Assessment Report of the 1st Phase of

Global Fund HIV/AIDS Project R8,
(IRN-810-G04-H)

In

The Islamic Republic of Iran

Alireza Shoghli; PhD

CCM National Consultant

September-2011
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgment</td>
<td>5</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>6</td>
</tr>
<tr>
<td>Object of assessment</td>
<td>7</td>
</tr>
<tr>
<td>HIV/AIDS Status in Iran</td>
<td>7</td>
</tr>
<tr>
<td>Overview of Iran National Aids Plan (2010-2015)</td>
<td>7</td>
</tr>
<tr>
<td>Review of Global Fund HIV/AIDS Project- R8 in Iran (IRN- 810-G04-H)</td>
<td>9</td>
</tr>
<tr>
<td>Global Fund HIV/AIDS - GF Project R8 Main stakeholders in Iran</td>
<td>10</td>
</tr>
<tr>
<td>Provinces covered by GFR8-phase 1 project activities</td>
<td>10</td>
</tr>
<tr>
<td>Assessment Purpose, Objectives and Scope</td>
<td>12</td>
</tr>
<tr>
<td>Methodology of assessment study</td>
<td>13</td>
</tr>
<tr>
<td>Desktop review</td>
<td>15</td>
</tr>
<tr>
<td>Key informants and peripheral health staff informal interviews</td>
<td>15</td>
</tr>
<tr>
<td>Field visits</td>
<td>16</td>
</tr>
<tr>
<td>Findings of assessment study</td>
<td>17</td>
</tr>
<tr>
<td>GFR8 phase 1 inputs assessment</td>
<td>17</td>
</tr>
<tr>
<td>Assessment of GFR8 implementation process</td>
<td>19</td>
</tr>
<tr>
<td>Governance and Stewardship</td>
<td>19</td>
</tr>
<tr>
<td>GOs involvement in the GFR8</td>
<td>19</td>
</tr>
<tr>
<td>Data quality and management system</td>
<td>22</td>
</tr>
<tr>
<td>Interventions sustainability and Value for the money</td>
<td>23</td>
</tr>
<tr>
<td>Assessment of the financial performance of the PR/SSRs/SSRs</td>
<td>23</td>
</tr>
<tr>
<td>GFR8-phase 1 service integrity Analysis</td>
<td>23</td>
</tr>
<tr>
<td>Quality of services and end user verification</td>
<td>25</td>
</tr>
<tr>
<td>GFR8 phase 1 progress in top 10 output indicators</td>
<td>25</td>
</tr>
<tr>
<td>Discussion and lessons learned</td>
<td>28</td>
</tr>
<tr>
<td>Conclusion and recommendations</td>
<td>29</td>
</tr>
<tr>
<td>Recommendations</td>
<td>30</td>
</tr>
</tbody>
</table>
All observations and notes mentioned in this report were made based on overall assessment study of GFR8-Phase 1 implementation which was conducted with the aim of benefitting from lessons learned for designing the work plan of the 2nd phase and filling out RCF template and related documents. Therefore any interpretation or decision making based on this report should be made by caution and in light of supplementary evidences.
Abbreviations:
AIDS: Acquired Immune Deficiency Syndrome
ARV: Anti-retroviral treatment
BCC: Behavioural Change Communication
BSS: Behavioural Surveillance Survey
CBO: Community Based Organization
CSW: Commercial Sex Worker (High risk Women)
CDC: Centre for Diseases Control
DHS: Demographic and Health Survey
DIC: Drop In Centre
GF: Global Fund
GFATM: Global Fund for AIDS, Tuberculosis and Malaria
HIS: Health Information System
HIV: Human Immunodeficiency Virus
HMIS: Health Management Information System
HVW: HIV/AIDS Vulnerable Women
IDU: Injecting Drug User
IEC: Information, Education and Communication
INAMEC: Iran National Aids Monitoring and Evaluation Committee
LFA: Local Fund Agency
MARP: Most At Risk Population
M & E: Monitoring and Evaluation
MESST: Monitoring and Evaluation System Strengthening Tool
MICS: Multiple Indicator Cluster Survey
MoE: Ministry of Education
MoH: Ministry of Health
NAC: National AIDS Committee
NAP (NSP): National AIDS Program (National Strategic Plan)
NGO: Non-governmental Organization
OVC: Orphans and Vulnerable Children
PHC: Primary Health Care
PLHIV: People Living with HIV
PMTCT: Prevention of Mother-to-Child Transmission
RCF: Request for Continuous Funding
STI: Sexually Transmitted Infection
SCM: Supply Chain Management
UA: Universal Access
UN: United Nations
UNDP: United Nations Development Program
UNGASS: United Nations General Assembly Special Session (on HIV and AIDS)
VCT: Voluntary Testing and Counselling
WHO: World Health Organization
**Acknowledgment**

The consultant acknowledges the valued cooperation extended by the Country Coordinating Mechanism (CCM) of Iran, the officials of the United Nations Development Program Country Office, the officials of the Center for Communicable Disease Control (CDC) of Ministry of Health and Medical Education, the CCM Secretariat and also GF HIV/AIDS project staff of CDC, Welfare Organization, Prisons Organization and Ministry of education. The Consultant would like to pay his special gratitude to the following colleagues for their invaluable guidance and coordination of the study:

Dr. Gholamreza Heidari, Vice Chair of CCM;
Ms. Elzira Sagynbaeva, Deputy Resident Representative of UNDP Country Office;
Dr. Mohammad Mehdi Gouya, CDC General Director; and
Dr. Abbas Sedaghat, National HIV/AIDS Program Manager.

