



**APMG**  
HEALTH

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**FOCUSED COUNTRY EVALUATIONS**

**IRAN HIV EVALUATION**

REMOTE EVALUATION REPORT

September 2020

## Introduction

As defined by the World Bank, Iran is an upper middle-income country in Western Asia with 83 million inhabitants. Iran is the world's 18th most populous country; its territory spans 1,648,195 km<sup>2</sup>, making it the second largest country in the Middle East and the 17th largest in the world. Iran has thirty-one provinces that were grouped into five regions, based on decision of Interior as of 22 June 2014. Regions are not the constituent units of the country and exist purely for the convenience of governmental administration.

The first reported case of AIDS in Iran was registered in 1986. The country's first wave of HIV epidemic emerged in the early 1980s among the hemophilia patients who received contaminated plasma-derived medicines. The second wave of HIV in Iran came about in the early 1990s among people who inject drugs (PWID). The third wave was initiated by popularization of stimulants in around 2010, mainly amphetamines and methamphetamines, which may stimulate uncontrolled/unprotected sexual behaviors. The percentage of HIV infections registered through sexual contact increased especially among the youth.

According to the latest Spectrum projections, the number of PLHIV in Iran in 2019 was 59,314 (Range: 32,685 - 125,636) (862 children < 15 years, 42,952 men over 15 years, and 15,501 women over 15 years), with an estimated 4,089 (Range: 3,635-4,507) new infections occurring during the same period. Meanwhile, the HIV National Case Registry System reported 22,054 registered people living with HIV (PLHIV) up to the end of 2019 (661 children < 15, 15,804 men and 5589 women). There have also been a cumulative 19,026 recorded deaths among PLHIV (UNAIDS, 2019).

HIV prevalence among the general population in Iran remains low. However, the proportion of recorded cases attributed to sexual transmission has been steadily growing. The prevalence of HIV among vulnerable women (VW) was 1.23%<sup>1</sup> in 2019 (a decrease from 2.1% in 2015) and for vulnerable men (VM), estimated in two cities, was 1.5% in 2019. Prevalence among PWID has significantly reduced during the past five years from 13.8% to 2.8%, according to the new BBS data (Sharifi et al, 2019). HIV prevalence among prisoners, which was 2.1% in 2009, stood at 0.8% in 2016. A 2014 study of transgender people (TG people) in Tehran, recruited by respondent-driven sampling, reported 1.9% HIV prevalence.

Ninety-three percent of TB patients diagnosed in 2018 received HIV testing (8,062 out of 8,671) and HIV prevalence among them was 3.5%. One study among beggars, and another among homeless people, both conducted in Tehran in 2010, reported HIV prevalence values of 1% and 1.7%, respectively. HIV prevalence, ranging from zero to 4%, has been reported among non-representative samples of street children. The HIV National Strategic Program (NSP) has partly been funded by the Global Fund since 2005. The current grant. "Enhancement of National HIV Response with Focus on Target Beneficiary Groups in line with fourth National Strategic Plan (NSP) 2015-2019" started on 01 April 2015 and will end on 31 March 2021. The new Funding Model 2 grant (NMF2: US\$10,461,630) is the second implementation period of the Global Fund - IRN-H-UNDP grant and planned for 01 April 2018 - 31 March 2021. The Global Fund has been investing in Iran since 2005. During that period the Global Fund disbursed US\$ 62,412,067 through three grants, for supporting Iranian HIV National strategy.

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<sup>1</sup> It should be noted that because of selected study methodology (RDS) and travel restrictions due to COVID-19, the results are not final and valid.

Islamic Republic of Iran was selected to receive a field-based evaluation in Quarter 2 of 2020; however, due to COVID-19 pandemic, in consultation with the Global Fund country team, it was decided to conduct a remote evaluation. Two international consultants were responsible for conducting this evaluation, in collaboration with the Global Fund country team and in-country stakeholders. The evaluation of NFM2 grant in the context of full national disease program was carried out through data and document review and analysis and key informant interviews with stakeholders in Iran. Data capture took place over an extended period of time from May-August 2020, with key informant interviews taking place in July-August. An evaluation of the current Global fund grant in the context of full national disease program was implemented through data/document review and analysis, as well as interviews of key informants (KI) and stakeholders in Iran.

The Global Fund Country Team identified the following priorities for this evaluation:

- Available evidence (epidemiological data) on the dynamics of transmission: shift from injecting mode to sexual transmission and implications for programming the response;
- KP programming and service delivery, including results and implementation;
- Mobile HIV testing, including results and implementation; and
- Transition and sustainability planning.

More detailed information on the evaluation methodology and agenda are available in the [Supplementary Information Document](#).

## Findings

**Objective 1. To evaluate the extent to which – and how – the Global Fund grants have helped enable countries to achieve a) the goals and objectives described in their national disease strategic plans and overall health sector strategy, and b) the goals and objectives agreed in the grant agreements.**

Iran is the only country in the Middle East North Africa (MENA) region that has committed itself to reach the global target of 90-90-90 to help end the AIDS epidemic by 2020. The 4th National Strategic Plan for HIV/AIDS (4th NSP) and the Global Fund HIV grants have been developed and are being implemented in line with these ambitious targets. The 4th NSP includes several goals, objectives and interventions which were prepared to cover a 5-year period (2015-2019). The overall budget for 4th NSP was about US\$ 1,002,300,503, mainly supported by public financial resource allocations. The program budget was endorsed through an official process involving cabinet approval and parliament endorsement. More than 50% (51.57%) of the budget was allocated to Harm reduction activities and for vulnerable populations.

The Global Fund funding request was based on programmatic gaps and national priorities identified during the country dialogue in full alignment with the country's 4th NSP. The current grant (NFM2) is the continuation grant for the period of April 2018 - March 2021 and is aligned with priorities set out in the 4th NSP, with the goal of limiting prevalence rates among key populations (13% for injecting drug users and 5% for men and women engaged in risky sexual behavior). Another target of the NSP is to reduce HIV-related mortality by 20% over the same period (National AIDS Committee, 2018).

The interventions are being implemented within the scope of NFM2, strategically planned as part of the continuum of the country's pursuit for sustainability in its financing of HIV services. The analysis of the total expenditure disaggregated by source of funding indicated that domestic funds constituted 93.4% of the total expenditures for HIV, funds from external sources made 6.6% (data for 2015) (Aboulhallaje & Najafi, 2017). The NASA 2019 is in process and not finalized yet.

## **Domain 1.1. Strategic information, planning, and investment**

Inputs: The government of Iran supports a significant portion of HIV services in the country, and the Global Fund financing is mainly required for the areas where the government does not have sufficient budget.

Thirty eight percent of the grant budget is allocated for human resources, who are required not only for the Global Fund grant implementation, but also for creating adequate workforce which strengthen the HIV national strategy and will support the financial transition process.

A number of formative studies, evaluations and assessments, presented below, costing over US\$250,000, has been planned within the current grant (see Domain 3.1 for complete list and update on implementation) (UNDP, 2017).

Outputs: At the end of 4th NSP 2015-2019, a technical-consultative meeting for development of the 5th NSP 2020-2024 was held from 2-4 November 2019. The meeting was supported by UNDP/under the Global Fund to fight HIV/AIDS, TB and Malaria Country Coordinating Mechanism (CCM) project and was hosted by the Deputy of Health of Hormozgan University of Medical Science. Over 50 representatives from public and private sectors, CBOs, affected people, national experts, as well as representatives of multilateral partners have been participating in the development of new NSP. The aim of this initial meeting was to gather technical experts and key stakeholders to review the 4<sup>th</sup> NSP, conduct a SWOT analysis, and initiate the development of 5th NSP. Within the current grant, the PR hired a national consultant who will support the CCM and UNDP in the development of the new allocation request to be submitted to the Global Fund. During this process the consultant will ensure the Global Fund grants are fully aligned with the 5th NSP and the Global Fund instructions and guidelines (UNDP, 2020).

The 5th NSP will prioritize the strategies, identify the vision, missions, and define the mid and long-term goals. The budget is being formulated based on qualitative goals, costs of service packages and unit costs with consideration of inflation costs. The workplan, list of implementer organizations, as well as monitoring and evaluation (M&E) plan will be part of the NSP. After document finalization, it will be discussed within the working groups and submitted for revision to High Council for Health and Food security which is chaired by the President. Once NSP is approved and signed by the president, it is officially released. Since the NSP is a reference national AIDS control program document, other programs indicator should be aligned with NSP targets. Global Fund grant alignment will be done after finalization of the NSP. (Key Informant interviews, 2020)

During key informant interviews, national stakeholders reported that all core strategies of 4th NSP will be transferred to the 5th NSP, and the list of KPs will be complemented with additional vulnerable groups, such as TG people and mobile populations/seasonal workers. It is presumed that the new NSP objectives and indicators will correspond to the current epidemiological situation and commitments of the country. (Key Informant interviews, 2020)

Besides, the results of studies, presented in “Input” section, will contribute to the revision of current strategies, turning decision-making process evidence-based and facilitating the development of 5th NSP.

Outcomes: It is not possible to assess the level of achievement for the goals and objectives described in 4th NSP because the NSP review report was neither provided to evaluators, nor is publicly accessible. The rating for NFM2 was B1 during the last two reporting periods, since the beginning of 2018. There is no evidence that the next reporting period will see an improvement in performance. More details are presented in the dashboard of core indicators for this objective, below.

## **Domain 1.2. Resilient and sustainable systems for health**

Inputs: The Global Fund remains the major external source of financial contribution in Iranian HIV NSP. There is no direct Global Fund funding for improvement of PSM capacities in the country within this grant; however, indirectly, UNDP contributes to improvements of National LMIS system. The significant financial and non-financial resources and mechanisms of the PR are used for procurement of HIV test kits, ARVs, test kits for clinical monitoring and lab equipment. Support is vital for the program due to sanctions and economic situation in the country (Key Informant Interviews, 2020).

HIV management and service delivery infrastructure that were created during the years of cooperation with the Global Fund encompass all types of organizations (governmental, non-governmental and private) that are balanced and structured with strong division of their responsibilities defined by HIV NSP. A significant range of activities have been transferred from the Global Fund financing to domestic funding during NFM1 and previous grants. NFM2 does not support directly any community-based organization; however, CBOs are involved in service provision at the field level through sub recipient organizations (SRs) (Key Informant Interviews, 2020). US\$ 123,555 is allocated to NFM2 to cover salaries of Positive Clubs (PC) staff (UNDP, 2017).

Outputs: All procurements, including procurement of services under the Global Fund grants, are being conducted by UNDP as the PR. Some limited procurement activities are allowed at SR/Sub-sub-recipient (SSR) level. Within the HIV NSP all quantification, estimation and forecast of health products, test kits, ARVs and other products/medicines are planned and managed by the National AIDS Control Program (NAP). The management information system software (MIS) allows the calculation and estimation of national need with regard to ARVs and prevention commodities. The portions of these commodities for PR and government procurement are determined (Key Informant interviews, 2020).

Health products and commodities are procured for one year in advance; however, fractional distribution is being applied to prevent overstocking and expiry. The buffer-stocks are calculated for preventing stock-outs of ARVs. Health products procured by the PR under the NFM2 are being delivered to the Ministry of Health (MoH) and medical education (MoHME's) warehouse; MoHME is responsible for further distribution within the beneficiary organizations (Key Informant Interviews, 2020).

The PR regularly monitors the warehousing and delivery conditions at central and peripheral level to ensure proper storage and distribution. Non-health products, such as mobile stations or vehicles, procured by PR are delivered to each SR's warehouse and in some cases the products are delivered to provinces where they are located (Key Informant interviews, 2020).

The involvement of CBOs/NGOs in service provision has been the key element of the national response ever since the first NSP was developed in the early 2000s. Harm reduction programs for PWID were planned, launched and scaled up with the help of non-governmental organizations. At the end of 2018, all 269 drop in centers (DIC) for PWID, 53 DICs for vulnerable women, and 480 outreach teams working over the country are operated by CBOs. These centers are supported and undergo quality control by either the MoH (through the nearest medical university) or the State Welfare Organization.

The opioid substitution therapy (OST) program in Iran has also been expanded with the direct and widespread involvement of the private sector to the extent that, by the end of 2018, more than 98% of the approximately 8,000 OST centers, were supervised by either the MoH or the Welfare Organization, was administered by the private sector (UNAIDS, 2019).

Outcomes: There is no positive improvement in PSM observed during the last two years. Total economic embargo in Iran, which includes sanctions on companies doing business with Iran and consequent deteriorating economic situation in the country, appears to be a significant challenge for sustained development (Key informant Interviews, 2020).

