverage of the testing to reach the target populations in a wide range of geographical areas, the current number of community-based organizations and outreach teams working in prevention and providing testing services to the key populations.

There is also no systematic standardized mechanism for conducting testing for the reached populations especially for the outreach teams and their referral to be tested.

Counselling

The counselling is still considered a main pillar in the prevention service package provided to the beneficiaries from key populations, the counselling is often provided through trained personnel working in whether the governmental or the non-governmental VCT centers and it should include a standardized message notifying the main disease related information specifically modes of transmission, prevention and harm reduction.

The main challenge in providing the pre and post counseling to key populations is how to ensure a quality service with a standardized content adapted as per the clients' needs assessment, the significant progress in the prevention and harm reduction services in the last 2 years leads to a need to update the counseling message to be more comprehensive and focusing on each client needs and summarized as possible.

Still many outreach workers and counseling providers are sticking to an outdated message for counseling and is not aligned with the latest updates and recommendations, for many years most of the capacity building activities were focusing on the care and treatment as there was a tremendous progress in the ART and treatment regimens provided to PLHIV, one of the main targets of the updated NSP 2021-2025 is to tackle the prevention and capacitating the counselors and prevention services providers.

Referral

One of the main findings of the stakeholders' interviews and discussions, is the lack to have a standardized clear referral mechanism and services mapping that includes all services starting from prevention, harm reduction, care and treatment services as well as other services like the legal services, economic support…. etc.

There are some trials to have unified platforms that can have this national unified mapping for whether governmental and non-governmental services.

The prevention and outreach services providers should have a good knowledge and well understanding about where to provide services to systemically guide the clients as per their needs.

This guidance tries to provide and clarify the different national governmental and non-governmental platforms where prevention and harm reduction services are provided.

Harm Reduction Package

For people who inject drugs, harm reduction is critically important to reduce the risk of infection with HIV or viral hepatitis and to improve prevention, diagnosis and treatment.

"Harm reduction" refers to policies, programs and practices that minimize negative health, social and legal impacts of drug use. Harm reduction approaches focus on supporting positive change without requiring that people stop using drugs.

Removing human rights-related barriers to services and ensuring that community leadership is at the heart of the HIV response, are also strategic priorities. The harm reduction is considered as "program essential" — that is, a critical part of a country's comprehensive HIV response.

Injecting drugs with non-sterile equipment spreads HIV, hepatitis C (HCV) and other bloodborne diseases quickly, so it is very important not to wait before starting or scaling up programming.

HIV risk comes not just from non-sterile injecting equipment, but from policies, practices, and attitudes that keep people who use drugs from accessing services.

Global AIDS Strategy: Some Key Targets By 2025:

90% ***OF PEOPLE WHO INJECT DRUGS*** have access to comprehensive harm reduction services integrated with or linked to hepatitis C, HIV and mental health services.

50% ***OF PEOPLE WHO INJECT DRUGS*** and are opioid dependent have access to OST.

80% ***OF HIV PREVENTION SERVICES,***

30% ***OF TESTING & TREATMENT SERVICES, &***

60% ***OF PROGRAMS*** to address societal enablers for people who inject drugs are community-led.

Less than 10% of people who inject drugs or living with HIV experience stigma or discrimination, **less than 10%** of women who use drugs or living with HIV experience gender inequality/violence, and **less than 10%** of countries have punitive legal or policy environments that lead to denial or limitation of services.

The Global AIDS strategy calls on countries to sharply scale up harm reduction to ensure that 90% of people who inject drugs have access to harm reduction services. The Global AIDS strategy, the Global Fund strategy, and the 2021 Political Declaration on HIV and AIDS endorsed by the UN General Assembly all emphasize the need to change laws and policies so that HIV services can be effectively delivered.

Harm reduction programming is high impact in preventing infection with HIV and hepatitis B and C, and can help link those infected to diagnosis, treatment and care. By contrast, counselling or behavioral interventions that aim to get people to stop using drugs have shown great challenges to reduce HIV or viral hepatitis epidemics.

For HIV prevention, priority harm reduction includes mainly:

- Needle and syringe programming (NSP) that offers people who inject drugs the recommended quantity of sterile injection equipment (~300 needles per person per year for HCV prevention,~200 for HIV prevention, calculated based on total population of people who inject drugs), at a variety of places and times. To maximize access, sterile injection equipment should be offered without confidentiality violations, without requirements for 1:1 exchange, without requirements for identity documents, and without police interference. Outreach, staffing and services should be sensitive to the needs of women who inject drugs, of youth, of sex workers, and of trans and gender-diverse people.

Egypt has launched a needle syringe program in 2021 under the authorization and monitoring of Ministry of Health, still needs to have effective tools for monitoring and evaluating the outcomes of the program.

- Opioid substitution therapy (OST) that is easy for people to start and continue for as long as necessary; that can be scaled up or complemented via take -home doses, mobile units, satellite clinics and distribution at pharmacies and community centers; and that can be integrated with HIV, hepatitis B and C, and TB testing and treatment.
- Overdose (OD) prevention with the opioid OD antidote naloxone distributed to those most likely to witness an OD (people who inject drugs, their families and friends), along with training on use, mechanisms for peer distribution.
- Hepatitis B and C testing and treatment for people who inject drugs;
- Health communication and demand creation.

In evaluating plans for harm reduction, it is recommended to:

- Understand the HIV and related needs of people who use drugs, including through biobehavioral surveillance or rapid assessment to determine which people are at highest risk based on their injecting and sexual practices These assessments should also look at the environment where risk occurs, and the barriers to harm reduction and other services.
- Design a mix of harm reduction interventions that strengthen each other, including in prisons and other closed settings. Combining OST, NSP, HIV and hepatitis testing and treatment reduces community transmission more than any one of these interventions alone. STI treatment reduces risk of HIV infection. Provision of naloxone for OD prevention can increase uptake of HIV prevention. Since people who use drugs often move between communities and detention, prevention and treatment should be equally available to them within and outside prisons and other closed settings, with mechanisms in place to ensure continuity of care.
- Deliver effective and efficient services, as gauged by people who use drugs as well as by those delivering services. This includes supporting community-led monitoring and drawing on peer networks and navigators in the design and delivery of prevention, diagnosis and treatment services. Differentiated NSP and OST delivery (at pharmacies, drop-in centers, mobile units, and fixed sites) can increase reach, as can integration of NSP and testing and treatment for HIV, HCV, TB and STIs. Countries should plan to evaluate impact from the start, including real time tracking of service delivery, regular HIV prevention performance review and accountability processes that include community. Review should include ongoing assessment of service gaps and consider changes to drug markets and to the environment and policies that shape drug use and risk.
- Sustain services by creating mechanisms and providing national/municipal funding for service continuation during and after the Global Fund grant. This can be achieved through “social contracting” with networks and groups led by people who use drugs, with community-based, non-governmental organizations, and with funding from and collaboration between health, social welfare, and law enforcement/drug control agencies.

Follow up

As one of the main findings of the desk review and interviews was the lack to have a proper follow up for all the prevention and harm reduction services, the clients follow up is unsystematic especially for challenging programs like the needle & syringe program where the clients follow up is very critical and important to ensure the sustainable use of sterile syringe and injecting equipment.

The scheduled follow up also for HIV negative clients from the targeted key populations should be at least every 3 months to be re-tested as per the National guidelines, however this is not the case for the work undergone in Egypt.

Integration & Sustainability

The National HIV Strategic plan 2021-2025 update stresses on the urgency of integrating the HIV services among other relevant health and community services to ensure the sustainability of the HIV response especially with the reduction in the funding opportunities directed to HIV.

The HIV response in Egypt showed great resilience in this regard, some of the prevention and harm reduction services for people who use drugs is integrated with the drug addiction services provided through the governmental addiction treatment facilities, including screening for all in and out patients.

The first implementation phase of the opioid substitution therapy will be introduced in the addiction treatment hospitals.

Also, the integration with the National Committee for combating viral hepatitis is clear in many pillars related to injecting drug use as it is also one of the challenging epidemic drivers for HCV epidemic in Egypt, this integration has taken great steps since 2019, as the harm reduction is considered one of the core pillars in the dossier for HCV elimination in Egypt.