Special thanks go to Ms. Hedieh Khanegahpanah, UNDP GF HIV/AIDS Project Manager for her constructive and useful cooperation in designing and implementation of the study.
Executive Summary

This is an assessment study report on GF HIV/AIDS project R8, phase 1 in Iran entitled "Scaling up Iran HIV/AIDS Prevention Program Toward Universal Access with Increasing Partnership of Non-Governmental Sector Iran, Grant No: IRN- 810-G04-H", which was conducted with the aim of exploring the significant achievements and challenges of the first phase (from April 2010 until September 2011) and to benefit from lessons learned for revising the work plan of the 2nd phase.

This assessment was conducted using different research methods including site visits, facility based survey, desktop and literature review, informal interviews based on Q1 to Q6 implementation period of GF project phase 1.

According to the assessment team observations and findings, considerable improvement has been made through the GF Project implementation in Phase I. GFR8-phase 1 attribution is resulted to the better implementation of NAP and the overall national response has been improved significantly. Additionally, good harmonization and a sense of cooperation have emerged among counterpart organizations resulting in a more systematic and effective response to HIV/AIDS countrywide.

The lessons learned in phase 1, the GF eligibility policies for upper middle income countries, the global financial constraints and the need for sustainability of achievements call for a gradual and systematic integration of the GFR8 project activities in current health services network to guarantee the sustainability of the system in place. Strengthening capacity of the health system in this regard is strongly suggested. It is necessary to revisit the overall project organization and implementation process. Defining standard minimum service packages, allocating ID number for DIC clients and harmonization of the harm reduction and educational activities among SRs/SSRs are non-negligible duties during phase 2 of the GFR8 project.

It is important to mention that while the phase 1 achievements have exceeded the intended targets in the majority of project activities, there is still room for improvement especially in areas related to project ownership, data quality management, financial management and quality of services. Needless to mention that the efforts have to be continued with more emphasis to be given to advocacy, NGOs partnership, program leadership, reproductive health, stigma reduction and cost effective strategies.

Considering the findings of the current assessment the overall A2 rating recommended on the entire Phase I performance.
**Object of assessment**

The Islamic Republic of Iran is an upper middle income country with an estimated total population of 75 million. The country is administratively divided into 31 provinces. Iran is one of the Middle East countries. 31% of population settles in the rural and 69% in urban areas. Literacy rate for male and female above 15 years old are 87% and 77%, respectively. Life expectancy at birth is 73 and under-5 five mortality rate is 31 per 1000.

**HIV/AIDS Status in Iran**

Iran is in concentrated stage of HIV/AIDS epidemic with regard to <1% serum positivity among general population and >5% HIV+ among high risk groups. Prevalence of HIV in 15-49 years is 2 per 1000. There were 23497 known affected people until September 2011 of which 91.3% were men and 11.5% between 15-24 years old. The most prevalent routes of transmission are injecting drug use (69.8%) and sexual (10.1%). However, bio behavioral surveys show a slight shift of epidemic from injecting drug use to extra-marital sexual behavior. 18.2% are unknown cause of infection. It is estimated that the real number of infected cases may be much more (about 80,000 cases according to global estimates).

**Overview of Iran National Aids Plan (2010-2015)**

The National Program on Prevention and Control of HIV/AIDS for 2010 (March)-2015 (March) is aligned to national strategic frameworks and the international commitments of Iran have embraced. In this regard Iran's national strategic plan has aimed at the goal of keeping HIV prevalence less than 0.12% among general population. This means prevention of new cases and continuation of finding already affected people. Identifying existent cases will lead to increase up to about 80,000 HIV+ and slowing down incidence of new cases by the end of the plan. It is obvious that during the implementation years of the plan the number of AIDS cases that need more intensive and expensive care will be increased too. The contributors to the NSP expect the plan to cover all of these issues and provide a supportive and enabling environment along with empowering PLHIV and strengthening of infrastructures and services.
A set of strategic objectives has been established according to the high risk and at risk groups and general population. Each strategic objective has been translated in to a collection of specific, measurable, attainable, relative and time bound objectives which cover all levels of target population. Therefore based on the plan, by the end of the program, the following strategic objectives are to be expected:

Strategy 1: Information, Education and Communication
Strategy 2: Blood Safety
Strategy 3: Voluntary Counselling and Testing
Strategy 4: Harm Reduction
Strategy 5: Prevention of Sexual Transmission of HIV/AIDS
Strategy 6: Management of Sexually Transmitted Diseases
Strategy 7: Counselling, Treatment and Care for PLHIV and their families
Strategy 8: Support and Empowerment
Strategy 9: Establishment of an Epidemiologic Surveillance and Data Management System
Strategy 10: Strengthening Infrastructure