As a result of those sanctions, Iran's gross domestic product (GDP) contracted an estimated 4.8% in 2018 and is forecast to shrink another 9.5% in 2019, according to the International Monetary Fund. Sanctions have drastically constrained the ability of the country to finance humanitarian imports, including medicines, causing serious hardships for ordinary Iranians and threatening their right to health (Human Rights Watch, 2019). This includes creating vital domestic shortages to life-saving medicines which limit the treatment access for some diseases. Sanctions have also crippled Iran's domestic pharmaceutical industry, leading to the disruption of generic medicines production and forcing the country to import medicines and raw materials that are of lower or questionable quality. The shortage of 73 drugs that closely tracked with the disease burden in the country was observed. Forty four percent of these drugs are classified by WHO as essential medicines (Setayesh & Makey, 2016).

Stock-outs of ARVs were not reported by respondents during interviews for the past two years; however, in 2018, the country reported stock-out of one or more required ARVs in 6.6% of facilities dispensing antiretroviral medicines. Ten sites from 160 health facilities involved in ART provision (6.3%), faced a stock-out of one or more required antiretroviral medicines. There is no available information related to ARVs stock out in prisons. Stock-outs of ARVs were reported also in 2017 and 2016 - in 3.6% and 5.5% facilities accordingly (UNAIDS, 2018).

There were also problems in the procurement of test kits, outlined in "Performance Letter Progress Report" for the period 1 April - 30 September 2019. The main changes pertained to a lengthy national procurement process and limited willingness from suppliers to provide services due to the current economic situation. As described by key informants, a situation of "near stock out" of HIV test kits was observed in 2019. Due to a lack of HIV test kits in some areas and uncertainty in dates for receiving planned quantities of test kits, some service providers minimized their testing activities (Key Informant interviews, 2020).

During key informant interviews, no changes in the scope of NGO core services provision were reported as a result of transition to domestic financing. Some additional/attractive services provided by PCs, like sewing classes or swimming pool passes for PLHIV, are no longer available. (Key Informant interviews, 2020)

### **Domain 1.3. Supportive and sustainable legal, policy, and financial environments**

Inputs: The Legal Environment Comparison Study and Assessment and the Stigma Index II have been carried out by country with the support of UN agencies and the Global Fund grant. A comprehensive multilevel study was launched with desk review of the national policies and laws, as well as comparative study of the laws in different countries. The results of the first stage qualitative study were validated via national stakeholder workshops, discussion sessions and individual interviews (Key Informant interviews, 2020).

With the support of UNAIDS, the country used Fuzzy modeling to understand root causes of Stigma and discrimination health care settings.

The analysis of the total expenditure disaggregated by source of funding indicates that domestic funds constituted 93.4% of the total expenditures for HIV, funds from external sources makes 6.6% (data for 2015) (Abdoulhallaje & Najafi, 2017).

Outputs: The Legal Environment Comparison Study and Assessment findings are being used for recommending amendments to relevant laws and regulations, as well as an information, education, and communication (IEC) campaign for health care providers. An anti-discrimination directive has been drafted by MoHME based on the same assessment and will be issued to all medical universities to end HIV related discrimination in healthcare settings. The process will be strengthened by training and workshops on stigma and discrimination for healthcare providers in 2020. A bylaw to ‘Prevent Discrimination and Stigma against People Living with HIV’ was developed based on findings of this evaluation. Although the bylaw cannot be legally binding, it will be submitted to the new parliament. (Key Informant interviews, 2020)

UNAIDS has supported the following initiatives to reduce stigma and discrimination in the country and to develop ethical frameworks:

1. Development of an interactive program to educate medical and health students on S&D using Gamification. The Redxir Project was aimed at stigma and discrimination elimination in healthcare settings. Pilot activities, from September 2018 till July 2019, were implemented among students of medical universities. 241 students participated in nine-month project (REDXIR, 2019).
2. Start-up of the project of legal capacity building for service providers in Adolescent Wellbeing (AWB) Centers and establishment of a referral system to address adolescents’ legal issues and Development of Ethical Framework for Adolescent Well Being Centers.

Since late 2015, the MoHME has been working with UN agencies to establish targeted programmes for young people in Iran seven Adolescent Well-Being (AWB) Centres have been established in six provinces. The AWB Centres target vulnerable adolescents and the youth with high-risk behaviour, provide a safe space for these groups, in which they can come together in an environment free of stigma and discrimination to acquire the required skills to lead a healthy life. The MoHME, in collaboration with other relevant stakeholders and UNAIDS, are developing policies and services for adolescents that empower them to address their sexual and reproductive health needs. The project is aimed at supporting capacity building for service provision and empowerment of adolescents. This includes capacity building on ethics and legal support to the AWB centres for implementation of health programmes for adolescents, and community-based activities. UNAIDS is supporting the capacity building of service providers of AWB centres, as well as the development and publication of educational materials on ethical and legal framework of AWB centres. Protocol on establishment of a referral system to address adolescents’ legal issues through citizen rights clinics will also be developed (UNAIDS/UNICEF, 2020).

3. Start-up of a study on the National Citizen’s Rights Charter in the context of National response to HIV.
4. Development of Ethical Framework for NSP5 and Development of Anti-Discrimination Directive for health care setting; The Directive is in the process of official announcement.

Outcomes: In general, comprehensive national laws in Iran cover a wide range of issues: fundamental freedoms, political and civil rights of people living with HIV (PLHIV) - such as non-discrimination, equality, liberty, security of person, and confidentiality. The results of legal environment study implemented in 2017 indicate that Iran, like many countries outlined in report, provides legal support for PLHIV. It is reflected in the body of fundamental laws as constitution (a chapter related to citizen rights), labor, travel and public health laws. These policies and laws protect PHLIV from stigma, discrimination, forced testing and privacy violations (Abbasi et al, 2017).

Most laws and policies are primarily dedicated to the organization of the health system, provision of services and elimination of stigma and discrimination. In some cases, such as employment law or law on public health, legal protection of PLHIV is implicit and unspecified, they require additional interpretation. Overall, the review of available documents and results of the study show that there is no specific analysis of legislative field to determine the existing legal barriers and obstacles for provision of HIV/AIDS prevention activities to key populations (excluding PLHIV). Most legal policies are directly focused on PLHIV. KPs who are prosecuted by law (e.g. VW and VM) are considered a part of the general population until they self-identify as a KP. They benefit from all the rights of Iranian citizens by constitution and other legal acts. In practice, this approach creates additional obstacles on the way of health services utilization. Legal protections for KPs enable these individuals to seek support and obtain HIV services without fear of punishment or being stigmatized. Protection helps to ensure that services are available, effective and accessible to communities (Key Informant interviews, 2020).

It is not clear whether gradual increase of AIDS financing has been ensured within recent years or if the 5th NSP will reflect transition in its budget. Absence of national HIV subaccount does not allow for tracking and there is an absence of reports on AIDS actual expenditures in Iran. However, it should be considered that since 2015, the Iranian Rial has suffered significant fluctuations in the exchange rate and inflation. According to Iranian Central Bank, at the time of assessment the official exchange rate was approximately 42,000, while in 2015 it was around 25,500 IRI for US\$1 for the same period. In 2018, the Iranian Rial had its lowest rate in 35 years, of almost 60,060 Rials for US\$1. The total economic embargo on Iran has significantly affected the country's ability on perspective planning including health sector expenditures (Key informant interviews, 2020).



## Dashboard of Core Indicators: Objective 1

Dashboard Key			
1	Very poor		
2	Poor		
3	Moderate		
4	Good		

Indicator	Score	Justification	Source of Data
<b>Strategic planning:</b> Availability of National Strategic Plan	2	<p>The National HIV Strategic Plan in Iran is the main document that guides HIV/AIDS response in the country for the five-year period. The 4th HIV NSP, which was developed at the end of 2013 for the period 2015-2019, has finished. The current Global Fund grant is contributing to the development of the new, 5th NSP for the period 2020-2024.</p> <p>The format of NSP is envisaging that the M&amp;E and Costed Action Plans will be the part of the 5thNSP.</p> <p><b>5th NSP is in the process of finalization.</b></p>	<p>5<sup>th</sup> NSP development update, 2020</p> <p>Key Informant interviews, 2020</p>
<b>Strategic investment:</b> Appropriateness of goals and objectives to epidemic context	3	<p>Overall, the 5th NSP objectives for achieving the 90/90/90 goals seem to be relevant to current epidemic content. In existing documentation, there was no observed evidence for shifting programs or strategies and changing the scope of existing efforts.</p> <p>National KI envisage that all core strategies of 4th NSP will be transferred to the next one and the list of KPs will be complemented with additional groups, such as TG people and mobile populations/seasonal workers.</p> <p>It is presumed that the new NSP objectives and indicators will correspond to the current epidemiological situation and commitments of the country.</p>	<p>UNAIDS. 2019, Online reporting tool's data analysis</p> <p>Key Informant interviews, 2020</p>

		<p>There are still persistent challenges that need to be addressed:</p> <p><b><u>First 90 (testing)</u></b></p> <ol style="list-style-type: none"> <li>1. Limited/difficult access to certain key populations;</li> <li>2. Low demand/motivation for testing services among key populations.</li> <li>3. Challenges for involvement of new clients (KPs representatives) in testing programs.</li> </ol> <p><b><u>Second 90 (treatment)</u></b></p> <ol style="list-style-type: none"> <li>1. Insufficient linkage to care;</li> <li>2. Retention in care/ART.</li> </ol> <p><b><u>Third 90 (suppression)</u></b></p> <ol style="list-style-type: none"> <li>1. Insufficient adherence</li> </ol>	
<p><b>Performance:</b> Achievement of targets set in grant agreement<sup>2</sup></p>	<p><b>2</b></p>	<p>Average achievement for all indicators of the current Global Fund grant was 64% for the period 1 April 2018 – 30 September 2019. The latest grant performance rating corresponds to <b>B1</b>.</p> <p>There is no evidence that at the next reporting period an improvement in performance will be observed.</p> <p>In mid-March-April 2019, widespread flash flooding affected large parts of Iran. The flooding caused infrastructure destruction worth hundreds of millions of dollars, as well as the collapse of at least 314 bridges across the country. 23 of the country's 31 provinces were affected. The floods have fully and partially destroyed 1040 health facilities and 81 hospitals, leaving patients with limited access to essential and life-saving health services. In some provinces, health facilities were not functional due to inaccessibility of roads and landslides.</p>	<p>Grant Rating Tool: Period Start: 01 Apr 2018-31 Mar 2019</p> <p>Performance Letter Progress Report covering the period 1 April, 2019-30 September 2019</p>

<sup>2</sup> Refers to most recent grant agreement except when the grant was signed less than 12 months before evaluation: in these cases, this refers to previous grant agreement

		<p>Currently, the COVID-19 pandemic is having a catastrophic impact on the most vulnerable communities around the world. The situation in Iran is particularly harsh, with formal notification to date of almost 332,000 cases and 18,800 deaths.</p> <p>There is a significant decrease in indicators achievement in the last two reporting periods.</p>	
<b>Resilient and sustainable systems for health: Stockouts of key commodities<sup>3</sup></b>	<b>2</b>	<p>6.3% of treatment sites faced a stock-out of one or more required antiretroviral medicines during 2018 (10 sites from 160 health facilities dispensing antiretroviral medicines during 2018).</p> <p>There is no available information related to ARVs stock out in prisons.</p> <p>Challenges in the procurement of test kits as a result of a lengthy national procurement process and limited willingness from suppliers to provide services due to the current economic situation, have been mentioned in Performance Letter (Period -1 April, 2019-30 September 2019).</p>	<p>UNAIDS. 2018. GARPR Online Reporting Tool, Iran</p> <p>Performance Letter Progress Report covering the period 1 April, 2019-30 September 2019</p> <p>Key Informant interviews, 2020</p>
<b>Resilient and sustainable systems for health: Recognition and realization of role of community response and systems in the national response</b>	<b>3</b>	<p>CBOs/NGOs play the key roles in HIV/AIDS control program. The involvement of community-based organizations in service provision has been the key element of the national response since the first National Strategic Plan. CBOs/NGOs and the private sector are the main service providers on the field level; currently, they are contracted by the government following a bidding system for services provision.</p> <p>No information is available with regard to the level of financing for CBOs/NGOs.</p>	<p>UNAIDS. 2018, GARPR Online Reporting Tool, Iran</p> <p>Key Informant interviews, 2020</p>
<b>Supportive and sustainable legal, policy and financial environments<sup>4</sup>: Identification</b>	<b>3</b>	<p>HIV/AIDS legal environment assessment was conducted in Iran with the support of Global Fund in 2019. The assessment was mainly focused on the review of the national policies and laws, as</p>	<p>HIV/AIDS Legal environment assessment report;</p>

<sup>3</sup> For HIV, these are: ARVs, condoms, lubricants, needles and syringes (if harm reduction programs present) and test kits for HIV, CD4 and viral load.