2. The Operational Prevention Guidance Toolkit

INTRODUCTION

This guide and toolkit are designed to help the National AIDS Program, Civil society organizations (CSOs), and other partners implement and monitor programs for HIV prevention.

KPs bear a disproportionate burden of HIV but have much lower access to HIV-related services and other services than members of the general population. In keeping with the global commitment to end AIDS by 2030, governments and donors have put renewed emphasis on developing programs that target KPs. This guidance aims to accelerate the ability of national AIDS program, civil society organizations (CSOs), to plan, deliver, and optimize comprehensive HIV prevention.

The main goal is to reduce HIV transmission among KPs and extend the lives of individuals who are HIV positive. The LINKAGES approach is summarized in the cascade framework that presents services along a continuum of HIV prevention, diagnosis, care, treatment, and VL suppression. The cascade is aligned with the UNAIDS 95–95–95 objective—that by 2030, 95 percent of all people living with HIV (PLHIV) will know their HIV status, 95 percent of people diagnosed with HIV infection will receive sustained antiretroviral therapy (ART), and 95 percent of people receiving ART will have viral suppression.

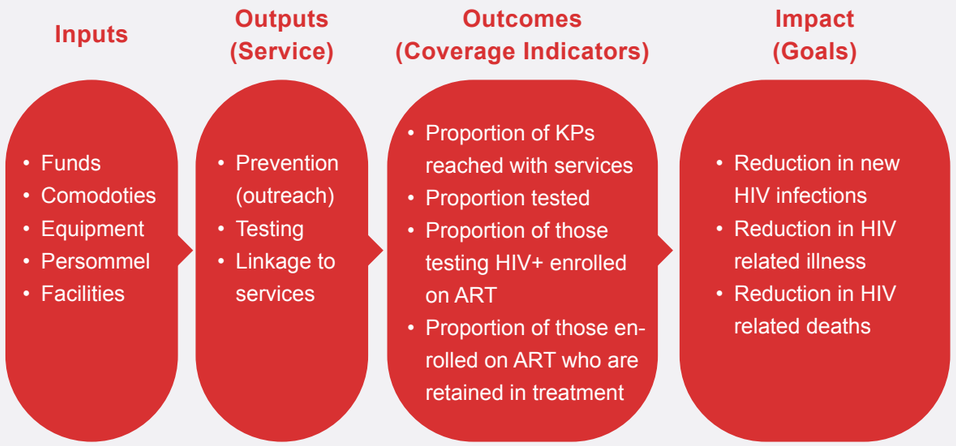
The main goal is to reduce HIV transmission among KPs and extend the lives of individuals who are HIV positive.

ESTABLISHING AND MAINTAINING EFFECTIVE PREVENTION PROGRAMS FOR KPS REQUIRES:

- Detailed and regularly updated estimates of the size and locations of KPs in order to set targets for outreach and determine infrastructure, personnel, and budgets.
- Individual tracking of KPs members to ensure they regularly access high-quality outreach and clinical services.
- Regular monitoring of programs to ensure that prevention, testing, treatment, and VL services meet the needs of KPs and are run efficiently. This monitoring includes regular analysis of tracking data by those who deliver services, as well as by their supervisors, and use of data in real time to manage programs and improve performance at scale while maintaining service quality.
- Regular reporting of data to subnational and national program levels as required by the government or other funders.
- Ensuring data confidentiality and security at all levels of the program. This guide is designed to help programs with all these requirements. It shows how to establish monitoring systems that can be used to understand and improve performance by program managers, monitoring and evaluation (M&E) advisors, and donors, as well as frontline workers including peer outreach workers, peer navigators, 2 staff outreach supervisors, and program managers.

The guide offers a comprehensive tool used at the local level to collect and analyze data to establish, manage, and improve the program, to ensure KP individuals receive adequate services, to report on the global indicators, and to demonstrate progress toward the 95–95–95 goals. The tools are designed to ensure that monitoring systems and data will be consistent and compatible, and they can be modified as needed to take into account the national guidelines and the monitoring systems of National AIDS Program.

Model for HIV Prevention Program



Goals are often broken down into a set of more detailed objectives. Effective objectives have specific, realistic, and measurable results and time frames, with accountability assigned to specific organizations or individuals. Targets can then be set for each objective. Clear goals and objectives are important because they lead to better monitoring systems and set standards for using data to improve performance. The same process of setting objectives and targets can be done at the local level by each implementing partner. Typically, these objectives and targets closely follow those of the national aids program, but they also reflect the local context, e.g., the type and number of KP individuals, or the ease or difficulty of outreach due to geographical constraints or the attitude of law enforcement officers.

In addition to the program targets, during the initial stage of planning it is also important to set program quality standards. These could include:

- Ratios for staffing, e.g., the number of peer outreach workers per staff outreach supervisor.
- Ratios for infrastructure, e.g., the number of KP individuals per clinic or drop-in center
- Standards for service delivery, e.g., the number of times a year a KP individual will be offered screening for HIV.

At each level of the program, well-defined targets and quality standards set a benchmark for interpreting data and help the program maintain focus as activities change over time. Standard operating procedures (SOPs) can help ensure that targets and standards continue to be met as the program is scaled up. The continual use of monitoring data informs everything — objectives, targets, standards, and SOPs.

3. Standard Operating Procedures

I.

TESTING AND COUNSELING

Clients initiated Testing and Counseling

- The counselling and testing intervention includes at least one pre-test counselling session and one post-test counselling session. It is anticipated that counselling sessions will last a period of time depending on the individual client's situation.
- Pre- and post-test counselling is separated by the length of time required to generate test results (approximately 20 minutes). If there are many clients, consider having group information sessions.

Pre-test counseling

- Counselling is a relationship. Connect with the client, answer questions and make sure that the client understands the information you are providing.
- Review client knowledge on HIV and AIDS and correct any misconceptions about the HIV and AIDS and transmission of HIV.
- Then engage the client in assessment of his or her own HIV-related risk behavior and negotiating a realistic, personalized risk reduction plan.
- Form an alliance with the client to undertake the risk assessment, including gathering information about the client's sexual and other risk behavior as well as his or her interpersonal, social, and resource situation.
- Work with the client to develop strategies to reduce his or her risk. For each risk reduction behavior, assess internal and external barriers to change, perceived efficacy to enact the new behavior, readiness to change, and the availability of resources to change.
- Acknowledge and support the client's strengths and his or her enactment of the personalized risk reduction plan, work with the client to solve problems regarding anticipated difficulty in enacting the plan.
- Assess clients' knowledge on proper use of condoms and do a condom demonstration.
- Confirm that the informed consent has been obtained and assure client confidentiality.
- Inform client that they can withdraw consent at any stage of the HTC process.

Preparation for testing

This is done during pre-test counselling. The counselor should:

- Solicit the client's knowledge about the HIV antibody test and any previous testing experiences.
- Provide information about the test as needed and correct any misconceptions about testing and/or test results.
- State the meaning of a negative test result and a positive test result.
- Discuss with a client on action plan in case of a negative test result or a positive test result.
- Provide contact information for crisis management in the case of negative HIV-related life events.
- Ensure sufficient time is given to think through the issues.
- At the end of pre-test counselling, ask the client if he or she would like to proceed with HIV testing. If the answer is no, thank the client, plan for next counselling session and let him/her go ,If the answer is yes, fill out the laboratory form with the client's unique personal code. Refer the client to a testing staff for taking the sample and testing or proceed with the testing if you are doing it yourself.
- The testing staff will then prepare for the test according to Laboratory SOPs, client is asked to rest in a waiting room or space.

Disclosure of results

- The test result will be given to the counsellor by the testing staff or will be available to the counsellor if she/he does the test by themselves.
- The counsellor will then invite the client to return to the counselling room and will check with the client to determine if he or she is prepared to receive the test result and post-test counselling.
- For continuity purposes, it is recommended that the same counselor offer both pre- and post-test counselling to the client.
- The results will only be disclosed to the client during post-testing counselling.