The main objectives of 3rd NAP in terms of long term, intermediate and end line outcomes are:

- By the end of March 2015, the proportion of PLHIV to the overall population remains at 0.12 per cent.
- By the end of March 2015, HIV prevalence among injecting drug users will not exceed 14.3 per cent.
- By the end of March 2015, HIV prevalence among most-at-risk women remains below 5 per cent.
- By the end of March 2015, less than 13% of children born to HIV-positive mothers will have acquired HIV.
- By the end of March 2015, more than 85% people with advanced HIV disease or AIDS remain under treatment for longer than one year.
- By the end of March 2015, at least 50% of people aged 15-24 can correctly identify methods of preventing transmission of and important misconceptions about HIV and AIDS.
- By the end of March 2015, at least 55% of injecting drug users can correctly identify methods of preventing transmission of, and important misconceptions about, HIV and AIDS.
- By the end of March 2015, at least 35% of most-at-risk women can correctly identify methods of preventing transmission of, and important misconceptions about, HIV and AIDS.
- By the end of March 2015, at least 90% of injecting drug users use a sterile needle and syringe at last injection
- By the end of March 2015, at least 65% of most-at-risk women use a condom in their last sexual contact
- By the end of March 2015, at least 75% of people aged 15-49 who have had more than one sexual partner in the preceding 12 months are using a condom in their last sexual contact
- By the end of March 2015, at least 50% of the estimated number of PLHIV has been identified.

A list of target populations (beside the general population) has been provided depending on the program area and types of NAP interventions:
General population, intermediate and high school students, university students, draftees and armed forces, IDUs, truck drivers, street children, young workers, prisoners and their families, spouses of PLHIV, IDUs, HIV/AIDS vulnerable women and PLHIV.

Review of the Global Fund HIV/AIDS Project- R8 in Iran (IRN- 810-G04-H)
In line with the National Strategic Plan for HIV/AIDS control, the Iran’s Global Fund HIV/AIDS project, phase 1, started on April 2010. The main goal of HIV/AIDS R8 is:
- To Halt and began to reverse HIV /AIDS spreading among general population and most at risk groups (MARPs).

The main target groups are school students, IDUs, HIV/AIDS vulnerable women, prisoners and PLHIVs.
GFR8-phase 1 main objectives are:
Objective 1: At least 60% of 15-45 year-old population has universal knowledge about HIV transmission
Objective 2: At least 85% of IDUs adopt safe injecting practices and 42% of IDUs adopt to use a condom in the last time they had sexual intercourse
Objective 3: At least 55% of women at higher risk of HIV adopt to use a condom in the last time they had sexual intercourse
Objective 4: At least 60% of prisoners have universal knowledge about HIV transmission
Objective 5: Second line ARVs are available for 100% of PLHIV infected with HIV resistant to first line ARVs

Objective 6: 10% of PLHIV covered by positive clubs

Objective 7: Capacity building for NGOs to deliver effective HIV services

Objective 8: Capacity building to assure successful implementation of NSP

To achieve aforementioned objectives 45 main activities are planned. These activities will be coordinate and supervised by different stakeholders. The overall time period of the round 8 grant is 5 years and the total budget granted was 32,354,404.

UNDP-Iran country office as the Principal Recipient (PR)\(^1\) in collaboration with SRs/SSRs under guidance and overall supervision of Country Coordinating Mechanism (CCM) has handled phase 1 of the project.

**Global Fund HIV/AIDS - GF Project R8 Main stakeholders in Iran**

HIV/AIDS- GFR8 project is a multi-partner venture. The project stake holders are divided to Sub recipients (SRs) and Sub-Sub recipients (SSRs).

HIV/AIDS GFR8 project sub recipients are:
- Ministry of Health and Medical Education- Centre for Diseases Control (CDC)
- Prisons Organization (PO)
- Ministry of Education (MoE)

HIV/AIDS GFR8 project sub- sub recipients are:
- Welfare Organization (WO)
- Universities of Medical Sciences and Health services (UMS)
- Islamic Republic of Iran Broadcasting (IRIB)
- Iran Blood Transfusion Organization (IBTO)

**Provinces covered by GFR8-phase 1 project activities**

SRs/SSRs have selected different provinces for project implementation. Followings are the list of target provinces based on each SRs/SSRs:

MOE, GFR8-phase 1 project target provinces:
- Students education:
  - Azerbaijan Gharbi, Charmahal va Bakhtiari, Fars, Gilan, Isfahan. Kerman, Kermanshah, Khorasan Razavi, Khozestan, Kohkiloyeh va Boyer Ahmad, Lorestan