<sup>4</sup> Supportive environments may vary considerably by population. Once an indicator receives a score, rationale will be provided. In some cases, this indicator may be sub-divided and scored for different populations, and then an average score will be calculated for the indicator overall.

<p>and addressing of legal barriers to health outcomes for individuals and populations</p>		<p>well as on comparative study of the laws in different countries. In-depth review of the legal barriers for implementation of HIV/AIDS prevention activities was not conducted.</p> <p><b>There is no gap analysis of existing legislation related to KPs. Assessment report does not include structural and detailed recommendation and action plan for addressing the barriers.</b></p> <p>A bylaw to ‘Prevent Discrimination and Stigma against People Living with HIV’ was developed based on findings of this evaluation. Although the bylaw cannot be legally binding, it will be submitted to the new parliament.</p>	<p>UNAIDS. 2018, GARPR Online Reporting Tool, Iran Key Informant interviews, 2020</p>
<p><b>Composite across all relevant (6) components Note: please change number of components if any indicators were unable to be scored.</b></p>	<p><b>2.5</b></p>		

**Objective 2. To evaluate the extent to which service delivery systems (health facility and community) deliver quality services.**

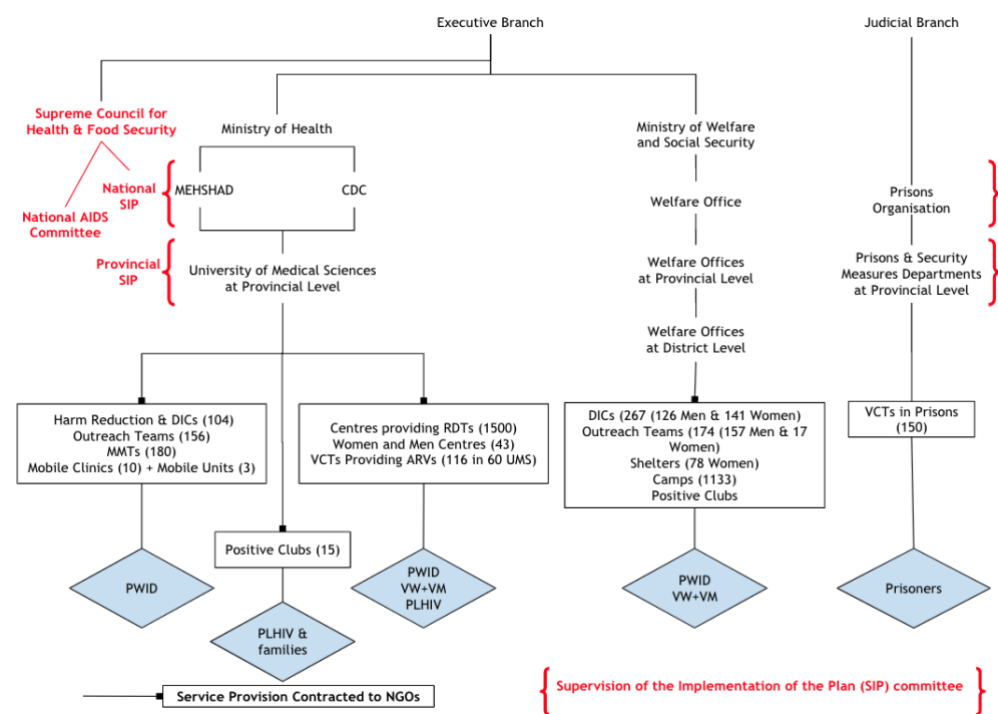
The majority of HIV prevention and harm reduction services planned in 4th NSP was funded from domestic resources - public resources for HIV/AIDS financing constitute 64.5%. Twenty-eight percent of HIV/AIDS expenditures was covered from private sources of financing (UNDP, 2017).

Thirty four percent of NFM2 grant – US\$3,681,512 -- was allocated for implementation of comprehensive prevention programs among KPs, as well as for PMTCT (UNDP. (2020). IRN-H-UNDP, Budget summary). Ministry of Health and Medical Education (IRANIAN CDC, MEHSAD and provincial UMSs), the State Welfare Organization of Iran, and the Prison Organization are the main entities responsible for implementation of harm reduction, HIV prevention and HIV testing activities for KPs. CBOs/NGOs and the private sector are the key service providers on the field level; currently, they are contracted by the government following a bidding system for services provision.

Field work (outreach, peer education, etc.) and other activities, such as awareness raising, psychological support, operation of PCs, DICs, shelters, mobile service delivery platforms’ operation, OST, etc. are implemented through staff, including peer staff, that are contracted via CBOs/NGOs and the private sector, but selected, monitored and regulated by the three above-mentioned key governmental organizations. (Key Informant interviews, 2020)

Supervision of the implementation of the NSP is monitored through a committee which at the national level is based under the Supreme Council for Health and Food Security and includes members from every relevant governmental ministry and the NAP. At the provincial level, Supervising of the Implementation of Program Committee (SIP) operated through Universities of Medical Sciences, provincial welfare or prisons offices. The overall implementation arrangement map is seen in Figure 1.

**Figure 1. Updated supervision and implementation arrangement map (obtained through Key Informant Interview, 2020)**



Global Fund resources are being provided for procurement of HIV rapid tests and activities aimed at expansion of prevention and testing services through mobile testing centers. The salary for staff involved in new mobile units' operation (two persons per unit) is covered by the current grant (UNDP, 2020). The introduction of mobile units as points for service delivery and HIV testing has significantly increased the geographic coverage for services provision for KPs and has made services more acceptable in terms of time and location (Key Informant interviews, 2020).

HIV services for PWID are being distributed through geographically well-balanced network of organizations, which include governmental, nongovernmental and private sectors. The supervision and coordination of these services are fragmented between the Mental Health, Social Health and Addiction Department (MEHSHAD), Iranian CDC and the Welfare Organization (Key Informant interviews, 2020).

MEHSHAD receives funds for the implementation of these activities from the Secretariat of Iran drug control Headquarter, the Ministry of Health and Medical Education and the National Social Affairs Organization. The activities implemented by WO are financed from National budget directly. (Key Informant interviews, 2020)

HIV services to VW, VM, and TG populations are less geographically distributed, and VM primarily are served in the four centers in Tehran. (Key Informant interviews, 2020)

Over the quarter of NFM2 grant, US\$2,733,456 is allocated for the HIV treatment, care and support component. Procurement of ARVs, provision of VL and CD4 test kits, costs related to establishment of HIV drug resistance reference laboratory in Iran, as well as provision of CD4 testing equipment are covered from the Global Fund current grant. Human resources for PCs operation, annual bulletins publishing costs and PCs staff capacity building workshops are also included in NFM2 grant. (UNDP, 2017).

### **Domain 2.1. Prevention**

Inputs: HIV prevention and harm reduction activities, provided to KPs (PWID, VM, VW, and TG people), are financed primarily from domestic sources, and Global Fund provides supplementary funding. As such, the Global Fund supported the procurement of four customized minibuses/trucks in late 2018 within the NFM1 grant to serve as mobile clinics, while government procured 43 additional units.

The NFM2 grant plans the procurement of 50 mobile units:

- 1<sup>st</sup> year - eight mobile vans (four - MEHSAD and four - WO) and five mobile stations for WO;
- 2<sup>nd</sup> year - fifteen mobile vans (two – IRANIAN CDC, five – MEHSAD and eight – WO) and 15 mobile stations for WO; and
- 3<sup>rd</sup> year - seven mobile stations for WO (UNDP, 2020)

Operation of the mobile service delivery points is funded from domestic resources. The NFM2 grant covers only the salaries of staff and outreach workers for these mobile units procured under the grant.

The current Global Fund grant will support OST and drug dependency treatment for PWID; US\$93,556 is budgeted for two methadone maintenance therapy (MMT) centers prefabrication and staff salary. (UNDP, 2020).

Salaries for outreach workers and medical staff, as well as HR costs for technical counseling services for VM (other vulnerable populations) will also be supported by the current grant – US\$169,935 has been budgeted over the three years of implementation (UNDP, 2017).

HR capacity building for staff of DICs, women centers, an outreach teams of SRs and SSR are planned within the current grant. Three days' workshops are scheduled for capacity building of 1,520 specialists from Iranian CDC, WO and PO, US\$254,755 is budgeted for this activity (UNDP, 2017).

Outputs: Service delivery points (CBOs/NGOs or private organizations) for HIV prevention and harm reduction services are being supervised by either the MoHME or the WO.

The 4th NSP defined a standard package of services (see Annex 1) for all KPs which are included in strategic plan, and there are midterm NSP indicators for accessing these packages delivery level. A standard package of harm reduction services includes:

- information, education, and communication (IEC) materials;
- needle and syringes;
- male and female condoms;
- referral to drop-in centers for HIV testing and counselling;
- reproductive, maternal, new-born, and child Health (RMNCH); and
- other services, such as empowerment interventions.

In order to standardize HIV service delivery throughout the country and assure the quality of provided services, the standard service delivery guidelines were developed for each target group. They are revised annually and if required, updated each year.

National guidelines for provision of HIV prevention services for VM was developed in 2019. VM have participated in development of these guidelines, which outlines the principles of HIV prevention services provision for this group. HIV pre-exposure prophylaxis (PrEP) is recommended as an additional prevention options and four triangular clinics are currently dispensing PrEP (UNAIDS, 2019).

HIV prevention services for TG people were also rolled out in 2019, through two dedicated sites with five outreach teams, which have so far served 389 transgender persons in the same year (2019).

Only 17 mobile service delivery units out of the planned 43 mobile service units in Y1 and Y2 of the current grant, are currently deployed. The expansion of services through mobile units for NAP-identified key locations include the following package:

- male and female condoms distribution;
- needle and syringes;
- referral to DICs (and VCTs for diagnosed PLHIV);
- HIV testing and counselling;
- nutrition counseling and warm meals; and
- education and training sessions on HIV/peer education. (Key Informant interviews, 2020)

The list of service delivery points for KPs receiving harm reduction and prevention services include:

- 371 DIC (141 for women), of which 93 are run by IRANIAN CDC, and 267 by WO
- 330 outreach teams (17 for women), of which 161 are run by IRANIAN CDC, and 157 by WO
- 8,000 OST centers
- 80 Women Centers (38 MoHME & 42 WO)
- Four Men's Centers
- 47 mobile platforms
- 1,133 camps
- 1,300 HIV rapid diagnostic testing (HRDT) centers
- 78 shelters

Within the above service delivery points the following outreach and harm reduction services have been made available for KP designated in 4th NSP:

- needle and syringe program;
- opioid substitution therapy (OST) and other drug dependence treatment, including methadone maintenance therapy (MMT);
- HIV testing and counselling (HIV rapid tests are partially procured by Global Fund);
- condoms distribution;
- prevention and treatment of sexually transmitted infections;
- provision of antiretroviral therapy;
- provision of services related to HIV/TB co-infection, mental health support and hepatitis; and
- social support.

In 2020, the Health Insurance Mechanism for Drug Abuse Disorders was introduced. Currently, 70-90% of the treatment tariffs are covered by the Health Insurance Organization and 10-30% is paid by person (this amount is determined personally) (Key Informant Interviews, 2020).

The minimum package of services, presented below, is used for reporting KPs - as reached by prevention services:

**PWID and their partners:** Defined minimum package of services includes needle & syringe distribution, condom distribution, and BCC. Additional services include referrals to other services as necessary, such as HIV VCT, TB and mental health services.

**Sex-workers and their clients:** Defined minimum service package includes condom distribution and BCC. Additional services include HIV VCT, STI screening, pregnancy test, PAP Smear, needle & syringe, nutrition, social work, referrals to specialized physician.

**People in Prisons and other closed Settings:** HIV prevention services are provided to all prisoners based on individual needs. Testing is offered as an additional service to all prisoners voluntarily, frequency is one test per year.

A person is considered as reached only if the individual receives the minimum package of services every six months. As the services are available for people based on individual need, and as such, a person may receive a one-time prevention or testing service, but not counted as reached. (Key Informant Interviews, 2020)

**Outcomes:** The Fourth National Strategic Plan combines a number of strategies to reduce the risk of HIV sexual transmission, including IEC for different population groups, harm reduction among PWID, condom distribution, PrEP, STI diagnosis, care and treatment, and treatment of PLHIV. Despite the numbers and variety of service delivery points, the coverage of KPs with harm reduction and HIV prevention services still remains low and far from targets set in performance framework of NFM2 grant.