Post-test counseling

Post-test counseling will begin with the disclosure of test results.

Giving negative results

- Make sure you have the test results ready then: Greet the client, establish rapport, Give the client time. Ask the client: “Are you ready to receive your HIV test result?”
- If the client is ready, state in a neutral tone: “Your test result is negative, meaning you have not been infected with HIV.”
- Pause and wait for the client to respond before continuing. Give the client time to express any emotions.
- Client should be shown the result slip if they so wish.
- Discuss and support the client’s feelings and emotions.
- Check the client’s understanding of the meaning of the results.
- Discuss the following questions :
- Do you remember the differences between HIV and AIDS?
- How is the knowledge of your status going to help you?
- How can you protect yourself further from HIV infection?
- Who else will be affected by this result?
- Inform the client to consider having another test in three months and/or encourage his/her partner to go for testing.
- If there was a recent risk exposure, discuss the need to retest. For persons with ongoing risk of exposure, recommend follow up testing at least every six months.
- Discuss ways to remain negative and assist the client in exploring future risk reduction so that her or his status remains negative, in view of the high risk associated with new infections.
- Discuss disclosure support and subsequent counselling sessions.
- Discuss some basic risk-reduction strategies with the client.

II. HARM REDUCTION

A. CONDOM PROGRAM

Step 1

Understand condom clients and the whole environment.

Step 2

Assess the program and create action plan.

Step 3

Procure high quality condoms and manage the pipelines.

Step 4

Expand distribution system.

Step 5

Promote condoms at distribution units.

Step 6

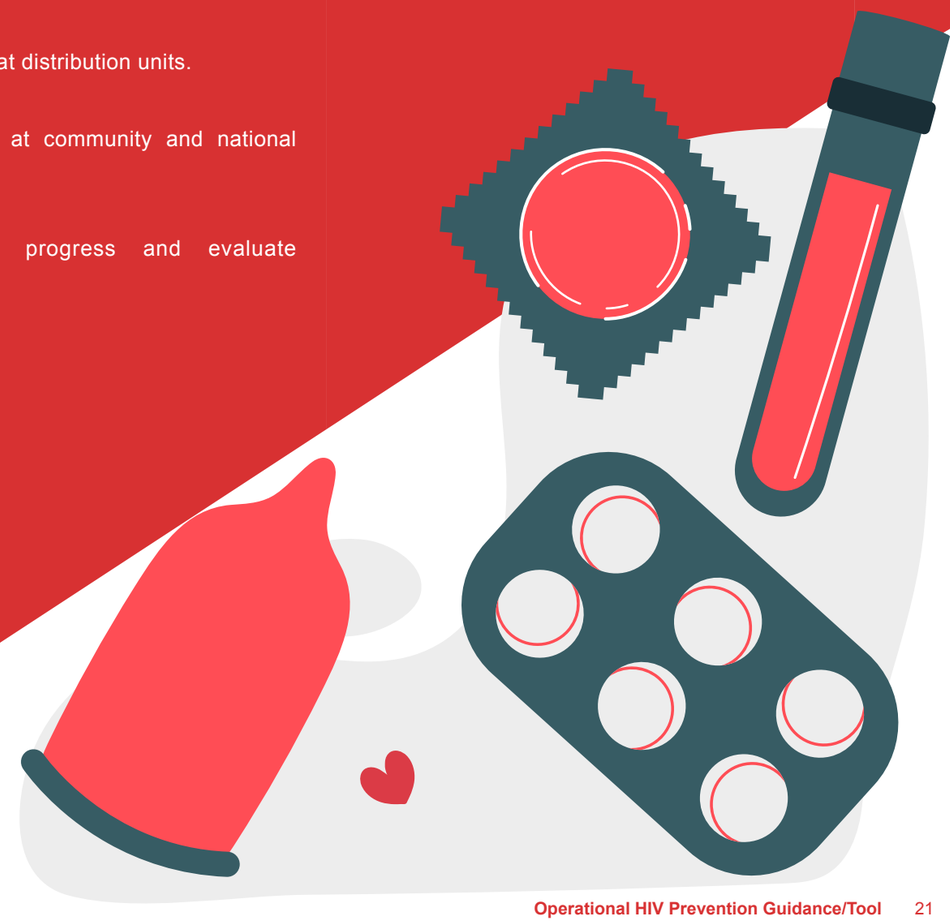
Promote condoms at community and national levels.

Step 7

Monitor program progress and evaluate outcomes.

B. NEEDLE & SYRINGE PROGRAM

Needle Syringe Exchange Program can be implemented through different models of service delivery. Three significant models are discussed below. Usually, an ideal NSEP is a combination of two or more models.



Modalities to provide service

Fixed site

This refers to the provision of NSEP services from a stand-alone premises. The premises for such services should ideally be located in areas where the client does not feel threatened by the surroundings. These may include, for e.g., busy roads, marketplaces, etc. The premises for NSEP delivery should be easily accessible to the clients and should be close to services required by clients. These may include hospital services, other health care services and other community services, such as those offering food, clothing, shelter, etc. Staff is designated for the distribution of needles and syringes and to maintain records. While distributing needles, the used needles should be collected and carefully stored in a puncture proof disposable bin. These used needles/syringes should then be destroyed through an approved medical waste management system.

Outreach

The Outreach Workers (ORWs) and Peers Educators (PEs) can also distribute needles and syringes through key outreach points. While distributing needles and syringes, it is recommended to give only the required number of needles and syringes for a day. In case of a holiday or strike, adequate stock should be provided for a maximum of two days. At the same time, this norm should not, in any way, restrict the access of IDUs when they actually require the needles and syringes.

Staffing a Needle Syringe Exchange Program

NSEP requires all the staff in an IDU TI to function in coordination with each other. The roles and responsibilities of the staff should be clearly defined for NSEP. The backbone of the NSEP is the team of outreach workers and peer educators working in the IDU TI. The NSEP staff providing outreach services should be issued identification cards. Staff must always carry their identification cards when conducting outreach. *The recommended roles and responsibilities of the staff in a NSEP are as follows:*

Project Manager

- Supervise NSP outreach staff.
- Build staff's capacity and skill on NSP.
- Develop work plans on NSP along with outreach workers and peer educators.
- Organize and conduct weekly and monthly meetings to identify short falls and to evolve corrective measures and further plans of action.
- Liaise with other agencies, local NGOs, CBOs and other groups in the community.
- Monitor the NSEP on a regular basis

Outreach workers

ORWs should ideally be from the drug using community e.g., an ex-drug user and/or someone undergoing OST, be a local resident, know the local language, have basic literacy and possess a cultural and social understanding of the project area and context. In addition, an ORW needs to have certain attributes to be successful in his/her work. *These include:*

- A non-judgmental approach.
- Strong communication, organizational and record keeping skills.
- The ability to network.
- Strong commitment to working with the IDU community.
- Respect for IDUs and their partners.
- A view of him/herself as an advocate for those at risk.
- A flexible approach to various lifestyles of IDUs.

The ORW's key responsibilities should be to:

- Map sites with PEs for planning NSEP and regularly updating information.
- Regularly visit the target areas and ensure regular distribution of needles and syringes to IDU clients.
- Maintain adequate supply of needles and syringes, and other commodities.
- Manage PEs and provide back-up support to PEs, in case a particular PE is not able to cover a particular area.
- Conduct one-to-one as well as one-to-group sessions with clients.
- Motivate IDUs to access drop-in center facilities.
- Accompany and motivate clients for uptake of testing at ICTC and other referral services.
- Maintain records as required by the project.
- Prepare weekly reports and participate in staff meetings.