\(^1\) UNDP country office in Iran has been assigned as Principal Recipient (PR) by Country Coordination Mechanism (CCM) which is the highest decision making entity on GF projects in Iran.
PO, GFR8-phase 1 project- target provinces:
- Inner cell prisoners peer education:
  Isfahan, Kerman, Hamedan, Golestan, Khorasan Razavi, Tehran
- After release education:
  Golestan,
- Prisoners' family education:
  Tehran, Khorasan Razavi
- After release MMT:
  Bushehr, Sistan and Baluchestan, Khorasan Razavi, Kerman
- Inner cell VCT:
  Eastern Azerbaijan, Western Azerbaijan, Ardebil, Isfahan, Ilam, Bushehr, Tehran, Chahar mahal and Bakhtiari, Southern Khorasan, Khorasan Razavi, Northern Khorasan, Khozestan, Zanjan, Semnan, Sistan and Baluchestan, Fars, Ghazvin, Ghom, Kordestan, Kerman, Kermanshah, Kohgiloyeh and Boyer Ahmad, Golestan, Gilan, Lorestan, Mazandaran, Markazi, Hormozgan, Hamedan, Yazd

WO, GFR8-phase 1 project- target provinces:
- Peer education for IDUs
  Tehran, Fars (Shiraz), Sistan & Baluchestan (Zahedan), Hamedan
- DIC Harm reduction services for IDUs
  Tehran, Alborz (Karaj), Kermanshah, Kerman (Bam)
- Outreach harm reduction services for IDUs
  Tehran, Mazandaran (Sari), Kerman (Bam), Kerman (Bardsir), Kermanshah, Markazi (Arak), Alborz (Karaj), Fars (Shiraz)
- Sleep in centres for IDUs
  Tehran,
- HVW peer education:
  Tehran, Hamedan, Sistan o baloochestan (Zahedan), Kerman (Jiroft)
- Harm reduction services for HVW:
  Tehran, Mazandaran (Sari), Fars (Shiraz), Kerman (Bardsir),
- Sleep in centres for HVW:
Tehran, Mazandaran (Sari)

CDC, GFR8-phase 1 project- target provinces:

- Hot lines:
  Hormozgan, Kordestan, Yazd, Tehran (Shahid Beheshti and AIDS Research Center), Zanjan, Boushehr, Zahedan, Hamedan, Lorestan, Positive clubs, Hormozgan, Yazd, Boushehr, Lorestan, Tehran (Shahid Beheshti), Tehran (AIDS Research Centre), Mashhad, Shiraz, Isfahan, Qom, Ahvaz, Kerman, Kermanshah

- HVW harm reduction and Reproductive health:
  Kordestan, Zahedan, Isfahan, Tehran UMS, Azarbayejan Sharghi, Mazandaran, Golestan

- HIV/AIDS Rapid test pilot
  Hormozgan, Boushehr, Khorasan Razavi, Kermanshah, Azarbayejan Sharghi

**Assessment Purpose, Objectives and Scope**

The main purpose of the assessment was:

- To provide CCM with an overall HIV/AIDS project performance, success stories, challenges and lessons learned to provide clear recommendation for the 2nd phase planning and implementation.

The objectives of the assessment study were:

- To review the integrity of GFR8 in relation to 3rd NAP

- To review the progress of phase 1 in term of work plan targets.

- To identify factors that account for a particular success or failure.

- To review the implementation arrangements of PR/SRs/SSRs and the quality of different stakeholders partnership and cooperation

- To assess the quantity and quality of services delivered to the clients

The scope of assessment was all of the decisions, activities and processes either finished or ongoing in relation to GFR8-phase 1.
Methodology of assessment study

By definition the assessment study is collection of information that enables executives to track, support and guide GFR8 continuous progress and improvement towards achievement of the objectives. Assessment is done in two ways: Summative and diagnostic. Summative assessment occurs at the end of a period of implementation and provides opportunities for implementers to demonstrate their achievement of the important/enduring learning addressed during that period of time. Diagnostic assessment occurs at the middle of the project cycle. This type of assessment will provide executives with an understanding of the prior period of performance, as well as the strengths and specific corrections need of the activities in relation to the overall objectives. This study was therefore a diagnostic assessment.

To assess HIV/AIDS global fund phase 1, one of the most popular models called Logic model was employed\(^2\). A logic model sets out how an intervention (such as a project, a program, or a policy) is understood or intended to produce particular results. Some versions of a logic model present it as four components in a linear sequence: inputs, activities, outputs, and outcomes. These represent the logical flow from:

1. inputs (resources such as money, employees, and equipment) to
2. work-plan and its activities or processes, to
3. the immediate outputs of the work-plan that are delivered to clients or stakeholders, to
4. Outcomes or results that are the medium-term to long-term consequences of delivering outputs.

This is displayed in a diagram such as this:

INPUTS --> ACTIVITIES OR PROCESSES --> OUTPUTS --> OUTCOMES

Logic models can be drawn with the causal and temporal sequence running from left to right, from top to bottom, or from bottom to top. The logic model is often used in public sector or not-for-profit organizations, where the mission and vision are not

aimed at achieving a financial benefit. In such situations, where profit is not the intended result, it may be difficult to monitor progress toward outcomes. A program logic model provides such indicators, in terms of output and outcome measures of performance. It is therefore important in these settings to carefully specify the desired results, and consider how to monitor them over time. Often, such as in health services the outcomes are long-term and mission success is far in the future. In these cases, intermediate or shorter-term outcomes may be identified that provide an indication of progress toward the ultimate long-term outcome.