**Table 1. KPs reached with HIV prevention programs – received defined package of services**

Indicator	1 April 2018 – 31 March 2019*		1 April 2019 – 31 March 2020**	
	Target	Result	Target	Result
Percentage of people who inject drugs reached with HIV prevention programs – defined package of services.	75% N: 150,000 D: 200,000	60.4% N: 120,823 D: 200,000	50% N: 100,000 D: 200,000	29% N: 58,199 D: 200,000
Percentage of sex-workers reached with HIV prevention programs – defined package of services.	65% N: 58,500 D: 90,000	58.7% N: 52,842 D: 90,000	45% N: 40,500 D: 90,000	36.4% N: 32,800 D: 90,000

\* IRN-H-UNDP: Performance Letter Progress Report covering the period 1 April 2018-31 March 2019.

\*\* PUDR covering the period 1 April 2019- 31 March 2020.

In 2019, about 7,990,000 free needles/syringes were distributed to PWID (UNAIDS, 2019). By December 2019, OST was offered to PWIDs at more than 8,000 centers supervised by Universities of Medical Sciences (UMSs), state Welfare Organization (WO) or Prisons Organization (PO). There is a 6.4% regress in condom use indicator for PWID population for the last six years: 41.8% in 2014 and 35.4% in 2020. However, it should be noted that the results should be studied with caution due to different sampling methodologies of these studies (UNAIDS, 2019).

Similarly, a rather interesting negative shift can be observed at analysis of safe injecting practices indicator for PWID from 2011 to 2019. The percent of PWID reporting the use of sterile injecting equipment at the last injection was rather high in 2011 (91.7%), then decreased to 78.7% in 2014 and 73.4% in 2019 (UNAIDS, 2019). Overall regress over the eight-year period is 18.3%. Again, the negative shift can be explained in various ways, and should be interpreted with caution, but an in-depth analysis is required to give a precise explanation for negative change.

At the end of 2019, a total of 80 centers provided HIV prevention services for high risk behavior women affected by HIV, (38 sponsored by MoHME and 42 by WO). The NAP has also rolled out four mobile units to provide HIV prevention services among VW. More than 2,260,000 condoms were distributed and about 32,000 VW received HIV prevention services in 2019 (UNAIDS, 2019). PrEP is recommended for VW by the latest national guidelines; however, the coverage remains very low (Key informant interviews, 2020).

Slight progress is being observed in condom use indicator for FSWs; there was an 8.18% increase from 2015 to 2020: 59.1% in 2015 - 67.26% in 2020<sup>5</sup>.

Whilst 75% of high-risk behavior women affected by HIV report having received free condoms during the preceding year, only 59% report using them during last sex (UNAIDS, 2019).

Prevalence among PWID has significantly dropped down during the past five years - from 13.8% to 2.8% - according to the new BBS data. The BBS study implemented among VW indicates that HIV prevalence among VW is 1.23%. It should be noted that because of selected study methodology (RDS) and travel restrictions due to COVID-19, the results of VW BBS cannot be validated by BBS team. Therefore, as stated in the study report, one should be cautious in interpreting and generalizing the results.

<sup>5</sup> The 2020 study is not finalised yet and the data is preliminary.

HIV prevalence among TG people according the results of cross-sectional study was 1.9% in 2014, no recent data is available (UNAIDS, 2019).

Piloting the provision of HIV services through mobile units was launched in late 2015. The mobile VCT model covers the needs of a large number of people who will not otherwise seek HIV-related care or advice. After achieving promising results, NAP decided to focus the work on key locations and KPs. Having the evidence-based success in utilization of mobile services and to accelerate the move towards 90-90-90 targets, the Global Fund supported the procurement of four customized mobile clinics (Key Informant interviews, 2020). However, delays in procurement of the vans and trailers due to Iranian national currency devaluation, bureaucratic procedures in registration and issuing license plates, and the COVID-19 pandemic hindered early launch, so the change in outcomes through this targeted approach has yet to show itself (UNDP/PR, 2020, update).

A positive shift was observed as a result of PMTCT integration in PHCs. In 2019, 74.6% of all pregnant women were tested for HIV and knew their status (880,218 from 1,180,000 pregnant women who delivered within the past 12 months). Two hundred seventy-three HIV positive cases were diagnosed among them (0.031%). It should be mentioned that these 880,218 pregnant women constitute 94.5% of those attended an antenatal clinic or gave birth at facilities. In 2018 only 31.8% all pregnant women were tested for HIV and knew their status (477,395 from 1,500,000 pregnant women who delivered within the past 12 months) (UNAIDS, 2019).

## **Domain 2.2. Screening/testing and diagnosis/knowledge of status**

Inputs: The HIV grant mainly supports two categories: rapid test kits and human resources in the form of HIV/STI specialist salaries. The current Global Fund grant supports the procurement of HIV rapid diagnostic tests for vulnerable populations. Overall, US\$712.373 has been budgeted for procurement, handling, insurance and custom clearance of HIV test kits.

Testing is provided through mobile clinics, mobile stations, DICs of Iranian CDC and WO, as well as through PO centers for prisoners. The following quantities of tests are set in the budget of current grant:

- PWID – 2,100 kits will be procured each year for Iranian CDC (1,000 kits) and WO (1,100 kits). It is assumed that 52,500 PWID will be covered by testing services each year with the support of the global Fund through Iranian CDC (25,000 PWID) and WO (27,500 PWID) settings. Testing frequency is annual.
- VW – 600 test kits will be procured for Iranian CDC and 400 for WO, annually. It is planned that 15,000 VW will receive HIV rapid tests through these settings (15,000 VW will be tested through IRANIAN CDC and 10,000 WO settings, annually).
- Prisoners – 6,000 test kits will be procured for PO. It is assumed that 150,000 Prisoners will be covered each year by the support of the Global Fund through PO settings.
- PMTCT - 20,000 Pregnant Women will be covered each year by the support of the Global Fund through Iranian CDC settings. (UNDP. (2020). IRN-H-UNDP, Budget summary)

Despite the fact that the general share of the Global Fund grant in HIV test procurement is minimal, over 50% of tests used with KPs are covered by the NFM2 grant.

Except for test kit procurement within the testing strategy, the current Global Fund grant covers the expenses for HIV testing services provision for people in prisons – salaries of 20 counselors (over US\$385,000 during the grant period) (UNDP, 2020).

Outputs: In 2019 the country performed about 1,510,331 HIV tests in total. This number includes HIV tests among pregnant women and general population. According to the national testing guidelines, the frequency of HIV testing is two times per year for KPs; however, for the purposes of monitoring of this grant, if a person receives one test per year, he will be counted. Iran has updated their national HIV testing protocols and algorithms according to latest WHO recommendations and moved away from Western blot in favor of simpler and cheaper RDTs and enzyme immunoassays (Desk review of available literature and Key Informant interviews, 2020)

HIV rapid testing services for KPs and their sexual partners, pregnant women, TB and STI patients are available at all levels of the service delivery system.

Though the country reports the application of community-based testing, the latter is primarily done at the facility level, and in mobile clinics, with only a few outreach workers conducting testing in the field outside of the mobile facility. The opt-out provider-initiated testing approach is being applied to these groups for HIV RDT. HIV testing and counseling also can be initiated by clients of those facilities.

A relatively large number of HIV tests are provided by the private sector, but no exact figures are available (UNAIDS, 2019).

Outcomes: Almost all HIV tests at the facility level were provided by PITC approach, but a small proportion of them were VCT, and disaggregation is not available. After a pilot study in 2018, a large community intervention for assisted pharmacy-based HIV self-testing was planned in several cities over Iran. The launch of this initiative was put on hold due to COVID-19 epidemic in Iran (UNAIDS, 2019).

A study among PWID in 2019 and another one among high risk women affected by HIV in 2015 showed 71% and 70% received HIV testing in the last 12 months, respectively.

**Table 2. KPs that received the HIV test and know their results**

Indicator	1 April 2018 – 31 March 2019*		1 April 2019 – 31 March 2020**	
	Target	Result	Target	Result
Percentage of PWID that have received an HIV test during the reporting period and know their results.	112.5% N: 225,000 D: 200,000	66.2% N: 132,450 D: 200,000	62.5% N: 125,000 D: 200,000	23.8% N: 47,591 D: 200,000
Percentage of VW that have received an HIV test during the reporting period and know their results.	46.1% N: 83,000 D: 180,000	32.3% N: 58,140 D: 180,000	52.2% N: 47,000 D: 90,000	23.5% N: 21,141 D: 90,000
Percentage of prisoners that have received an HIV test during the reporting period and know their results.	72.5% N: 386,093 D: 532,543	52.5% N: 279,409 D: 532,543	42.5% N: 226,330 D: 532,543	44.4% N: 236,305 D: 532,543

\* IRN-H-UNDP: Performance Letter Progress Report covering the period 1 April 2018-31 March 2019.

\*\* PUDR covering the period 1 April 2019- 31 March 2020.

During the last two reporting periods of the current grant, the targets for testing were not achieved and the number of tested KPs was very low. Of note, the same discrepancy between targets and results between the two reporting periods of April 2018 to March 2019 and April 2019-March 2020 is observed.

Among the many possible reasons for low HIV testing coverage, the major challenges are HIV RDT procurement issues due to sanctions, lack of scale up of existing outreach, mobile services and involvement of new clients in prevention and testing programs. The significant decrease of PWID population size in recent years, as a result of the change in drug use patterns, was also indicated as one of the reasons for not achieving the indicators. (Key Informant interviews, 2020)

In 2018 the country reported performance of 71,148 tests at community level through mobile services; with a 0.1% positive yield. In 2019, the level of positivity for community level testing was reported 0.3% (224 HIV cases from 77,721 tests). Five positive results were received from 2,665 HIV tests, reported by mobile testing services in 2019 (UNAIDS, 2019). The perspective of receiving this prevalence in case of proper organization and implementation of testing activities is less probable.

Analysis of late diagnosis data for four years (2016-2019) demonstrates that there was no significant data change for this indicator in these years (UNAIDS, 2019).

- Almost half (57.3% - 52.7%) of PLHIV is diagnosed at a stage when CD4 cell count <350 cells/mm<sup>3</sup>.
- Almost one-third of diagnosed PLHIV (35.5% - 34.2%) at the time of diagnosis had CD4 cell count <250 cells/mm<sup>3</sup>.

Thus, it can be assumed that in more than 50% of cases the patients apply to health system with other problems, and only then, they are being diagnosed. Even when they are diagnosed, it is at a late stage, which key informants suggested is due to the low testing provided by the general medical community due to their low levels of awareness of HIV. In any case, an in-depth evaluation is required to understand the reason for low testing coverage and to provide a proper solution.

A study conducted in early 2018 revealed low levels of skill among staff in testing facilities, which leads to uneven recording of test results, data duplication, poor client tracing, and targeting of HIV testing services towards lower risk groups as possible reasons. The research has identified some areas for improvement, such as a unified registration system for HIV testing; capacity development and knowledge networking among HTS providers; and introduction of differentiated HIV testing based on five pillars:

- Partner notification testing;
- Key population testing;
- HIV testing in high-risk locations;
- Symptom-based HIV testing; and
- Intensifying PMTCT (UNAIDS, 2019).

Results of data analysis related to performance of mobile units in 2018, received by the PR from Iranian CDC, state that mobile service delivery units are more efficient than stationary centers, and are more accessible. During the same reporting period, mobile units tested twice as many PWID as the facility-based drop-in centers (UNDP, 2019). Those data should be analyzed more deeply to understand if the deployment of mobile units affected the number of tested PWID overall or just tested a similar number across the two different testing modalities.

As mentioned with regards to prevention services, it is too early to assess the impact of mobile units' deployment, provided within the Global Fund grant, due to short period of operation. This delay in observing a positive change is even more relevant in the case of testing than prevention as coverage through testing depends on various other factors as well.

Operation of mobile platforms has not only increased the access to HIV services, but also proved to be efficient in using mobile facilities to prevent the spread of COVID-19 in Iran. UNDP and the WO joined forces to support government-led response efforts by conducting preventive and precautionary activities in harm reduction centers – specifically mobile centers – to prevent the spread of COVID-19 in Iran. Staff were trained on COVID-19 preventive measures by WO provincial authorities while the centers were adapted and equipped with PPEs and disinfectants, masks, gloves, hand sanitizers, soap and alcohol pads (Key Informant Interviews, 2020).