Materials distributed under NSP

1. Needles: 24”, 26” gauge
2. Syringes: 1 ml, 2 ml, 5 ml, and 10 ml
3. Alcohol/spirit swabs, (at least two swabs with each needle and syringe to clean the site before injecting) and bandages, etc. to manage abscesses
4. Distilled water

5. Filter, cooker, tourniquet – where budget permits
6. Condoms
7. Water-based lubricant sachets, if required
8. Need based IEC materials

Calculating the syringe demand

An example An IDU TI working in a city 'X' has to initiate NSEP in its target areas. Through the outreach planning, about four hotspots were identified in the area of operation of the TI. It was also seen that hotspot 'A' has 20 IDUs. Of these, 10 IDUs inject thrice a day, five IDUs inject twice a day and remaining five inject once a day. All of these IDUs use a 5 ml syringe to inject a cocktail of buprenorphine and diazepam. On the basis of the above information, the number of syringes required for the hotspot 'A' would be: Syringe demand for hotspot A: (10 X 3) + (5 X 2) + (5 X 1) = 45 syringes of 5 ml size.

Procedures for day-to-day NSP

Outreach distribution modality

On a day-to-day basis, the service delivery of NSEP for outreach begins with the outreach team (ORWs and PEs) going to the fi eld early in the morning to provide services to IDUs who would be visiting the hotspots to procure their fix. This may not be the case in every hotspot and also in places where there are no hotspots.

For example, IDUs may not visit a hotspot to inject drugs, but may inject at their homes. In such cases, the outreach strategy should be accordingly modified. The outreach staff should have an outreach bag to carry materials to be distributed during outreach. The outreach bag should be a thick puncture proof bag to carry all the materials in the field.

Usually, the NSEP staff should distribute needles and syringes as per the client's requirement. If the client, for example, is injecting twice a day, he/she should be provided with two needles and syringes. Sometimes, it may be required that the client is given more than a day's supply of needles and syringes. This is usually at places where the contact with the client is less frequent, such as places which have hilly terrains, where law and order is an issue, or if the client is moving out for some days. A supply for seven days can usually be provided. However, staff may use their discretion and supply more equipment if requested by the client. Sometimes, clients sell the needles/syringes distributed to them by the TI. To dissuade the client from selling such supplies in the open market, the TI project should have special markers on the wrapper of the needles and syringes provided to the client (e.g., bold writings on the syringe wrapper, making a 'nick' on the wrapper, etc.).

Additionally, the client should be encouraged to return the used needles and syringes. However, it should not be mandatory for the client to return his/ her used needles/syringes to obtain a new needle/ syringe. Along with providing needles and syringes, the staff should befriend and educate the client on other harm reduction messages, including safe injecting, safe sex and the need for availing referral services. Other materials such as abscess prevention materials, condoms, etc. are also provided in this contact. Finally, the transaction is noted down by the staff in the fi eld diary. It is not necessary for the peer educator, especially, to visit the DIC on a daily basis. The outreach worker acts as a liaison between the PE and the DIC. He/ she should ensure that – enough commodities are available with the PE, PE visits the hotspots and conducts NSEP daily, and finally ensure that the transaction made by the PE is entered in the appropriate records. The outreach worker should also ensure that all the hotspots are covered between the team of PEs and himself/herself.

DIC Distribution Modality

Immediately after opening, the DIC staff should ensure that a staff member is stationed to provide needles and syringes in the DIC along with provisions for storing the used needles and syringes and recording the transaction. Additionally, basic education on harm reduction and provision of other commodities such as abscess prevention materials and condoms should be conducted. Finally, disinfection of the collected needles and syringes should be carried out periodically.

The proper management of sharps is extremely important to prevent accidental needle stick injuries and to avoid the risk of transmission of HIV and other blood-borne viruses. The retrieval and disposal of used needles are essential components of a NSEP project. The project should have built-in strategies and mechanisms to increase return rates of used sharps. Collecting as many used needles and syringes as possible is important, as this will ensure that the circulation of the used needles and syringes for injecting is minimized. Research has shown that 60-70% return rate is indicative of good functioning of a NSEP. The collection of used needles/syringes also ensures that the non-using community members, especially children, do not get accidentally pricked with the used needles/syringes.

Opioid Agonist Therapy

1. **Steps to provide medication (Receipt, distribution, Security)**
   - Holding a meeting with representatives of the Medicines Authority and the Unified Procurement Authority to determine the steps to be taken to receive the drug shipment once the medicine arrives in Egypt
   - Prepare all forms required to complete the procedures

- Steps to deliver the medicine from the airport or port to the Egyptian company's stores securing the arrival of medicine to service centers
- Determining the quantities to be allocated to each hospital
- Preparing forms for the documented course of the drug:
- Receipt forms for the quantities
- Medication delivery forms at the main hospital pharmacy, identifying the custodian responsible for receiving the medication and recording the received quantity
- Disbursement forms from the main pharmacy to the subsidiary pharmacy on a daily basis – Forms for disbursement of quantities and daily inventory in treatment centers –
- Forms for delivery of the remaining undisbursed quantities

2. Needs to be met:

- Special lockers to save the quantity received in the main pharmacy store in each hospital
- Print the aforementioned necessary forms with a serial number, and deliver them to hospitals Treatment dispensing tools ( )

3. The target group: Basic criteria required for the patient to be included in the program to start treatment:

1. The age should not be less than 18 years
2. A diagnosis of opioid dependence according to ICD-11 (just irregular use or abuse is not enough)
3. The ability to give informed consent
4. Intravenous drug users (IDUs)
5. Infection with HIV/AIDS through a rapid test or confirmatory test
6. Hepatitis B virus infection (HBV, HCV) through rapid screening or confirmatory testing
7. Pregnant women who inject opioids: You must have injected a psychoactive substance at least once in the past 3 months for non-medical purposes.
8. Length of use and injection use of opioids: Indicates a long history of opioid use (more than 3 years)
9. The patient's willingness to attend daily to receive treatment (if the program is applied in outpatient clinics)
10. There are no medical contraindications: - The only major contraindication to the use of OST is the presence of sensitivity to the drug. Second: additional criteria, it is preferable to enroll the patient in the OST program, if any: While the following criteria are not necessarily present for the patient to start treatment, if any, the patient is given priority in joining the OST treatment program 1) Several previous attempts to stop using have failed 2) Motivation for treatment and cessation of drug use Third: Criteria for exclusion from joining the opioid replacement therapy program 1) The presence of severe impairment of liver function, or a severe degree of hepatic insufficiency: A liver function test is performed and based on the results, a decision can be made:

It is completely forbidden for the patient to join the program in the event of severe impairment in liver function tests / or the presence of confirmed clinical evidence of liver failure. - If the impairment is mild to moderate, OST therapy can be initiated, but with careful titration of the dose. 2) The presence of a severe degree of respiratory problems: In conditions such as severe asthma or chronic airway disease that results in severe impairment of respiratory function, caution should be exercised when initiating treatment with opioid medication, as it may exacerbate respiratory problems.

Benzodiazepines should not be prescribed to such patients for sleep disorders due to their additive depressant effect on the brain. 3) Known hypersensitivity to any opioid substitute (buprenorphine, methadone) Equipping hospitals to implement the program: - Examination of the place designated for the methadone program to determine its suitability and implementation requirements - Providing a pharmacy and a storage place monitored by cameras Allocating 5 beds in each hospital to be a place for observation of patients during the Induction Phase. - Providing special lockers to store methadone

4. Medical team:

The following team shall be identified in each hospital to be responsible for the implementation of the program: - Physician (Consultant/Specialist) Director of the Opioid Treatment Program - 2 doctors ((consultant / specialist) - 3 resident doctors 10 Nursing 3 pharmacists.

An intensive training program is required for the medical teams Coordinating with the Ministry to provide financial incentives to medical teams on a regular basis.

4. Key Monitoring Indicators

Summary Overview

The below table lists key monitoring indicators recommended for an HIV prevention program for key and vulnerable populations. *It provides a description of each indicator and shows:*

- Suggested disaggregation for data (e.g., by KP type, demographics)
- Which indicators contribute to indicators required for reporting to Global AIDS Monitoring (GAM)
- Which tools supply the data for the indicator
- Frequency of reporting

This list should be reviewed and updated at least every 3 years or when needed in case there is significant epidemic updates or as a result of National PSE and/or BBSS studies.

It is also important that all implementing partners across a program collect data for a minimum, agreed-upon set of indicators, as dictated by the program objectives. The national program must oversee implementing partners and monitor sites to ensure indicators and definitions are understood and used consistently.