Traditionally, GF programs were focused mainly in term of their budgets. It is easy to measure the amount of money spent on a project, but this is a poor indicator of mission success. Likewise it is relatively easy to measure the amount of activities done but the SRs/SSRs may have just been spinning their wheels without getting very far in terms of ultimate results or outcomes. The production of outputs is a better indicator that something was delivered to clients, but it is still possible that the output did not really meet the client's needs, was not used, of low quality etc. Therefore, the focus on results or outcomes has become a valuable approach in not-for-profit programs.

Although outcomes are used as the primary indicators of program success or failure they are still insufficient. Outcomes may easily be achieved through processes independent of the program and an evaluation of those outcomes would suggest program success when in fact external outputs were responsible for the outcomes. In this respect, a typical assessment study should concern itself with measuring how the process indicators (inputs and outputs) have had an effect on the outcome indicators. A program logic model would need to be assessed or designed in order to an assessment of these standards to be possible.

Considering the abovementioned points, based on components of the Logic model, several research methods both quantitative and qualitative were used to gather necessary data. Main methods for conducting the study included desktop review, facility based survey, NGOs consensus meeting, Key informants and peripheral health staff informal interviews.
Desktop review
In order to benefit from recent papers and reports related to HIV/AIDS, all available information sources in hard and soft format including most popular databases were reviewed and related information was gathered.

The required documents below which were reviewed had been collected by the assessment team assigned by different partners (PR, SRs, SSRs and CCM):

- GFATM- Project original proposal round 8
- Project grant agreement and its attachments, work plan, PF (Performance Framework), PR-SRs agreement, NSP3 monitoring and evaluation plan, procurement and supply management plan.
- Project progress reports by PR, SRs and SSRs.
- Field visit reports,
- Auditory and financial reports, disbursement requests.
- Related administrative documents.
- Existing guidelines and SOPs currently in use
- Minutes of CCM and PR-SRs meetings
- HIV/AIDS NSP (second and third)
- WHO, UNAIDS Iran HIV/AIDS Updates
- IRAN HIV/AIDS progress reports -2010
- GF most recent policies and decisions posted on web

Key informants and peripheral health staff informal interviews
Series of informal interviews made with a number of individuals involved in GF project. Interviews were mostly disorganized and prepared to talk freely about the different aspects of GF project focusing on challenges, lessons learned, success stories and recommendation for better planning of phase two.
Field visits
Field visits covered areas such as Data Quality Assessment (DQA), assessment of project stewardship and monitoring system, inventory management and spot checks on quality of provided services.

The objectives of field visits were:
- Checking the quality and validity of the reported data.
- Conducting talks with peripheral project focal points and key beneficiaries in the field.
- Checking the quality of implemented activities and processes by SRs and SSRs.
- Checking GF project asset inventory management.

Seven provinces (Tehran, Alborz, Khorasan-Razavi, Golestan, Mazandaran, Hormozgan, Sistan & Baluchestan) were selected for field visits based on the phase 1 activities of SRs/SSRs.

The visited sites were selected to assess quality of reported data to Global Fund and also recipients of the services (IDUs, HVW, PLHIV and those patients who received HIV/AIDS diagnosis and treatment services).

Details of the visited places are as following;
- Hormozgan Province
  - Hormozgan UMS, Disease management department-HIV/AIDS office
  - Bandar Abbas central prison
  - Bandar Abbas VCT-ARV-Rapid test
  - Bandar Abbas positive club
  - Women harm reduction and RH center
  - Urban health center no.6
  - Urban health center no.8
- Tehran province
  - Tehran Jonob Health Center, Disease management department - HIV/AIDS office
  - Imam Khomeini Hospital –VCT
  - Imam Khomeini Hospital- Hot line
- Imam Khomeini Hospital- Positive Club
- Shahid Imami Women harm reduction and RH center
- Gezel-Hesar prison

- Alborz province
  - Karaj prison

- Golestan province
  - Gorgan prison

- Mazandaran province
  - Mazandaran Health Center, Disease management department -HIV/AIDS office
  - Sari VCT
  - Women Harm reduction and RH center (UMS-NGO)
  - WO – Office of social harms prevention
  - Women harm reduction center (WO-NGO)
  - Women outreach team (WO-NGO)
  - Women Sleep in Center(WO-NGO)

- Khorasan Razavi province
  - Khorasan Razavi Education organization- Office of Health
  - Positive club (UMS)
  - VCT - ARV(UMS)

- Sistan & Balouchestan
  - Women harm reduction and RH center of Zahedan (UMS-NGO)
  - Women outreach team
  - Hotline

Findings of assessment study

In this section findings of assessment have been presented based on Logic model:

GFR8 phase 1 inputs assessment:

Inputs are essential for any plan or project to guarantee successful implementation. We examined the GFR8 phase 1 inputs in terms of 3M (Man, Money and Material) and work-plan design and assumptions. The findings revealed that all necessary
inputs including human resources, funds, materials and facilities have been provided adequately.