### **Domain 2.3 Linkage to treatment and care**

**Inputs:** The current Global Fund grant supports the PCs operation. More than US\$198,000 is allocated for PC staff salaries training and development, designing and publishing of annual bulletins to reflect PC activities. The number of PC staff supported through the Global fund grant will be gradually transferred to domestic funding. In Y1 of NFM2, the grant staff of 14 PCs was financed from the grant resources, staff of seven PCs in Y2 and by the Y3 all PCs will be financed domestically. HR capacity building workshops will be implemented during the whole grant period (UNDP, 2020).

**Outputs:** HIV testing, counselling, treatment and care services are integrated at the VCT centers. The new testing protocol, updated at the beginning of 2020, should reduce the loss to follow up due to shorter time needed for confirmatory test. Clients tested at mobile units are referred to VCTs to receive confirmatory ELISA tests, but those tested at VCTs receive all tests on the same day. Accompanied referral is available for those tested at mobile clinics and follow up is provided after confirmatory tests. (Key Informant interviews, 2020)

ART is initiated after confirmatory test, in-depth consultation and preparation for lifelong treatment. Prior to initiation of ART, tests for TB, hepatitis, and other comorbidities are conducted and baseline CD4 is tested, provided free of charge. Baseline viral load and resistance testing are conducted from three to six months after ART initiation, primarily to save kits that are limited due to sanctions (Key Informant Interviews, 2020).

According to the national protocols, in the first three months following ART initiation, medications are provided on a monthly basis and after three months, if the patient is stable, ARVs can be collected every two to three months; however, a monthly schedule continues for pregnant women and children. Due to Covid-19 epidemic the ARVs can be provided to PLHIV for a longer period – up to six months (Key Informant interviews, 2020).

VCTs link PLHIV to PCs, which are run and organized by peers, offering a highly supportive and non-discriminatory environment. The services and support to PLHIV provided through PCs are aimed:

- Reduce loss to follow up;
- Provide support for adherence;
- Provide support for partner notification and disclosure (available also in VCT centers);
- Provide family counseling and support;
- Reduce internalized stigma;
- Provide social support; and
- Offer empowerment classes, education and awareness raising.

**Outcomes:** According to national data, linkage to care has improved in the last three years from 62% to 72%. By the end of 2019, 67% of those who know their HIV status were on ART (14,685 from 22,054 PLHIV who know their HIV status).

Triangular clinics are the principal health facilities, responsible for giving care and treatment to PLHIV. During the last three years, some efforts have been made to diversify service delivery ("task shifting"), by increasing ART outlets and authorizing general physicians to dispense ART. During the last year, ART delivery through MMT sites and PHC clinics was successfully piloted in two cities, with plans to scale up in 2020. NAP has also rolled out phone recall and peer adherence and retention support over the past couple of years and last year achieved a 10% improvement in linkage to care among PLHIV (UNAIDS, 2019).

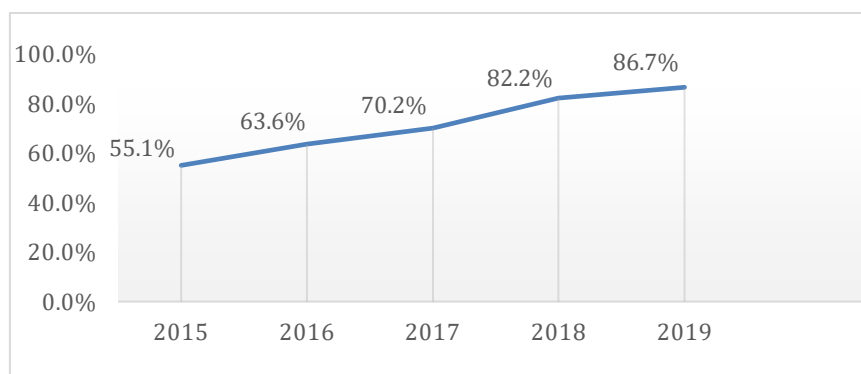
According to key informants interviewed during data collection, the primary reasons for refusal to initiate treatment are unstable housing, family problems, not wishing to disclose status, drug use, mental health problems, economic problems triggered by sanctions and inflation, lack of psychosocial support, stigma (and, in the past, high burden of pills, but this is no longer the case). A thorough consultation is provided to prepare PLHIV for life-long treatment and in cases where it is believed the patient is not ready to start ART referral is made to positive clubs to help the patient prepare for ART.

'Loss to follow up' is defined when PLHIV do not collect ARVs in three months; however, for pregnant women and children the cut-off remains a one-month window to be considered loss to follow up. By the end of 2019, 14,685 from 22,054 PLHIV who know their HIV status were on care. 27.9% were lost to follow up (Desk review of available literature, 2020)

### PMTCT

The provision of ARV therapy for prevention of MTCT was introduced in 2006 as part of the national care and treatment guidelines. Originally related services were delivered as part of those intended for HIV positive women under the PLHIV Care and Treatment Strategy. Significant improvements have been observed during the five-year period in linkage of the HIV-positive pregnant women to PMTCT services.

**Figure 2. Percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) to reduce the risk of mother-to-child transmission (UNAIDS, 2019)**



### Domain 2.4 Treatment, clinical care, and monitoring

Inputs: The current Global Fund grant supports the country in procurement of ARVs. Over US\$1.3 million is allocated for procurement, handling and distribution of ARVs. The drug resistance lab was established in the country with the support of Global Fund - US\$378,000. Around US\$554,964 is planned for the procurement of HIV PCR, DCP and CD4 tests within the current Global Fund grant. Four CD4 count machines were provided to Prisons Organization (UNDP, 2020).

The Global Fund provides support for the network of personnel specialized in treatment and HIV support. Especially in prisons, the Global Fund support is used to hire more specialists, until these personnel are accepted and funded by Prisons Organization (Key Informant interviews, 2020).

Outputs: A network of physicians, trained in ART provision and care, manage and supervise treatment in VCTs, both in hospitals and in prisons. A network of infectious disease specialists with a fellowship in HIV also provides support.

Annual in-person training workshops are provided to treatment and HIV specialists, both from prison and hospital VCTs. Protocols are regularly updated according to the latest WHO treatment guidelines, and training is provided to specialists accordingly. Health worker and staff sensitivity training is provided in VCT centers and positive clubs; peers are hired as staff to provide PLHIV/KP friendly services and to empower PLHIV and reduce internalized stigma. Further support for adherence is provided through PCs, which include social support in addition to medical support received from VCTs.

Treatment monitoring includes viral load tests that are offered three to six months following ART initiation and CD4 tests that are offered every three months free of charge to PLHIV. Resistance monitoring and testing are offered on a case by case basis when treatment is not showing efficacy in suppressing viral load tests.

HIV case management protocol is updated regularly, and training is provided to these specialists. Transition to Dolutegravir-based regimens was completed in 2019, and there is no waiting list for ART initiation; all eligible patients receive medication according to protocol and switch lines of treatment if resistance is detected.

ART delivery is customized according to patient needs to overcome challenges faced by patients, which include access and transportation challenges, especially stemming from recent inflation caused by sanctions, increasing cost of transportation. A customized approach includes delivering medication to patients or offering less frequent pick-up schedules for patients who are adherent.

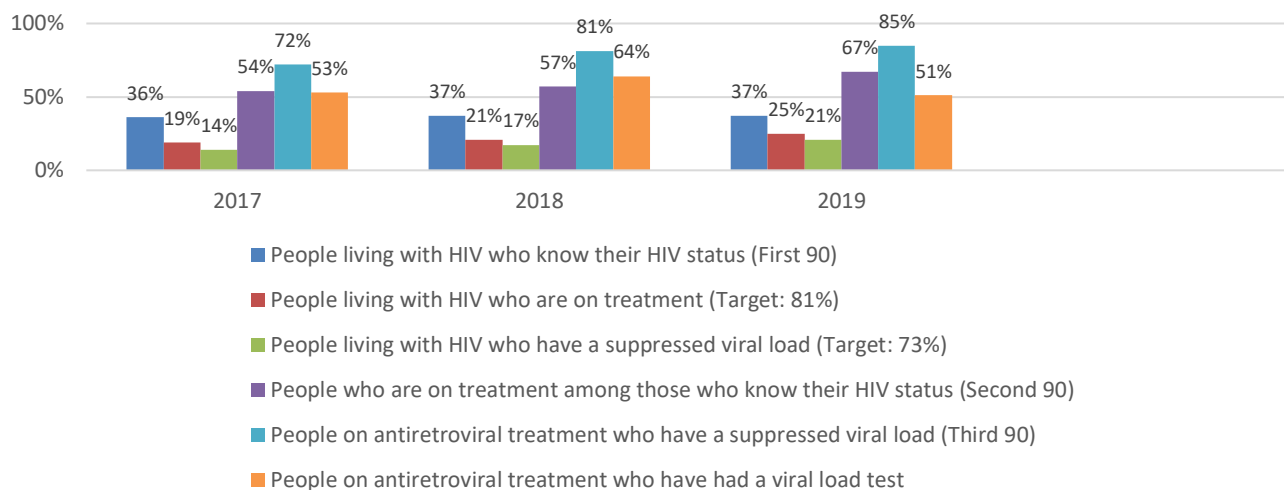
Positive Clubs (PC) are operated by PLHIV and provide psychosocial services. Much of the awareness raising activity, targeting young people and the general population, is also carried out with the help of CBOs. The main activities of CBOs are as follows:

- HIV prevention activities implementation in the field level (outreach work, peer education, commodities distribution, etc.);
- awareness raising;
- reduction of stigma and discrimination;
- psychosocial support;
- support for HIV case finding;
- positive clubs' operations;
- linkage increase to treatment and care and other (National AIDS Committee, 2018).

Outcomes: By the end of 2019 only 36.9% of estimated PLHIV knew their status. Country reported that 85% of PLHIV on antiretroviral treatment had a suppressed viral load though only 51% of those on ART had a viral load test in the last year (UNAIDS, 2019).

The following data on HIV care cascade, and 90-90-90 targets shed lights on the gaps in coverage and linkage to care as discussed in the previous two domains, as well as show progress towards achievement of indicators.

**Figure 3. HIV care and treatment cascade by years (UNDP, 2020).**



Of the total estimated PLHIV, only 24.9% is on ART, which is an improvement from 18.68% in 2017, but far from sufficient: the target defined for achieving 90-90-90 is 81%.

**Prisoners:** In 2018 1,073 (66.1%) prisoners living with HIV received ART in more than 250 prisons over the country.

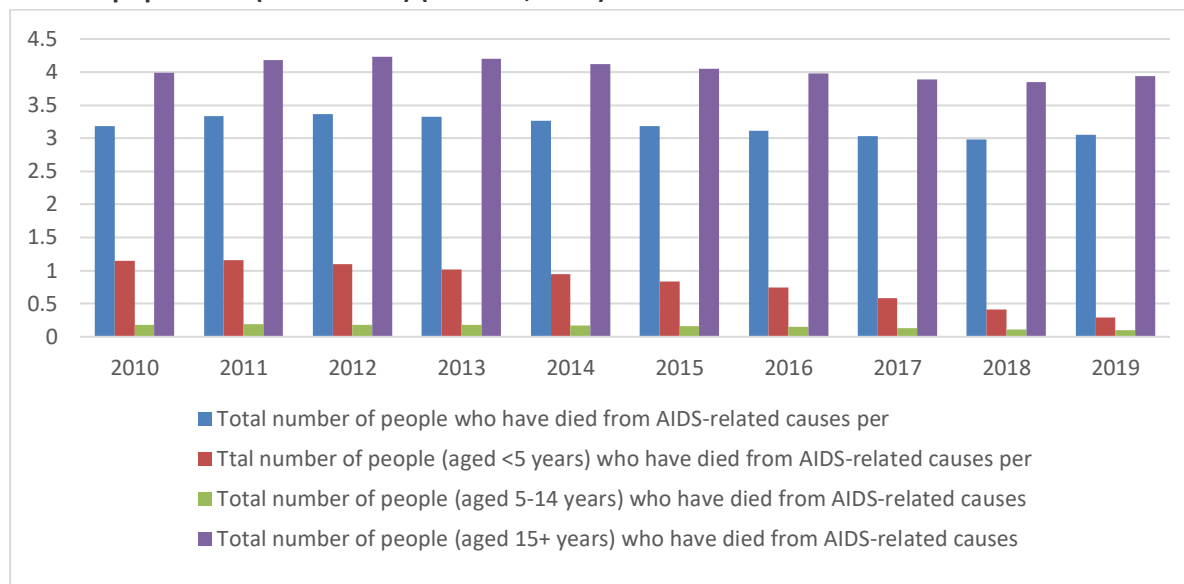
It is clear that the problems with PLHIV being aware of their status are the primary contributor to low ART coverage and viral load suppression. The positivity rate - 0.3% (224/ D 77,721) for all community-level HIV testing services was reported in 2019 through UNAIDS online reporting tool (Indicator "HIV testing volume and positivity"). There were 212 positive HIV tests (0.33%) out of 64,702 total HIV tests performed among PWID in 2019 by DICs and outreach teams (UNAIDS, 2019). Considering that most of community-level HIV tests were performed among KPs and taking into account the HIV prevalence among these groups, HIV testing positivity rate is quite concerning. In depth analysis should be carried out by the country in order to properly address the issue.