Data collection for these indicators may be carried out at the hot spot level or the implementing partner level, and by different staff at each level. The frequency of data collection also varies: some indicators may be collected on a one-time basis at the beginning of the project, while others are collected weekly, monthly, semi-annually, or yearly, depending upon the needs of the program.

The NSP through its objectives and targets provides a basis for tracking and demonstrating progress and achievements of NAP by the end of the planned period. The National AIDS Program in Egypt is multi-faceted, steered by the Ministry of Health and Population (MoHP), and implemented by a range of constituents such as:

- **National AIDS Programme,** which leads on designing, funding and implementing the NSP
- **Government health facilities at different tiers** (Governorate, district, and community level), responsible for implementing specific parts of the HIV response such as VCT clinics, PMTCT centres, etc.
- **Civil Society Organisations (CSOs)**, which are responsible for providing health education, and prevention and screening services targeting key populations (KEPS)
- **UN Joint teams,** contributing to mobilisation of resources for implementing the strategic plan and providing required technical assistance to various constituents to effectively carry out their roles.

As the response is multifaceted and is implemented by a range of stakeholders, each constituent in the response naturally follows their own performance management framework and indicators to measure progress and results. Each constituent in the response does not necessarily follow NSP mandated framework, indicators and data definitions. This flexibility, while being a strength also become a weakness in measuring the national response to HIV. This situation leads to complexity, duplicity and non-conformity to established global standards of measurement and reporting. As framework and data standards are different across constituents, it continues to be challenging to produce national level reporting whereby underreporting and double counting become more widely spread. Rightly, the NSP has suggested that the stakeholders involved should operate through a standardized M&E framework that meets the different information needs and is suited to the capacities of the local context. As one of the four strategic impact priorities of the NSP is "to build strong and sustainable systems for delivery of HIV services", a need for a harmonised and unifying M&E framework for measuring national level HIV response is critically needed. The following manual is an effort in this direction.

Egypt is facing numerous challenges in measuring its response to HIV. The national M&E plan has taken cognizance of these challenges to develop appropriate mechanisms so that these challenges can be well addressed within the current phase of programming (National HIV Strategic Plan 2018-2022). A summary depiction of measurement challenges as reported by stakeholders during the national consultation and as documented in the NSP are:

- **Quality of data** produced is weak around many aspects of the HIV response. This is seen in indicators such as actual number of people who know their status, number of those retained on treatment and percentage of patients receiving regular viral load testing. One of the reasons is that information on HIV testing in TB /HCV/HBV facilities is not regularly shared with NAP. Consequently, the NAP is rolling out an automated system for patients' records through WHO support to monitor new infections, viral load testing, adherence, among other data. The system has the likelihood of reducing duplication in reported numbers as well as improving the quality of data around the different aspects of treatment and care. A system for monitoring the health care outcomes for all people tested and entered care, requires further development so that care cascade diagrams can be used as a management tool.
- **Prevention projects** are not capturing and /or reporting a range of data related to their interventions, including data about prevention packages provided to key populations. There is a challenge in conducting regular monitoring of HIV incidence among PWID, MSM and FSW, as well as other groups of the population. There is currently limited NGO reporting to the government. Furthermore, NGOs implementing prevention projects have developed their own systems, driven by their institutional values and requirements. These systems, while representing strength of the country's repertoire of approaches to measure progress and impact, also pose a significant challenge in national level data consolidation. This is particularly evident when reporting annually on Global AIDS Monitoring (GAM) indicators. Clearly, a harmonised and unified framework continues to be needed. The M&E framework for prevention projects, proposed here, aims to enhance the reach and impact of projects, through the use of relevant and culturally sensitive tools which can be taken-up by a multiplicity of stakeholders in the national response.
- **Completeness and quality of routine data** needs to be enhanced such as those collected from VCTs and other designated health facilities. Duplicate health information for patients between clinics needs to be solved through linking records using unique identifiers, aiding in effective monitoring of service delivery. If two NGOs are providing prevention related services to the same member of KEPS, then it is possible that reach of KEPS is double counted. The proposed harmonized national level M&E framework aims to reduce these errors.
- **Weak sentinel surveillance** among women, and lack of systematic and representative behavioural data collection and monitoring.
- **Ambiguities** exist regarding indicator definitions among data providers at sub national level, creating challenges in data consolidation at the national level as different organizations may calculate and account for their services and numbers, in different ways. In the national consultation, a clear need was expressed for aligning indicator definitions so that all data entities across the board are able to capture and share proper estimates of their progress, which will then be easily amenable with national level consolidation, reducing estimation errors.

Whilst there are challenges and gaps in the current M&E, there is also ample strength in the existing ways of working, those that should be capitalized on. Some examples are iterated below:

- The NGOs implementing prevention projects in the country have followed elaborate processes while conducting their outreach work and establishing connections and rapport with members of key populations. NGOs often use coded questionnaires and develop baselines through pre-test questionnaires and case management systems, the latter which captures services provided to patients. Some NGOs have also integrated follow up systems for members of key populations covering prevention support, treatment and care. Overall, plenty of data is being collected, and NGO systems are able to meet different donor requirements for reporting. Consequently, the M&E manual for prevention projects can be readily integrated to address requirements of national level reporting as well as GAM reporting.
- Another NGO implementing a prevention project follows a Treatment as Prevention (TasP) approach which adds strength to its programming by monitoring 'prevention' and 'prevention to treatment and care' results. The NGO tracks all aspects of its programming

closely with case IDs and is generally in position to provide required progress data related to various prevention services.

The measurement challenges as well as existing strengths (as highlighted above) provide an indication that the HIV response in Egypt need to move towards a common vision or and unified framework for measurement and reporting. This unifying framework is recommended by the NSP as well. The NSP supports the view that in order to monitor the strategic plan, and to consolidate the different M&E frameworks used, consensus among stakeholders on targets to be used for monitoring the national response, is necessary. The NSP articulates a need to enhance the availability of strategic information from different sources to monitor HIV response coverage, quality, and impact. A unifying framework on how to implement this in the prevention projects is provided in subsequent sections of this document:

Size estimation of KPs						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Estimated number of KP individuals in the country program geographic area	Number of people engaging in the specific behaviour that put the given population at risk for HIV transmission or a proxy for those types of behaviour	Not applicable	Not applicable	Estimating population sizes by age or sex is generally impractical. However, if a survey measures women who inject drugs or male sex workers, for example, a size estimate should be included. Cities and other administrative areas of importance	National studies and surveys	Every 5 years
Percentage of key populations living with HIV	Progress on reducing HIV prevalence among key populations	Number of people in a specific key population who test positive for HIV	Number of people in a specific key population tested for HIV	By key population By Age groups By Gender By geographical area	This indicator is calculated using data from HIV tests conducted by CSOs and governmental VCTs. National surveys (BBSS)	Quarterly, Biannual and Annual (program data) or every 2 years (BBSS)
HIV Testing among key populations						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Percentage of people from key populations who report having tested negative for	Progress providing HIV testing services to	Respondent reports having tested for HIV in last 12	Number of respondents whom are reached by	By key population By Age groups By Gender By geographical area	Behavioural surveillance or other special survey	Every 2 years

HIV in the past 12 months, or who know that they are living with HIV	members of key populations	months and result was negative	testing services			
Organization (NGO)/program Planning						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Number of mapped hot spots in country program geographic area where outreach is to be done for KP individuals	The accuracy and efficiency of selected sites for outreach work	NA	NA	By KPs By venue (physical and/or virtual)	Data from NGOs and outreach teams	Quarterly Biannually Annually
Number of peer outreach workers needed (calculated from ratio of KP beneficiaries to peer outreach workers, as recommended by guidelines)	The required optimal human resources to have efficient prevention program	NA	NA	By KPs By NGO By venue	Data from NGOs and outreach teams	Biannually Annually
Number of staff outreach supervisors needed (calculated from ratio of peer outreach workers to staff outreach supervisors, as recommended by guidelines)	The required number of teams supervisor	NA	NA	By KPs	Data from NGOs and outreach teams	Biannually Annually