However phase 1 work plan assessment indicated some divergences with 3rd NAP in design and targets. The following table shows the findings considering that both the NAP and GFR8 work-plan end in 2015.

Table 1: Assessment of HIV/AIDS GFR8- Main targets in comparison with 3rd NAP:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3rd NAP Target</th>
<th>GFR8 Target</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people with advanced HIV disease or AIDS who remain under treatment for longer than one year</td>
<td>85</td>
<td>100 (second line ARV)</td>
<td>GFR8 target exceeds NAP target</td>
</tr>
<tr>
<td>% of people aged 15-24 can correctly identify methods of preventing transmission of and important misconceptions about HIV and AIDS.</td>
<td>50</td>
<td>60</td>
<td>GFR8 targets 15-45 age groups exceeds NAP target.</td>
</tr>
<tr>
<td>% of injecting drug users can correctly identify methods of preventing transmission of, and important misconceptions about, HIV and AIDS.</td>
<td>55</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>% of most-at-risk women can correctly identify methods of preventing transmission of, and important misconceptions about, HIV and AIDS.</td>
<td>35</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>% of injecting drug users use a sterile needle and syringe at last injection</td>
<td>90</td>
<td>85</td>
<td>NAP target goes further than GFR8 work-plan</td>
</tr>
<tr>
<td>% of most-at-risk women use a condom in their last sexual contact</td>
<td>65</td>
<td>55</td>
<td>NAP target goes further than GFR8 work-plan</td>
</tr>
</tbody>
</table>

It is assumed that GFR8 work-plan should be under the NAP umbrella and boost it but there are some differences between the NAP and GFR8 work-plan targets as summarized in the above table. The question is which one is correct and updated?

Some other variances in designing the work-plan were detected. For example the first objective of the work-plan aims at 15-45 years old population while the main activity focuses on students and the broadcasting multimedia programs do not seem to be sufficient to raise the awareness of 60% target population. The review of at least 3 KAP studies suggested that the percent of adolescents 15-19 years aware of HIV/AIDS preventive measures and routes of transmission have been steadily
remained around 16% so it is very optimistic to expect dramatic growth of students or general population awareness within a five year period.

Some other planning variances exist in the work-plan as well. For example under the objective No 4 (at least 60% prisoners have universal knowledge about HIV/AIDS...), there are a set of activities starting by peer education and continuing to after-release MMT and VCT which are not directly related to the mentioned objective.

**Assessment of GFR8 implementation process**

The work-plan interventions and activities are the key success factors toward achieving the GFR8 targets. To assess the efficiency and effectiveness of the activities and implementation processes following areas selected by assessment team.

**Governance and Stewardship**

CCM is the highest ranking entity that supervises the PR- SRs/SSRs GF project performance. CDC technically manages the overall implementation of the NAP and GFR8 work-plan. UNDP as PR disburses funds for activities implemented by SRs under supervision of the CCM.

The assessment findings showed a strong ownership of the project between the CCM, PR and SRs/SSRs. However the long chain of subcontracting work plan activities through PR to SRs/SSRs and interacting with several layers of governmental and non-governmental implementers potentially affected the efficiency and effectiveness of the phase 1 action plan. The result of such arrangements is involvement of several layers of implementing parties. Site visits, document reviews and informal interviews revealed that this kind of implementation may impose some risks vis-à-vis and the line of responsibility between the implementation layers.

**NGOs involvement in the GFR8**

The lessons learned and main strengths and weaknesses experienced by NGOs were put to discussion during a workshop which was held in Hotel Olympic (Tehran) on 3 June 2011. The main objective was to review the experiences of NGOs on interacting with PR and SR/SSRs and implementing designed activities during phase 1. After exploring the NGOs ideas the meeting continued with discussions about their potential to continue participating in phase 2 activities. The session was ended with
discussion about possible solutions to improve project efficiency and effectiveness during phase 2.

- Most important strength of NGOs
  - Capacity to deliver services for hard to reach people
  - Good access to target population
  - Efficiency and low cost
  - More trust of Hard to reach population on NGOs
  - Potential to develop participative services with other stakeholders
  - Effective role on supporting PLHIV rights
  - Accelerating target population access to services
  - Innovation and creativity in service delivery
  - Covering the current gaps of services delivered by governmental organization
  - Less bureaucracy comparing with government sector

- Most important weaknesses of NGOs
  - Low self-confidence
  - Weak administrative and financial capacity
  - Weak organization of resources and process
  - Weak independency in performance
  - Weak networking
  - Weak participation with target groups
  - High turnover of human resources
  - Shortage of technical knowledge
  - Low funds
  - Weakness in planning
  - Low number of NGOs
- **GFR8 most important advantages to NGOs**
  - Low cost efficiency of some services
  - Fruitful training sessions
  - Improvement of participation between NGOS and governmental organizations
  - NGOs capacity building to deliver more technical services
  - Improvement of government view on NGOs
  - New technical and scientific approaches to service delivery
  - Opportunity to produce services to marginalized and hard to reach groups such as vulnerable women and IDUs.