Another major challenge for low ART coverage are the losses within linkage to care, as it appears that many people chose not to seek treatment following diagnosis, although this is improving as explained in the previous domain.

Considering the efforts to scale up access to ART, including the updates in accordance with WHO 2016 guidelines that recommend treatment for all, it was expected that number of people dying from AIDS-related causes should significantly reduce if these services are accessible and delivered effectively. In general, the impact of HIV prevention, care and treatment programs is being assessed by monitoring the changes in AIDS-related mortality indicator over time. This indicator value (total number of people who died from AIDS related causes) remains almost the same during the last ten years and is in the range of 2.98-3.36 per 100 000 population. A significant reduction of mortality from AIDS related causes is being observed in the under five years age group, which can be partly explained with scale up of PMTCT efforts; the influence of other factors cannot be explained during this evaluation.



**Figure 4. AIDS mortality rate: total number of people who have died from AIDS-related causes per 100 000 population (2010 - 2019) (UNAIDS, 2019)**



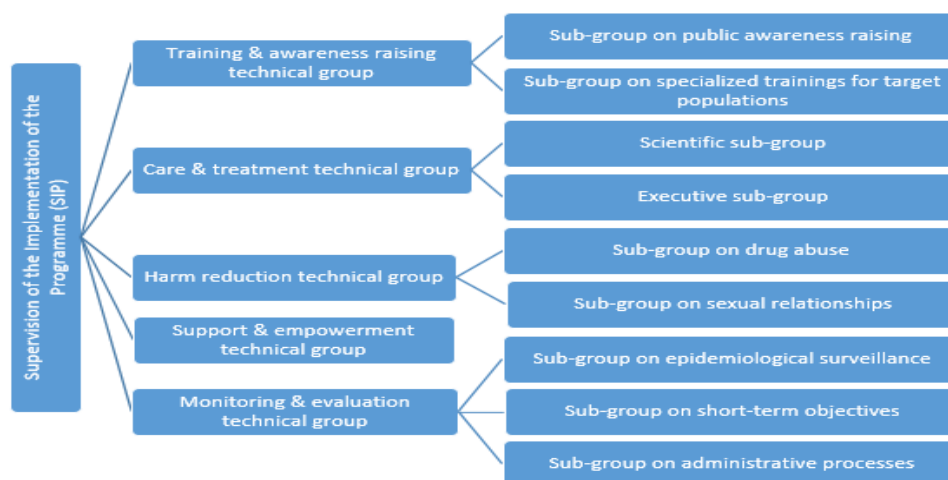
## Domain 2.5. Approach and Methods for Quality Assurance

Inputs There are no direct financing or planned activities for Quality Control or Quality assurance within the current Global Fund grant. However, given the role of quality in data management and M&E, the NFM1 grant supported establishment of an effective MIS system through which the partners are able to collaboratively manage information and take part in decision making process. The whole process was implemented in a participatory manner with involvement of SRs and the main stakeholders of NSP4 and with the leadership of the SIP Committee (Key Informant Interviews, 2020)

In overall, the SIP committee with its technical groups is responsible for Quality Assurance (QA) and Quality Control (QC) procedures at country level. SIP is a technical committee which includes permanent individual or legal representatives and experts as the key partners of the NSP appointed by the Health Deputy of the Ministry of Health and Medical Education.

The five technical groups of SIP are specialized teams with the main tasks of standardization of the processes and provision of executive guidelines for the National Plan; evaluation of the outcomes of executive activities; and revision of the general goals of HIV NSP. The members of these five technical groups are the key partners of NSP, diagrammed in Figure 5.

**Figure 5. SIP committee**



Outputs: The National SIP Committee categorizes the annual objectives of the NSP in accordance with the five main technical themes including training and awareness raising, harm reduction, care and treatment, support and empowerment, and monitoring and evaluation. Each group is responsible for technical follow up of the implementation of the relevant objectives (Monitoring and Evaluation Committee - National AIDS Committee, 2018).

The technical groups of SIP, according to their mandate, develop and distribute standard executive guidelines for implementation of all types of activities, planned by NSP. Relevant training materials for target groups and service providers are also being provided by these technical groups. Additional quality assurance approaches and methods are presented in the Objective 3 of this report.<sup>30</sup>

Outcomes: Definitions for all indicators, design of new registration and reporting forms, development of mechanisms and tools (such as checklists for data quality control), as well as frequencies for reporting and M&E were developed within the support of NFM1 grant (Key Informant Interviews, 2020).

Standard operational guidelines and protocols developed for service provision are being used by all stakeholders involved in NSP implementation. During supportive supervisory and M&E specialist visits, oversee the compliance of provided services with defined standards. Self-assessment and M&E templates are used for evaluating the services and identifying the gaps.

During data collection, interviews with service providers, peer groups and members of KPs and PLHIV, praised the quality of services in terms of:

- sensitivity to KP and PLHIV needs,
- friendliness,
- respect of privacy,
- social support and
- empowering attitude (National AIDS Committee, 2018).

Due to remote nature of evaluation and limitations described in supplementary information document, it was not possible to assess in full the QA and QC procedures application for all HIV services. More details related to data quality are presented in Domains 3.1 and 3.2 of the Objective 3.

## Dashboard of Core Indicators: Objective 2

Dashboard Key			
<b>1</b>	Very poor		
<b>2</b>	Poor		
<b>3</b>	Moderate		
<b>4</b>	Good		
Indicator	Score	Justification	Source of Data
<b>Key populations reached:</b> % of 2 key populations with highest prevalence reached by defined packages of services	2	51,242 PWID ( <b>25.6%</b> ) from estimated 200.000 are reached with HIV prevention programs - received defined package of services.	Performance Letter - Progress Report covering the period 1 April 2019-30 September 2019
	2	23,379 VW ( <b>26%</b> ) from estimated 90.000 are reached with HIV prevention programs - received defined package of services.	Performance Letter - Progress Report covering the period 1 April 2019-30 September 2019
<b>Average across the 2 Key population groups</b>	2	-	-
<b>PLHIV who know their status:</b> % of estimated people living with HIV who know their positive status	1	<b>36%</b> - 22,054 PLHIV from estimated 61,278 know their positive status	HIV treatment and care cascade, end of 2019
<b>Linkage to treatment and care:</b> Availability and types of linkage programs between diagnosis/ screening and treatment	2	During the last three years, some efforts have been made to diversify service delivery by increasing ART outlets and authorizing general physicians to dispense ART. During the last year, ART delivery through MMT sites and PHC clinics was successfully piloted in two cities, with plans to scale up in 2020.	UNAIDS: Global AIDS monitoring 2019 – Country progress report
<b>ART coverage:</b> % of estimated people living with HIV currently on ART (adults and children)	1	<b>23.1%</b> - 14.249 PLHIV from estimated 61.278 are currently on ARV	Performance Letter - Progress Report covering the period 1 April 2019-30 September 2019
<b>12-month ART retention:</b> % of people who ever initiated ART and are still on ART at 12	N/A		

months after ART initiation (adult and children)			
<b>Viral suppression:</b> % of people who are retained in ART for at least 6 months with viral load <1,000 copies/ml	<b>N/A</b>		
<b>Composite across all relevant (4) components Note: please change number of components if any indicators were unable to be scored.</b>	<b>1.5</b>		

### **Objective 3. To evaluate the extent to which country data systems generate, report, and use quality data.**

In recent years, Iran with the support of Global Fund, developed and established a new MIS for HIV treatment and care, which places the person at the center of assessing and measuring a sequence of health services. Utilization of this unified and online system allows to report and use precise/valid data on HIV treatment and care cascade, as well as facilitates M&E of treatment and care continuum (Key Informant Interviews, 2020).

The HIV prevention MIS system is currently in the piloting phase. At the time of data collection for this evaluation, new data registration and aggregation approaches are being piloted in Iran. Further development, integration and creation of links in MIS standalone systems will allow to create robust data management system in the country (Key Informant Interviews, 2020).

Well-developed infrastructure and mechanisms enable the implementation of various studies and assessments related to HIV/AIDS BBS and PSE, with use of modern and evidence-based methodologies. By further improvement of those systems, the country will be able to generate the report and use the quality data in program management and in decision-making processes (Key Informant Interviews, 2020).

Current Global Fund input in M&E and MIS is more directed to supporting the implementation of routine activities related to supervision of program implementation and monitoring, while more progressive planning and focusing on creation of strong, resilient and interlinked MIS will ensure the sustainability during the transition planning.

#### **Domain 3.1 Epidemiology, surveillance, and context data**

Inputs: Within the current grant, pertaining to RSSH, health management information system and M&E funds account for 12% of the total budget (UNDP, 2020).

The current grant also includes analysis review and transparency and surveys - US\$275,400 is allocated for technical assistance (TA) in 10 formative evaluations, studies, surveys and TA for supporting UNDP to review the 5th NSP and to align the Global Fund Project with new NSP (UNDP, 2020).

Outputs: Due to the timing of COVID-19 in Iran and multiple crises in the past two years including floods and sanctions, finalization of many studies was delayed or was still in progress at the time of data collection. Some data has not been provided to the evaluation team for the development of the report due to cultural and political sensitivities (Key informants, August 2020, update on requested documents). Global Fund support has been provided for the following studies and evaluations:

- Evaluation study on services for VW - The study of evaluation process and the deadline was extended for 6 months due to the COVID-19 pandemic in Iran;
- Formative evaluation vulnerable men – Evaluation of HIV services provision to VM in selected VCTs and reviewing the service delivery protocol will be implemented with delay due to the sensitivity of the subject matter and the COVID-19 pandemic;
- Formative programmatic evaluation of Positive clubs & Review on efficiency and quality of services in the extended framework of Positive club - Instead of these two planned studies, it was decided to provide TA for the Stigma Index 2.0. The study was conducted in collaboration with IRCHA and UNAIDS. The deadline was extended for six months due to COVID-19 pandemic;

- Assessment of factors affecting loss to follow up – a loss to follow up study was conducted in 2017 and based on the result of this study partner notification protocol and guidelines were developed in 2019 (partner notification guidelines were provided to the evaluation team during data collection);
- Assessment and review of patients' links modalities on VL, effective treatment coverage and addressing comorbidities and surveillance among ART initiators should be done by Iranian Research Center for AIDS (IRCHA) – these two planned studies will be combined and surveillance among ART initiators will be carried out. Surveillance among ART initiators are in progress and the delay was due to COVID-19 pandemic in Iran;
- Evaluation of health assessment programs in prisons & effectiveness of HIV preventive interventions in prisons – studies are completed, and reports are finalized; however, the results were not provided to the evaluation team due to of sensitivity of data.

Outcomes: There has been a progressive shift from measuring services to placing people and their access and linkage to HIV and health services at the center of monitoring in recent years with the support of the Global Fund. This shift was achieved by introducing a person-centered monitoring system of HIV treatment and care, which places the person at the center of assessing and measuring a sequence of health services (e.g. from HIV positive diagnosis to linkage to treatment). These developments were observed in HIV treatment and care MIS (Key Informant Interviews, 2020).

Iran has significant institutional and human capacity to plan and develop assessments and studies of various complexities. There is a well-established HIV sentinel system in the country. BBS and PSE studies are conducted through certified sentinel sites which should meet the defined minimum quality standards. The system uses updated protocols for BBS studies and HIV KPs PSE. The last BBS and PSE were implemented with use of respondent driven sampling methodology, and the reports for the last PSE and BBS for PWID and VW are available (Desk review of available literature, 2020).

### **Domain 3.2 Service use and program data and reporting**

Inputs: The main focus of RSSH interventions in the NFM2 grant is the strengthening of programs reporting capacities, data use, building an adequate health workforce and promoting more integrated service delivery.

More than US\$900,000 was budgeted in the current grant for ensuring the adequate human resources and capacity building of the PR, SR, and SSR, as well as for strengthening M&E and supervision of the program implementation (SIP). Hardware for strengthening the national MIS has been provided to one of the SRs (WO) (UNDP, 2020).