Enrollment and Outreach						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Number of KP clients registered (enrolled) by the NGO/VCT during the reporting period	Quality of enrollment in by NGO/VCT	NA	NA	By KPs By age group By Gender	Data collected from NGOs and governmental VCTs	Monthly
Number of KP clients served by minimum prevention package by the NGO/VCT during the reporting period	Coverage of prevention program	Number of KPs individuals receive minimum preventive package	Number of KPs individuals enrolled by NGO/VCT	By KPs By age group By Gender	Data collected from NGOs and governmental VCTs	Quarterly Biannually Annually
Recruitment and training of intervention team						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Number of staff	Working capacity	NA	NA	➢ Program services (doctor, nurse, counselor, etc.) ➢ Management ➢ M&E ➢ Administrative	Staff registry	Biannually Annually
Percentage of staff/peer outreach workers/ peer supervisors who received initial training	Coverage of training and capacity building programs	Number of trained staff	Total number of working staff	By working specialties' Initial training Follow-up/further training	NGOs training registry National training registry	Biannually Annually

Number of outreach personnel who discontinued working in the last month	Work satisfaction	Number of personnel who discontinued working in the last month	Total number of working staff	Supervisors Peer outreach workers	Staff registry	Monthly
Coverage of HIV Prevention/Harm reduction program						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
percentage of people in a key population reporting having received a combined set of HIV prevention interventions	People in key populations who received at least two HIV prevention interventions in the past three months	Number of people in a key population who report receiving two or more of the prevention interventions listed	Number of people in a key population responding to the survey	By KPs By Age By Gender	Biobehavioral surveys	Every 2 years
Percentage of KPs reporting using a condom with their most recent client.	Progress in preventing exposure to HIV among KPs through unprotected sex with clients	Number of KPs who reported using a condom with their last client	Number of KPs who reported having sex in the past 12 months	By Sex (female, male) By Age groups By anal/vaginal sex By KPs	BBSS or other special surveys	Every 2 years
Number of male/female condoms distributed by program to KP	---	NA	NA	Male condoms Female condoms	NGOs/VCT data registry	Quarterly Biannually Annually

individuals during the reporting period						
Percentage of people who inject drugs reporting using sterile injecting equipment the last time they injected	Progress in preventing HIV transmission associated with injecting drug use	Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs	Number of people who inject drugs who report injecting drugs in the past month	By Gender By Age group	Behavioural surveillance or other special surveys	Every 2 years
Number of needles distributed to PWID individuals during the reporting period	---	NA	NA	------	NGOs/VCT data registry	Quarterly Biannually Annually
Referral/provision of HIV testing services						
Indicator	**What it measures**	**Numerator**	**Denominator**	**Disaggregation**	**Methods of measurement**	**Measurement frequency**
Percentage of KP individuals successfully referred to or navigated to an HIV testing site	Quality of referral and linkage to testing services	Number of KPs referred successfully to testing sites	Total number of KPs enrolled/registered in NGO/VCT registry	By KPs By Gender By Age group	NGOs/VCT data registry	Quarterly Biannually Annually
Percentage of KP individuals tested for HIV who received their results during the reporting period	Quality of pre and post test counseling	Number of KP individuals tested for HIV who received their results during the reporting period	Total number of KPs individuals who are tested	By KPs By Gender By Age group	NGOs/VCT data registry	Quarterly Biannually Annually

Percentage of KP individuals testing positive for HIV during the reporting period among those tested and received results		Quarterly Biannually Annually
Number of individual HIV self-test kits distributed		NGOs/VCT data registry
Total number of KP individuals who are tested and receive their results	NA	NGOs/VCT data registry
Number of KP individuals testing positive for HIV during the reporting period among those tested and received results	NA	Quarterly Biannually Annually
		By KPs By Gender By Age group
		By KPs By Gender By Age group

Unique identifier codes (UICs)

The KP individual is assigned a UIC when they enroll in the program, and they use it whenever theyaccess services, ideally across all providers and partners. In some instances, UICs are the national ID numbers that are issued by governments as what is adopted in the governmental VCTs.

In other cases, they are comprised of a series of alphanumeric characters unique to the individual thatdo not change over time. It should be clear that only 100% approach to avoid any duplication is the use of the official ID whenever possible.

UICs support the confidentiality of information about KP individuals and can also enh ance the quality of monitoring data and improve data analysis and decision-making.

The advantages of using UICs for KPs include:

- Uniquely identifies everyone receiving services without disclosing personal information about them.
- Largely eliminates the risk of duplication when counting KP individuals receiving services.
- Makes it easier to identify new individuals engaging with services.
- Enables analysis of treatment cascades through indicator data
- Makes it possible to assess the mobility of KPs through outreach services and health facilities.
- Can help reorient services to meet the changing needs and attendance patterns of KPs.

Issues to consider when developing a UIC system include:

- Components of the code itself (ideally made up of data about the individual that are nonchanging and can be easily recalled, so they can give their UIC each time they receive services without having to memorize a long, random code)
- Who assigns the UIC and when?
- How to check that UICs are not duplicated among individuals
- How to verify UICs when offering services
- How the UIC system is integrated across service providers

Data cleaning and analysis

During data collection great care should be taken to ensure that only high-quality data are collected and used for developing the final list of hot spots and size estimates.

Following these steps:

- All data collectors should be trained to ensure that they understand the protocol and how to solicit the required information.
- Data collection should be supervised by trained supervisors.
- All forms should be checked at the end of each day for completeness, consistency, and meaningfulness of the information collected before it is entered into the Excel database derived from data collection tools.
- During data analysis, develop the estimates and adjust for mobility among hot spots.

Data Collection Forms and Tools

1. Unique Identifier codification guide

الكود الموحد :

- الخانة الأولي : اول حرف من اسم المستفيد
- الخانة الثانية : اول حرف من اسم الأب
- الخانة الثالثة : اول حرف من اسم الجد
- الخانة الرابعة : كود محافظة السكن
- الخانة الخامسة : الكود الخاص بالجمعية
- الخانة السادسة : يوم الميلاد (رقمين)
- الخانة السابعة : شهر الميلاد (رقمين)
- أربعة خانات : التسلسل الخاص بالحالة (من 1 إلى 9999)
- آخر خانتين : آخر رقمين فى السنة

اول حرف من اسم المستفيد	اول حرف من اسم الأب	اول حرف من اسم الجد	كود محافظة السكن	الكود الخاص بالجمعية	يوم الميلاد (رقمين)		شهر الميلاد (رقمين)		التسلسل الخاص بالحالة (من 1 إلى 9999)				آخر رقمين فى السنه	

أكواد المحافظات:

	المحافظة	الكود
1	القاهرة	ق
2	الجيزة	ز
3	القليوبية	ل
4	الغربية	غ
5	الدقهلية	ة
6	الإسكندرية	س
7	الشرقية	ش
8	المنوفية	م
9	البحيرة	ب
10	كفر الشيخ	ك
11	دمياط	ط
12	الإسماعيلية	ع
13	بنى سويف	ن
14	السويس	ي
15	بورسعيد	و
16	الفيوم	ف
17	المنيا	أ
18	اسيوط	ط
19	سوهاج	ه
20	قنا	ت
21	الأقصر	ص
22	اسوان	ن
23	البحر الأحمر	ح
24	الوادى الجديد	ج
25	مطروح	ر
26	شمال سيناء	لا
27	جنوب سيناء	وَ

أكواد الجمعيات:

	الجمعية	الكود
1	مؤسسة الشهاب	ش
2	برنامج الحرية	ح
3	الصديق المقرب	ق
4	صحتى من بيتى	ب
5	كاريتاس	ك
6	الضاهرية	ض
7	الدعم للتنميه	د
8	اصدقاء المنيا	ص
9	النوران	ن
10	التميز	ت
11	عادل زين	ع
12	المصريه لتنظيم الاسرة	ظ
13	الجيزويت	ز

2. Field Outreach Data Form

إستمارة وصول ميداني

إسم المثقف					التاريخ									
مكان المقابلة				منطقة							محافظة			
الكود														
السن								الوظيفة						
أول مرة	نعم		لا			موعد أخر مرة								