- **GFR8 most important limitations experienced by NGOs**
  - Multiple lines of authority
  - Lack of flexibility in the budget forecast
  - Lack of enough coordination between different organizations
  - Delaying on payments
  - Exhausting paper work specially in case of financial processes
  - Nonconformance of some provided equipment with local applications
  - Lack of independence in activities of provider NGOs
  - Rigidity in services which lead to low creativity
  - Lack of budget allocation for feasibility studies and M&E activities

- **Potential areas of NGOs participation in GFR8 phase 2 activities:**
  - Employment opportunities for PLHIV
  - Empowering other newly established NGOs
  - Education and focus on street children
  - Participate in VCT activities
  - Supportive activities for the family members of PLHIV and MARPs
  - Greater participation in MMT
To attract greater participation of clergymen and missioners

Sport and promotional activities

Greater social and legislative support for PLHIV and marginalized population

Potential capacity to extend range of groups covered by project

Financial participation in costs of treatment and some other costs

Potential of more focus on gender issue

Ability to identify and refer HVW to service centers

Greater participation on IRIB programs

Potential of delivering home care for PLHIV

Identify and support HIV Vulnerable families

Support government to give services to hard to reach groups

Data quality and management system

A top down strategy including end user verification was selected to examine the quality of data flow from service delivery points to the highest supervisory and decision making levels of the SRs/SSRs, PR and CCM. According to the findings the timeliness of the reports was in acceptable range however data accuracy, data registry, recording and documentation and reports completeness especially at some of the visited service delivery points were poor and unverifiable. In case of WO, several layers of reporting have made it difficult to track the quantity and quality of the activities and reports. The most important point is that the GF activities reporting system is not satisfactorily integrated with SRs/SSRs current data flow system and most of the generated reports are used only for financial auditory purpose rather than monitoring and supervising the activities and quality of delivered services. Therefore only GF focal points and related staff are involved in data processing and GF
activities are generally considered by the others, provisional and out of the current service delivery system.

**Interventions sustainability and Value for the money**
One of the most serious concerns is the ability of system in place to continue delivering services after discontinuation of external funds; hence the sustainability of the services. In this regard some of the activities in the work-plan do not seem to be cost efficient. What is the meaning of peer education of IDUs and HVWs in DICs? While we know any service package in DICs basically contain education for clients. Male Sleep-in Centres is challenging issue as well. How effective are they with regard to HIV prevention approach?

Another example is after-release MMT services for released prisoners. The question is whether it is the best solution to keep an IDU prisoner on MMT. Another important limitation of the after-release MMT exempt is the limitation of access by prisoners who are not residing at the same city of the after-release MMT centre. Eventually are those services that have been designed on per capita payment basis, sustainable in the future?

**Assessment of the financial performance of the PR/SSRs/SSRs**
According to the reviewed documents and interviews with SRs/SSRs money disbursement and supply chain management by the PR are in acceptable range. However NGOs believed that the financial clearance process is exhaustive and time consuming. When assessment team negotiated about NGOs concern with the related persons they confirmed the findings, in addition they believed that some activities and management costs have been underestimated or dismissed in the original work plan which are to be considered in phase II planning process.

**GFR8-phase 1 service integrity Analysis**
To examine the integrity of the delivered services following matrix was developed by the assessment team:

---

3 For example HIV/AIDS research center directly reports GF activates to GF office of CDC-MOHME while the diseases management office of the Tehran UMS –deputy for health is not directly involved in the process.
Table 2: HIV/AIDS GFR8-phase 1 services integrity assessment

<table>
<thead>
<tr>
<th>GFR8-phase 1 Target provinces</th>
<th>Students education</th>
<th>Male IDUs peer education</th>
<th>Female IDUs peer education</th>
<th>DMS &amp; Care</th>
<th>DMS + VCT</th>
<th>HIV peer education</th>
<th>HIV harm reduction</th>
<th>HIV sleep in centres</th>
<th>Harm line</th>
<th>Meth Lab</th>
<th>Rapid HIV testing</th>
<th>Prisoners peer education</th>
<th>After release peer education</th>
<th>Prisoners family education</th>
<th>Prisoners VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alborz</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ardebil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bushehr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chahar mahal and Bakhtiari</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Azerbaijan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fars</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghazvin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gilan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golestan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hamedan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hormozgan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ilam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isfahan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerman</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kermanshah</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khorasan Razavi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khozestan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kohgiloyeh and Boyer Ahmad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kordestan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorestan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Markazi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mazandaran</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Khorasan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semnan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sistan and Baluchestan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Khorasan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tehran</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Azerbaijan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yazd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zanjan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The assessment question was: what was the reason for choosing special provinces or places for service delivery?