Outputs: In general, a technical committee (SIP) is assigned by the Supreme Council for Health & Food Security to monitor the implementation of the HIV program. Monitoring of the project implemented within the NSP is being conducted on different levels. In line with the national M&E structure, SR organizations are using monitoring processes and tools to be able to supervise the implementation of their program including the Global Fund project activities. They conduct site visits monthly, collect reports from their settings and provide feedback through their organizational mechanisms.

The project staff at SR and SSR level have their M&E schedule and plan to visit project sites. They aggregate, analyze and submit monthly or quarterly reports from UMSs and project settings (DICs, PCs, Women Centers, and other settings) to the PR. The PR collects SR reporting data in templates. After aggregation and analysis PR provides feedback report to each SR in the format of an official Performance Letter. Depending on the results, the PR may hold a meeting with the SRs to discuss

findings, status of project's implementation, challenges and mitigation measures. (Preliminary questionnaire, 2020)

As elaborated above in line with national M&E structure, SRs are using monitoring processes and tools to be able to supervise the implementation of their program including the Global Fund project activities. They conduct site visits, collect monthly reports from their settings and provide feedback through their organizational mechanisms. HIV office staff of the MOH have limited (pre-defined level) access to a monitoring dashboard for assessing the performance of each University of Medical Sciences on HIV/AIDS indicators and outputs.

The project staff in SR offices have their monitoring plan to visit project sites, and their Back-To-Office Reports (TOR) are shared with the PR which are available in archive system. The project staff have regular monitoring tools to control the implementation of the project as per the workplan, such as collecting monthly or quarterly reports from UMSs and project settings (DICs, PCs, Women Centers, and other settings) (Key Informant Interviews, 2020).

Outcomes: Information on all HIV prevention, testing, harm reduction, care and treatment activities is being aggregated through national standalone systems. Paper-based data are incorporated into appropriate software or excel sheets, through which entities are providing reports.

The Information Management System for HIV treatment is a separate reporting system and is not integrated in any national system. It includes information on gender, age, route of transmission, AIDS stage, etc. This software is being used for ARVs quantification and forecast, as well as for quantification of test kits, necessary for treatment monitoring. It also allows to track treatment cascade indicators and generate data for reporting needs. Online operation of this software allows to track PLHIV patients all around the country and provide treatment from any other institution where patient will apply. With the exception of built-in features for minimizing errors during the data input process, Iranian CDC is in charge of regular QC and QA measures which are implemented through regular field visits, crosschecking and verification of random reported data with use of checklists. During field visits, the M&E specialists provide supportive supervision through mentoring and joint data entry.

The Information Management System for HIV prevention and testing is a unified excel-based reporting system that must be filled in and submitted to a defined organization by the end of each month (differs for each implementation site). Organizations working under MoHME report to universities of medical sciences (UMSs), UMSs report to Iranian CDC, and Iranian CDC reports to SIP. Organizations working within the WO submit their reports to SIP through provincial WO organizations. This report includes the information on quantities provided by each particular service delivery point. The patient's registration and coding are unique at the level of service providers but not across the country. **The absence of unique identifier coding (UIC) system for KPs receiving HIV services may lead to double-counting and double-reporting, they do not allow to track continuum of HIV services for KPs.** At the time of data collection for this evaluation, a new data registration and aggregation software was being piloted in the country. Further development of this software, introduction of unified UIC system, integration and creation of links in MIS standalone systems will allow to create robust data management system in the country.

Though the SIP, well-coordinated data flow and analysis take place; however, there is a significant lack of in-data disaggregation. The cascade of HIV prevention, care and treatment services for KPs is incomplete.

The electronic registration system for services delivered in the methadone centers is a system called Idatis. The Idatis system indicates the scale/volume of provided services, the people who provide services, etc. (UNAIDS, 2019).

In the last year, after integrating HIV testing in PHC, NAP linked the AIDS Registry System with Integrated Health System (SIB) software. Data on HIV tested pregnant women were registered in SIB.

The other tools for monitoring and reporting, data quality and data assurance in which UNDP collects and reports results of projects are including:

- Quality Standards and Assurance tool (QA)
- Transparency dashboard (IATI)
- United Nations Development Assistance Framework (UNDAF) report
- Result Oriented Annual Report (ROAR). (Preliminary questionnaire, 2020)

The UNDP Office of Audit and Investigations (OAI) conducts audit exercise once during each grant life cycle. As for current project the audit was conducted from 25 August to 5 September 2019. OAI noted “satisfactory performance” in the areas of program, financial and Sub-recipient management. The audit report is available in UNDP website (UNDP, 2019).

### **Domain 3.3 Using data to drive service design and practice**

Inputs: A number of formative studies, evaluations and assessments (implementation status is described in Domain 3.1) have been supported by the current Global Fund grant.

The previous Global Fund grant - NFM1 - supported the upgrade of existing National HIV MIS system. The current NFM2 grant also supports the operation of this system through provision of eight one-day trainings aimed at improving MIS system for harm reduction programs.

NFM2 covers M&E and supportive supervisory visits for SR and SSR organizations. Data analysis and review within the current grant is being organized by the PR after the review of reports submitted by SR organizations.

Outputs: Data availability at the central level has made significant improvements in use of information for strategic planning, ongoing monitoring and mitigation of challenges or inconsistencies revealed at the field level. On May 18, 2020, a meeting was organized by the M&E Committee of the SIP with SRs/SSR and the PR, to discuss all data provided by SRs and to understand the reason for low coverage for testing and prevention services (PUDR 1 October 2019 - 31 March 2020). This is a valuable approach for addressing the situation; however, the absence of an online and comprehensive system of reporting means that these issues can only be analyzed retrospectively and prevents solving problems at an early stage.

Outcomes: Results and reports of some core evaluations and studies were not provided to the evaluation team due to some cultural and political sensitivities and incomplete studies. Provided information does not allow to describe the outcomes for this domain.



### Dashboard of Core Indicators: Objective 3<sup>6</sup>

Indicator	Score	Justification	Source of Data
<b>Case surveillance functionality</b>	<b>3</b>	<p>Approved and unified guidelines for data collection is available in the country. The schedule of reporting and reporting mechanisms are outlined in the national M&amp;E protocol. The Iranian CDC is responsible for quality assurance and control. Iran has adequate human resources and infrastructure for HIV management in the country. UICs are available at separate service provision point's level.</p> <p>Limitations of the evaluation do not allow the evaluation team to assess whether funding is sufficient for the activity.</p>	<p>Key Informant Interviews, 2020</p> <p>HIV M&amp;E Plan 2015-2019</p>
<b>Availability and quality of PSE</b>	<b>4</b>	<p>There is a well-established HIV sentinel system in the country. The system uses updated protocols for BBS studies and HIV KPs PSE. The last BBS and PSE were implemented with use of respondent driven sampling methodology. BBS and PSE studies for PWID and VW were implemented in 2019-2020. Size of VM population was estimated in 2019 with use of network scale-up methodology.</p> <p>The recent PSE studies also show decrease in KPs sizes.</p>	<p>Key Informant interviews, 2020</p> <p>HIV M&amp;E Plan 2015-2019</p> <p>BBS study report, PWID, 2019</p> <p>BBS study report, VW, 2020</p>
<b>Country capacity to report coverage of preventive interventions among key populations</b>	<b>3</b>	<p>Iran has sufficient infrastructure and human capacity for reporting the coverage of preventive and testing interventions KPs. There is no harmonised UIC system in the country. Currently, another approach is being applied to eliminate duplications and double reporting through application of some</p>	<p>Key Informant interviews, 2020</p> <p>HIV M&amp;E Plan 2015-2019</p>

<sup>6</sup> The Dashboard key for this objective applies to only the composite score. For the component score, see Basic Protocol for scoring guidance.

		defined coefficients that will wipe out duplications. The existing system has lack of disaggregation and transparency in existing data.	
<b>Completeness of ART data reporting</b>	<b>4</b>	ART data is reported via existing MIS system. The declared level of completeness is 100%. The current MIS system does not contain the detailed information pertaining LTFU.	Key Informant interviews, 2020 HIV M&E pan 2015-2019
<b>Composite<sup>7</sup> across all relevant (4) components Note: please change number of components if any indicators were unable to be scored.</b>	<b>3.5</b>		

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<sup>7</sup> Composite Score for Objective 3 is a summation across all four component indicators, not an average.

## Analysis

### Impact

In financial terms, the Global Fund grants may be considered minimal as compared to the heavy investments of the country's national health system to control the three diseases; however, the strategic collaboration with the Global Fund has been an immensely welcomed experience in terms of linkages to the global efforts against the diseases. The access to the modern health supplies and technologies is of particular importance and appreciation, moreover, the up-to-date knowledge and best practices of the country have been linked through this collaboration. Iran is in the center of a serious economic and health crisis, and it was also hit hard due to economic sanctions and the coronavirus pandemic. The roadmap of eventual phase out of the Global Fund support was developed by the Country coordinating Mechanism of Global Fund Grants with the technical support of UNDP as a PR of Global Fund Grants.

### Effective Strategic Investment

**Findings from Objective 1** of this evaluation show that, domestic financing accounts for the overwhelming majority of the NSP budget in Iran. United States sanctions, combined with rising inflation, have severely limited the financial resources available to the National HIV Program, they significantly hamper the national response and, and if they persist, may cause the "rationalization" or re-prioritizing of current HIV activities. Although Iran monitors and plans National Health Accounts (NHA) on an annual basis, the NHA does not include an HIV subaccount. The only feasible means of tracking HIV resources flow in Iran is currently the NASA, which has been conducted once in full (in 2014, on 2012 data) and once as a "mini-NASA". Both previous NASAs were not able to provide reports on AIDS actual expenditures.

The Global Fund previous support for Iran was organized in a manner of seed or catalytic financing, where the initiatives are financed by the Global Fund and then taken over by the government for domestic financing. NFM2 grant support is a complementary to the ongoing national efforts for HIV NSP implementation. The current and previous grants supported by the Global fund contributed to development of human resources who are currently involved in NSP development. Moreover, the strategic partnership and technical collaboration with Global Fund both promote HIV planning and programming within the country, especially in times of sanctions and difficulties with medication procurement, but also generally with regards to scientific collaborations and advancements.

Though the current Global Fund grant does not provide direct support in PSM improvements, the PR helps the country to make procurements of HIV diagnostic test-kits, ARVs, as well as test kits and equipment for ART monitoring. This support is valuable, taking into account economic sanctions against Iran.

**Findings from Objective 2** of this evaluation show that Iran remains a country with HIV low prevalence ( $\leq 0.1\%$ ) of HIV among the general population. Prevalence among PWID has significantly dropped down during the past five years - from 13.8% to 2.8% according to the new BBS data (2019). While further information regarding this decrease in prevalence, it is suggested that estimations are further explored. Despite the steadily growing proportion of recorded HIV cases attributed to sexual transmission, PWID still appear to have the greatest share of new infections in Iran. The Global Fund support catalyzed the country scale up of HIV prevention and harm reduction projects for KPs.

Significant resources are being spent for PWID and VW projects, while the projects for VM and TG people have limited geographic coverage. The coverage of HIV prevention and testing projects for all KPs remains insufficient for achieving national strategic targets. Only 34.6% of VW and 29% PWID were covered by HIV prevention projects. Coverage of HIV testing projects is even lower at 23.8% for PWID and 23.5% for VW (UNDP, 2020). TG people and internal migrants/seasonal workers will be included in the 5th NSP as target populations with appropriate activities planned and budgeted. However, a significant scale-up for VM and TG people projects should be planned due to alarming prevalence shown in some studies. Use of mobile service delivery platforms have increased the geographic coverage of planned activities.

Effective implementation of HIV prevention and harm reduction activities in penitentiary institutions positively affected HIV prevalence among prisoners, which was reported as 0.8% in 2016 (2.1% in 2009).

The lack in testing coverage can be at least partially explained by significant external challenges in test kit procurement, but the volume of HIV positivity among tested KPs is very concerning and indicates possible gaps in testing initiatives.

A negative shift can be observed at analysis of safe injecting practices indicator for PWID from 2011 to 2019. Percent of PWID reporting the use of sterile injecting equipment at the last injection was high in 2011 - 91.7%, falling to 78.7% in 2014 and 73.7% in 2019 (data from UNAIDS reporting online tool).

**Findings from Objective 3** of this evaluation show that Iran has sufficient resources for implementing the various research and studies related to HIV and other communicable diseases. Global Fund support has been valuable in the creation of the existing MIS system for HIV treatment and Care. A significant portion of human resources involved in M&E and supervision of activities carried out by the Iranian CDC, as well as MEHSAD and WO are covered by the existing grant and were properly trained to perform their activities. Further development of HIV prevention and testing MIS, introduction of UIC systems are required to strengthen the NAP capacity for generating, reporting and use of quality data.