رجال					
إستخدام الواقي أخر مرة					
مخدرات أخري	نعم		لا		النوع	حقن( ) أقراص( ) حشيش( ) كحول( )
سلوكيات أخري					
ملحوظات					
رقم التليفون					
منطقة السكن					

3. Clients Basic Data Form

إستمارة بيانات اساسية

إسم المثقف:		التاريخ:	يوم	شهر	سنة	
المكان:		المركز:				
كود المستفيد						
كود جديد	نعم	لا	كود قديم	نعم	لا	تاريخ اخر زيارة

الخدمات المقدمة	نعم	لا		
معلومات				
مطبوعات			العدد	
واقيات			العدد	
مشورة				
تحليل			النتيجة	

تحويل

تحويل: نعم ( ) لا ( ) مكان التحويل:

1- مقر الجمعية ( ) 2- وحدة الفحص والمشورة( ) 3- مركز علاج فيرس سي( ) 4- مستشفي حميات ( ) 5- مكتب الاستشارات القانونية( ) 6- مستشفي الجلدية ( ) 7- مستشفي الصدرية( )

توصيل

نعم ( ) لا ( ) أين:1- مقر الجمعية ( ) 2- وحدة الفحص والمشورة( )

3- مركز علاج فيرس سي( ) 4- مستشفي حميات ( ) 5- مكتب الاستشارات القانونية( )

6- مستشفي الجلدية ( ) 7-مستشفي الصدرية( )

أخري

نوع السلوك:	نعم	لا	أخر مرة		
مخدرات بالحقن					
	نعم	لا	عدد الشركاء	متي أخر مرة	إستخدام الواقي
جنس					
سيدات					

تحويل من الميدان			كود الشريك	

السن	< من 15 سنة	15-19 سنة	20-24 سنة	25-35 سنة	36-49 سنة	> من 50 سنة

ذكر		أنثي	

	نعم	لا
يعمل		
طالب		

المهنة/الوظيفة:

التعليم						
بدون تعليم		يقرأ ويكتب		إبتدائي		إعدادي	
ثانوي		جامعي		دراسات عليا			

الحالة الإجتماعية					
اعزب		متزوج		أكثر من زوجة	
مطلق		أرمل		شريك	

شريك غير مقيم			مقيم

الحمل	نعم		لا		لا اعرف		لا ينطبق	

سبب التقدم للمركز (توضع علامة على كل ما ينطبق)		
فحص قبل عقد الزواج		
ترخيص عمل/دراسة		
سلوكيات الزائر فيها خطر الإصابة		
سلوكيات الزوج/الشريك فيها خطر الإصابة		
فحص بعد نقل الدم		
يستخدم مخدرات بالحقن		
علاقة جنسية جديدة		
إعادة فحص أجرى في مكان آخر		
تحويل من جهة صحية		
سبب آخر – حدد		

	ذكر		انثي		ذكر		انثي		ذكر		انثي		ذكر		انثي	
عدد الشركاء بصفة عامة																
عدد الشركاء اخر شهر																
عد الشركاء اخر اسبوع																
إستخدام الواقي بصفة عامة دائما – احيانا – نادرا – نهائيا																

الخدمة المطلوبة (توضع علامة على كل ما ينطبق)			
معلومات		مشورة	
خدمات نفسية		خدمات طبيب (نسا)	
استشارات قانونية		فحص	
إحالة			

نوع الجلسة فردية		ثنائية	

طريقة ممارسة الجنس مع الإناث	شرجي		مهبلي		سطحي		
طريقة ممارسة الجنس مع الذكور	مستقبل		معطي		سطحي		
لم امارس الجنس نهائيا	نعم		لا				

هل يتم تعاطي اي نوع من المخدرات	نعم		لا					
لو نعم، توجه الي صفحة 4								

ما نوع المخدرات التي يتم استخدامها:
كل اد ايه:

ممارسة الجنس في الستة أشهر السابقة	نعم		لا				
لو نعم إستخدام الواقي في اخر ممارسة جنسية	نعم		لا				
نوع الشريك							
	ملازم		غير ملازم				
	زواج	بدون زواج	بمقابل	بدون مقابل	بمقابل		

سبق حقن مخدرات

نعم

لا

لو نعم

من إمتي

اخر مرة إمتي

كام مرة في اليوم

نوع المخدرات إيه

جديدة مستعملة مغسولة

نوع السرنجة اخر مرة

نوع السرنجة بصفة عامة

سبق مبادلة الجنس مقابل المخدرات

نعم

لا

استخدام الواقي الذكري في اخر التقاء جنسي
مع الشريك الملازم

نعم

نعم لكن انقطع الواقي

لم يحدث

لم يمارس الجنس ابدا

استخدام الواقي الذكري في الستة اشهر
السابقة مع الشريك الملازم (اختر واحدة مما
يلى)

لم يحدث

احيانا

دائما

استخدام الواقي الذكري في الستة اشهر
السابقة مع الشركاء الاخرين (اختر وواحدة
مما يلى)

لم يحدث

احيانا

دائما

هل حللت إيدز قبل كده

نعم

لا

النتيجة إيه

سلبي | إيجابي | لا أعلم

فين

إمتي

هل بدأت العلاج

نعم | لا | لا اعلم

من امتي؟

منتظم على العلاج؟

نعم | لا | لا اعلم

ملاحظات على العلاج:

هل أجري الشريك تحليل الفيروس من قبل

نعم | لا

النتيجة إيه

سلبي | إيجابي | لا أعلم

فين

إمتي

هل تم توزيع واقيات

نعم مع الشرح | نعم | لا | رفض الزائر

عدد الواقى الذى تم توزيعه

هل تم توزيع سرنجات

نعم | لا | رفض

عدد السرنجات التى تم توزيعها

هل تم توزيع مواد تثقيفية

نعم | لا | رفض الزائر

العدد

تم عمل مشورة قبل الفحص

نعم | لا

تم عمل الفحص السريع

نعم | لا

تم عمل مشورة ما بعد الفحص

نعم | لا

نتيجة الفحص السريع

متفاعل | سلبي | غير محدد

نتيجة الفحص التاكيدي

إيجابي | سلبي | غير محدد

لم يأ

4. *Monthly Report form for Needle & Syringe Program*

التقرير الشهرى لبرنامج السرنجات	
اسم الجمعية	
التاريخ	
المركز الثابت (ان وجد)	
إجمالى(عدد مستخدمى المخدرات عن طريق الحقن الذين ترددواعلى المركز+ عدد الذين تم احالتهم من قبل فر العمل الميداني	
ذكور	
اناث	
خدمات الوصول الخارجى	
إجمالى عدد مستخدمى المخدرات عن طريق الحقن الذين تم الوصول لهم	
ذكور	
اناث	
البيانات المطلوبة	
عدد السرنجات التى تم توزيعها لكل مستخدم مخدرات عن طريق الحقن	
إجمالى أعداد السرنجات التى تم توزيعها	
عدد مستخدمى المخدرات عن طريق الحقن الذين أفادوا بلإستخدام سرنجة جديدة فى آخر حقن	
اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الذين تلقواخدمات الفحص	
اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HIV	
اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HCV	

						تم
هل تلقي الزائر النتيجة	نعم		لا			
هل ينوي إخبار الشريك	نعم		لا		لا ينطبق	
هل تم عمل احالة خلال 7 ايام من تاريخ تاكيد نتيجة التحليل						
هل تم عمل إحالة بعد 7 ايام	نعم		لا			
تم التحويل الي (ضع علامة صح امام كل ما ينطبق)						
لم يتم التحويل						
طبيب متخصص في الايدز						
خدمات الامراض التناسلية						
خدمات رعاية السل						
خدمات النسا						
خدمات نفسية						
خدمات قانونية						
المزيد من المشورة						
خدمات اخرى-حدد:						
تمت مشورة بعد الفحص (علم واحدة)						

التاريخ : الإسم: التوقيع:

	اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HBV
	اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HIV الذين تم إحالتهم لخدمة الرعاية و العلاج
	اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HCVالذين تم إحالتهم لخدمة الرعاية و العلاج
	اجمالى أعداد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HBV الذين تم إحالتهم لخدمة الرعاية و العلاج