The country is aware of the operational benefits of a robust system on HIV treatment data, so they should strive to create a complete MIS system which will allow the tracking of patients across the cascade of HIV prevention, care and treatment services.

### **Sustainability**

According to findings from Objective 4 of this evaluation, NGOs play key roles in the HIV/AIDS control program. CBOs/NGOs initiatives on HIV prevention among KPs have been supported by the all Global Fund grants and gradually were transferred to domestic financing. There is a clear mechanism for contracting CBOs/NGOs to perform any activities. In 2017 CBOs/NGOs, involved in NSP implementation, established the network SHAMSA to apply an institutionalized approach for their activities' implementation, to have a well-established and functional network of service providers and for field organization. The country has taken ownership of NSP implementation, KP projects are funded from domestic sources. There are some legal and stigma and discrimination-related challenges which hinder the full utilization of HIV services by KPs. Planning and budgeting appropriate activities are required to remove these barriers.

Currently, Iran is in the list of upper-middle income countries with low disease burden. It is highly recommended for those countries to prioritize or build upon existing sustainability and transition

planning during the 2020-2022 period. The country already has developed a Transition and Sustainability Planning document and submitted to the Global Fund.

Due to the existence of external challenges and as a result of the difficulties in procurement of some HIV commodities, equipment and ARVs, UNDP as a PR of the Global fund remains the only counterpart that can mitigate the consequences and ensure uninterrupted supply of these products. At this stage Iran should pay more attention to updating and improving of national LMIS in order to ensure proper inventory management and distribution.

Analysis relative to the Global Fund’s Blueprint for Country Portfolio Priorities Analysis (v1.0) is provided below.

**Table 3. Global Fund’s Blueprint for Country Portfolio Priorities Analysis**

Dimension	Critical Activities
<b>Find and effectively treat more cases</b>	<ul style="list-style-type: none"> <li>- Iran has updated their national HIV testing protocols, moved away from Western blotting; however, the level of KPs’ HIV testing remains low due to challenges on procurement of sufficient quantities of test kits and possible programmatic gaps. Only 51% PLHIV on ART had a viral load test in 2019.</li> <li>- Dolutegravir based ART regimens was introduced in 2019 and all eligible patients were switched to more effective and simplified treatment regimens.</li> <li>- Only 25% of estimated PLHIV is on ART.</li> </ul>
<b>Prevention of new cases</b>	<ul style="list-style-type: none"> <li>- There is no observed increase in coverage of HIV prevention programs among KPs.</li> <li>- VM are legally prosecuted. VM, VW and TG people face significant stigma and discrimination and violence, which inhibit their ability to seek preventative and testing services, as well as adhere to ART.</li> </ul>
<b>Increase funding available for HIV</b>	<ul style="list-style-type: none"> <li>- Currently, an overwhelming majority of HIV NSP funding is covered from domestic sources, external financing is used to cover some programmatic gaps.</li> <li>- At this point all KP programs financing is covered from domestic sources, external financing is used for HIV test kits procurement and M&amp;E activities.</li> <li>- CBOs are being contracted by the government.</li> <li>- Gradual increase in HIV/AIDS financing has been planned, however, due to external sanctions and as a result – poor economic situation and national currency devaluation, it is not clear whether the previous commitments will be made.</li> <li>- Except for the Global fund and government expenditures, minimal private and charity funds are used for financing HIV NSP.</li> </ul>
<b>Reduce cost of fighting (HIV)</b>	<ul style="list-style-type: none"> <li>- There is no evidence for price reduction and PSM improvement, total economic embargo on Iran has made the situation worse.</li> </ul>

	<ul style="list-style-type: none"><li>- HIV case management protocols were updated in 2019, simplified treatment regimens have been introduced, six months' supply of ARVs is being provided for some PLHIV.</li><li>- There is no task shifting implemented, however, it is highly recommended. A standardized and simplified mechanism for ART provision and ARV distribution will maximize the role of primary health care and community-led care can be piloted and deployed in order to make the use of available human resources more efficient. Additionally, mobile service delivery points can serve as a platform for ARV distribution or point of HIV care.</li><li>- Evidence in scale-up of HIV prevention activities has not been observed, coverage for all KPs still remains low.</li><li>- ART program piloting and integration is planned for TB clinics, harm reduction centers, MMT clinics, DICs, shelters, and mobile clinics.</li></ul>
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## Recommendations

#	Major Recommendations	Priority	Who to implement?	By when?	Implications for Global Fund funding
1	<p>Despite the existing economic situation, the country should ensure its transition plan and roadmap are integrated into the planning and budget for the 5th NSP. A gradual increase of domestic resources should be reflected in the new document. Due to floods, sanctions and COVID-19, the assumptions in current transition planning may need to be revisited: a transition preparedness reassessment will reveal the gaps that should be addressed while planning transition.</p> <ul style="list-style-type: none"> <li>• It should also be ensured that the NSP budget incorporates expenditures for National HIV implementation of the M&amp;E plan.</li> <li>• The NSP and transition preparedness reassessment should also ensure the inclusion of HIV sub-accounts in annual National Health Accounts to allow the capture of the total expenditure on HIV/AIDS and monitoring of finances from public, private and external sectors.</li> </ul>	High	NAP/SIP/Technical groups	Immediately	<ul style="list-style-type: none"> <li>- TA may be needed in transition preparedness reassessment update of roadmap.</li> <li>- Considering the challenges that the country met during the last two years (earthquake, flood, Covid -19), the country may seek funding for emergency responses and the introduction of new technologies. This approach is outlined in “Overview of the 2020-2022 Allocations the Global Fund allocations and Catalytic Investments”.</li> </ul>
2	Address enabling environment factors:	High	NAP/SIP/Ministry	Immediately (related to 5 <sup>th</sup> NSP) and	<ul style="list-style-type: none"> <li>- Piloting the innovative approaches within S&amp;D strategy and involvement of clergy in</li> </ul>

	<ul style="list-style-type: none"> <li>• HIV stigma is one of the major contributing factors in failing to achieve 90-90-90 goals. The S&amp;D strategy should significantly contribute to HIV service provision. Technical groups and stakeholders should ensure proper budgeting of S&amp;D strategy in 5th NSP. The data collected through PLHIV Stigma Index 2 must be used to design activities aimed at S&amp;D elimination.</li> <li>• Efforts advocating changes in punitive laws for KPs should be intensified as much as possible. Some progress has been observed in recent years but not sufficient to significantly reduce legal barriers to HIV services.</li> <li>• The initiation of dialogue with clergy at various levels and their gradual involvement in some activities (e.g. stigma elimination or awareness raising related to harm of drug use) can be considered for involving them in BCC and HIV awareness raising campaigns. The perspective of their involvement in 5th NSP development and including them as implementers of some activities of NSP should be discussed.</li> </ul>			ongoing for next 3 years	processes may be an implication for future funding.
<b>3</b>	Core HIV prevention services for organizations working under MoHME, MEHSAD and WO, to some extent, are providing overlapping services. Improvements in mapping of	High	NAP/SIP	2020 if possible	- TA may be needed for KP programs, HIV testing strategies assessment and improvement in linkage to care improvement.



	<p>services, creation of online and interactive maps are desirable. Field workers of these organizations should have a clear knowledge of facilities working in the same geographic area and of the services provided by them.</p> <ul style="list-style-type: none"> <li>• Urgent activities aimed at defining the HIV prevalence among VM are required to adequately plan and scale-up HIV prevention activities within this population.</li> <li>• Task shifting - the scope of work for outreach workers should be expanded and reconsidered. <b>For example, outreach workers can provide rapid HIV RD testing in the field.</b> Expanding HIV testing services to trained lay providers working in the community may help to increase access to these services and their acceptability to people from key populations and other priority groups. Improvements would also be needed in the client registration system, and appropriate trainings should be provided to the personnel on regular basis.</li> <li>• During some interviews the evaluators were informed that KP representatives - peers/leaders reach more effectively the target audience, so the model of including one peer-</li> </ul>				<ul style="list-style-type: none"> <li>- Application of modern financing (e.g. results based financing) or new testing (e.g. social network strategies to reach the extended networks and sexual partners of KPs, especially VM and VW) strategies for reaching more KPs and covering PLHIV can be piloted during the next Global Fund grant. The assessment of piloted activities must be done after at least a year of implementation. If there is no strong evidence in numbers of reached or tested proved by reliable data, the pilots should be discontinued. In case of success it should be transferred to domestic financing.</li> </ul>
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	staff in each outreach team is useful, but it would be beneficial to increase the proportion of peers within team structures to increase the reach.				
<b>4</b>	<p><b>Train and retrain Primary Health Care providers to:</b></p> <ul style="list-style-type: none"> <li>• Minimize stigma and discrimination against PLHIV within general healthcare infrastructure</li> <li>• Raise awareness among physicians and increase awareness of general population via reach of the general medical community</li> <li>• Increase coverage and testing at earlier stages by providing more HIV testing at primary health centers, in addition to VCT Centers.</li> <li>• Increase access to treatment provision and reduce losses to follow up.</li> </ul> <p>Provide text messaging interventions through PHCs and Positive Clubs in order to increase linkage to care, from the onset of diagnosis, and further reduce losses to follow up and improve adherence.</p> <p>Consider use of digital platforms and interventions such as video-based information, messages and counselling where feasible like in high-volume clinics with</p>	Moderate	NAP/SIP/Ministry of Education	By end 2021	- There is no direct implication for Global Fund funding.

	suboptimal HTS coverage. These platforms can be particularly appealing to adolescents, young people and key populations. This approach should be piloted in PHC clinics.				
#	Minor Recommendations	Priority	Who to implement?	By when?	Implications for Global Fund funding
5	The recent BBS and PSE data significantly differ from the previous studies and cannot be compared due to various sampling methods. At this moment triangulation is seen as a most valuable and feasible approach to validate the results of these studies, particularly HIV prevalence among PWID.	High	NAP/SIP	Immediately	- Taking into account the urgency of data validation process, the use of savings from current Global Fund grant can be considered from Global Fund County Team. Strong analytical report should be submitted to Global Fund as soon as possible, preferably prior to the next proposal.
6	Despite the negative attempts in introducing the Unique Identification Code (UIC) system for KPs, Iran must consider and seek for the new evidence-based approaches to introduce a UIC system for KPs receiving the HIV prevention and harm reduction services.	High	NAP/SIP	2021	- TA provision can be considered within the scope of the next Global Fund grant
7	Due to the existence of external challenges and as a result of the difficulties in procurement of some HIV commodities, equipment and ARVs, UNDP as a PR of the Global fund remains the only counterpart that can mitigate the consequences and ensure uninterrupted supply of these products. At this stage Iran should pay more attention to	Moderate	NAP/SIP	Ongoing	- There is no direct implication for Global Fund funding.

	updating and improving of national LMIS in order to ensure proper inventory management and distribution.				
<b>8</b>	Update of “One Health tool” or “Optima” software application will help decision-makers, program managers and funding partners to achieve maximum impact with the available funding for the HIV response and plan for sustainability.	Moderate	NAP/SIP	2021	- There is no direct implication for Global Fund funding.

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## Supplemental Information

Please see the following [document](#) for information regarding additional project background, specific methodology, and limitations of this evaluation.

## Annexes

### Annex 1

#### **Standard package of services defined by NSP**

##### **1. PWID, prisoners, and those using stimulants.**

HIV awareness raising and BCC, syringe and needle, alcohol pads, filter and distilled water at least 365 per year, nutrition - hot meal, hygiene services, protection and social service as well as condoms at least 3 per week, MMT counselling services and HIV tests.

##### **2. VW- FSWs, spouse of IDUs, and spouse of HIV infected people.**

HIV awareness raising, counselling, screening of STIs, treatment of STIs, pap smear test, pregnancy test, distribution of at least 60 male condoms and 10 female condoms, enough lubricants for each person, referring patients to gynaecologist and psychologist if needed, social work and protection services.

##### **3. VM and prisoners**

HIV awareness raising, counselling, screening of STIs, treatment of STI, distribution of at least 100 male condoms and 10 female condoms and enough lubricants for each person, referring patients to Infection Disease Specialist, Psychologist and Urologist if needed and HIV CT.

Harm reduction services in penitentiary institutions are being provided by Prisons Organization. The service package in the prisons setting includes:

- condoms distribution in conjugal rooms,
- HIV testing and counselling (provide initiated or VCT),
- screening for tuberculosis, HBV and HCV,
- diagnosis and management of STIs,
- education and training sessions on HIV/peer education and
- Methadone maintenance therapy.