5. *Client follow up form for Needle and Syringe Program*

الجمعية:

التاريخ:

الاسم/ الكود			
تاريخ اول زيارة			
النوع	ذكر	انثى	لا أرغب
السن	اقل من 15	16-24	25-35
	36-49	50 أو أكثر	لا أعلم
المستوى التعليمي	بدون تعليم	ابتدائى	اعدادي
	ثانوي	دبلوم	جامعي

عدد الزيارات	الاسبوع الاول	الاسبوع الثاني	الاسبوع الثالث	الاسبوع الرابع
مايو				
يونيو				
يوليو				
أغسطس				
سبتمبر				
أكتوبر				
نوفمبر				
ديسمبر				
يناير				
فبراير				
مارس				

أبريل				
هل قمت باستعمال حقنة نظيفة في اخر حقن	**نعم**		**لا**	
كم مرة تحقن المخدرات في اليوم	**مرة واحدة**	**من 2-4 مرات**	**5 مرات**	**10 مرات أو أكثر**
كم عدد الحقن النظيفة التي استلمتها خلال شهر				
هل تستخدم سرنجات غير نظيفة (مستعملة من شخص اخر)؟	**نعم**		**لا**	
هل حصلت هل خدمات اخرى في الجمعية؟	**نعم**		**لا**	
اذا كانت الاجابة نعم، ما نوع الخدمة المقدمة؟				

أسئلة لمقدم الخدمة

ما هو معدل تردد المريض منذ بداية مايو 2021 وحتى نهاية دسيمبر 2021؟	
كم عدد السرنجات التي تم توزيعها على المريض/ة خلال تلك الفترة الزمنية؟	

6. *Data Reporting Form (Monthly, Quarterly, Biannually, Annually)*

	نموذج التقرير	
	اسم الجمعية	
1	**إجمالى عدد الزوار**	
	ذكور	
	اناث	
	اجمالى عدد الفئات الأكثر عرضة	
	اجمالى عدد الرجال ممارسى الجنس مع الرجال	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن	
	اجمالى عدد العاملات بالجنس التجارى	
	ذكور	
	اناث	
2	**اجمالى عدد الفئات الأكثر عرضة الذين حصلوا على خدمة الفحص**	
	اجمالى عدد االرجال ممارسى الجنس مع الرجال الذين حصلوا على خدمة الفحص	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن الذين حصلوا على خدمة الفحص	
	اجمالى عدد العاملات بالجنس التجارى عن الذين حصلوا على خدمة الفحص	
	ذكور	
	اناث	
3	**اجمالى عدد الفئات الأكثر عرضة الإيجابى لفحص HIV**	
	اجمالى عدد االرجال ممارسى الجنس مع الرجال الإيجابى لفحص HIV	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن الإيجابى لفحص HIV	
	اجمالى عدد العاملات بالجنس التجارى الإيجابى لفحص HIV	

	ذكور	
	اناث	
	اجمالى عدد الفئات الأكثر عرضة الذين تم احالتهم للرعاية و العلاج	4
	اجمالى عدد الرجال ممارسى الجنس مع الرجال الذين تم احالتهم للرعاية و العلاج	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن الذين تم احالتهم للرعاية و العلاج	
	اجمالى عدد العاملات بالجنس التجارى الذين تم احالتهم للرعاية و العلاج	
	ذكور	
	اناث	
	اجمالى عدد الفئات الأكثر عرضة الذين تلقوا العلاج خلال ال12 شهر الماضية	5
	اجمالى عدد الرجال ممارسى الجنس مع الرجال اللذين تلقوا العلاج خلال ال12 شهر الماضية	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن الذين تلقوا العلاج خلال ال12 شهر الماضية	
	اجمالى عدد العاملات بالجنس التجارى الذين تلقوا العلاج خلال ال12 شهر الماضية	
	ذكور	
	اناث	
	اجمالى عدد الفئات الأكثر عرضة الذين افادوا باستخدام واقي في اخر التقاء جنسي	6
	اجمالى عدد االرجال ممارسى الجنس مع الرجال الذين افادوا باستخدام واقي في اخر التقاء جنسي	
	اجمالى عدد مستخدمى المخدرات عن طريق الحقن الذين افادوا باستخدام واقي في اخر التقاء جنسي	
	اجمالى عدد العاملات بالجنس التجارى اللاتي افدن باستخدام واقي في اخر التقاء جنسي	
	ذكور	
	اناث	
	اجمالى أعداد الواقى الذى تم توزيعه على الفئات الأكثر عرضة	7
	اجمالى أعداد الواقى الذى تم توزيعه على االرجال ممارسى الجنس مع الرجال	
	اجمالى أعداد الواقى الذى تم توزيعه على مستخدمى المخدرات عن طريق الحقن	
	اجمالى أعداد الواقى الذى تم توزيعه على العاملات بالجنس التجارى	
	اجمالى السرنجات التى تم توزيعها على مستخدمى المخدرات عن طريق الحقن	
	اجمالى المطبوعات التثقيفية التى تم توزيعها	8

7. NGO/VCT Registry Sample

تقرير عن الفترة _____ اسم الوحدة_____

الجدول الأول: خدمات الوحدة

	الذكور							الإناث							المجموع
	تحت 16 سنة	16-19 سنة	20-24 سنة	25-35 سنة	36-49 سنة	فوق 50 سنة	مجموع الذكور	تحت 16 سنة	16-19 سنة	20-24 سنة	25-35 سنة	36-49 سنة	فوق 50 سنة	مجموع الإناث	
عدد الزوار الجدد للوحدة															
عدد المترددين للمتابعة															
عدد متلقي مشورة ما قبل الفحص															
عدد من تم فحصهم															
عدد الزوار بنتائج إيجابية															
عدد الذين تسلموا نتيجة الفحص															
عدد متلقي مشورة ما بعد الفحص															
عدد الزوار الذين عقدوا نيّة إخبار شركائهم بنتيجة الفحص															
عدد من تم تحويلهم إلي خدمات أخرى															

الجدول الثاني:أسباب زيارة الوحدة

أسباب الزيارة	الذكور							الإناث							المجموع
	تحت 16 سنة	16-19 سنة	20-24 سنة	25-35 سنة	36-49 سنة	فوق 50 سنة	مجموع الذكور	تحت 16 سنة	16-19 سنة	19-24 سنة	25-35 سنة	36-49 سنة	فوق 50 سنة	مجموع الإناث	
نية عقد الزواج															
تصريح عمل/دراسة															
سلوكيات خطرة للزائر															
سلوكيات خطرة للشريك															

تلقّى نقل الدم																
إدمان بالحقن																
زوج/شريك جديد																
إعادة فحص تم في جهة أخرى																
تحويل من جهة صحية																
سبب آخر																
المجموع																

الجدول الثالث: المشورة الثنائية

	العدد
جلسات المشورة الثنائية	

الجدول الرابع: الوسائل

	العدد
وحدات الفحص السريع	
السرنجات	
الواقي الذكرى	
المواد التثقيفية	

ملاحظات أُخرى_____

توقيع مدير الوحدة_____ التاريخ _____/_____/_____

8. *Narrative NGO/VCT Activities Report Sample*

العنوان

- **ملخص (2-4 سطور)**

موجز عن التقرير ومحتوياته والفترة الزمنية

- **مقدمة**

- مقدمه عن المشروع
- خلفية عن العمل

- **أهداف المشروع**

المنهجية المستخدمة

تحديد اليات وادوات جمع البيانات المستخدمة المختلفة

تحديد الفترة الزمنية

الاشارة الي الاسباب وراء اختيار تلك المنهجية

- **النتائج**

- استخدام الرسوم البيانية
- تفصيل البيانات على حسب النوع
- شرح توضيحي موجز قبل اي رسم بياني

- **تحليل البيانات**

- الاشارة الي اي تغييرات في الانماط
- ربط البيانات ببعضها
- الالتزام بالترتيب في الشرح

توصيات

ختام


UNAIDS