To find answer to this question assessment team did some informal interviews with the selected key persons and GF focal points. According to the findings some of the main criteria for selecting the implementation sites were: prevalence of HIV/AIDS in the area, coverage of current services, density of high risk groups, ease of implementation of new interventions, readiness of managers, pilot interventions, history of former service delivery etc. However assessment team did not find any document or guideline showing a systematic approach for selecting of special provinces and sites for service delivery.

Quality of services and end user verification
The assessment team did onsite random checks of service delivery processes and interviewed with the staff and clients to assess the quality of delivered services and clients’ satisfaction. Majority of the verified clients demonstrated acceptable level of awareness about the characteristics of the services and materials (condom, syringe...) which they had received. In case of education about HIV/AIDS the knowledge\(^4\) of more than 95% of interviewees was satisfying. Despite these, harm reduction materials and services had been delivered with some variances in quality and quantity.

A most important concern in this regard is the probability of discontinuity of the harm reduction services. Since IDUs referred to the DICs are not registered with identification code so it is very difficult to trace them and to find out how many times they have received harm reduction services within a definite period.

**GFR8 phase 1 progress in top 10 output indicators:**

Review of the GFR8-phase1 top ten output indicators showed considerable success in achieving intended targets. Details of the indicators and the target values are shown in the following table:

Table 3: HIV/AIDS GFR8-phase 1 Programmatic Output Indicators:

\(^4\) The HIV/AIDS awareness criteria was giving correct answers to 5 questions indicated by UNAIDS.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Intended target</th>
<th>Actual</th>
<th>Achievement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of school students trained on life skills-based HIV education</td>
<td>505487(2009)</td>
<td>375000</td>
<td>544187</td>
<td>145</td>
</tr>
<tr>
<td>Number of IDUs reached with needle/syringe program</td>
<td>52662(2007)</td>
<td>3390</td>
<td>3390</td>
<td>100</td>
</tr>
<tr>
<td>Number of HVW reached with preventive HIV services at DICs and SICs</td>
<td>NA</td>
<td>545</td>
<td>732</td>
<td>134</td>
</tr>
<tr>
<td>Number of family members of prisoners trained by prison organization on HIV</td>
<td>24,348 (2007)</td>
<td>3750</td>
<td>6298</td>
<td>168</td>
</tr>
<tr>
<td>Number of prisoners enrolled in MMT program in release centers</td>
<td>1464(2007)</td>
<td>3000</td>
<td>3503</td>
<td>117</td>
</tr>
<tr>
<td>Number of prisoners who received HIV counseling and testing services and received their results</td>
<td>8387(2008)</td>
<td>4590</td>
<td>5111</td>
<td>111</td>
</tr>
<tr>
<td>Number of people with HIV infection currently receiving anti-retroviral therapy (ARVs) in Iran (2nd line drugs only)</td>
<td>82 (2008)</td>
<td>280</td>
<td>383</td>
<td>137</td>
</tr>
<tr>
<td>Number of Positive Clubs implemented and maintained</td>
<td>9(2008)</td>
<td>11</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>Number of M&amp;E Focal Points trained</td>
<td>NA</td>
<td>125</td>
<td>147</td>
<td>118</td>
</tr>
<tr>
<td>Number of people tested for HIV with rapid tests</td>
<td>0</td>
<td>1900</td>
<td>423</td>
<td>22</td>
</tr>
</tbody>
</table>

While noting the brilliant achievements in terms of phase 1 targets it is important to mention that some reported figures should be inspected for data quality and accuracy. The site visits and onsite data verification revealed that there is ambiguity about the number of IDUs covered by harm reduction services of some DICs since they also deliver harm reduction services to non IDU addicts so the reports are to be aggregated carefully to report only IDUs as indicator.
The same is true for the number of PLHIV covered by positive clubs activities since some registered members of the clubs are not PLHIV as we discovered during site visits and document review.

Another consideration is about MOE which we investigated that some students who received HIV/AIDS education are under 15 years old, marginally out of the age range of target group set in the work-plan phase 1. While raising awareness of adolescents, even under 15, is worthwhile, these kind of data should be discarded or reported separately and remaining service data should be adjusted to give a realistic image of the SRs/SSRs performance.

**Assessment of GFR8-phase 1 outcomes**

According to the logic of the selected model for the purpose of the assessment, the expectation of significant improvement in term of outcomes is not out of the mind. It should however be noted that the GFR8 objectives are adopted from NAP so the attribution of any achievement in national scale should be interpreted with adequate caution. The 18 month timeframe of the phase 1 does not seem to be enough to judge about the exclusive impacts of the project on the national outcomes. However review of at least 3 unpublished national studies highlighted that some intended outcomes even for the year 2014 have already been achieved. Table below shows the baselines and intended targets over the lifetime of the project:

**Table4: HIV/AIDS GFR8-phase 1 Programmatic Outcome Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Date)</th>
<th>Intended Target (2012)</th>
<th>Intended Target (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of young women and men aged 15-45 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>16.3% (2008)</td>
<td>30%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Percentage of IDUs who reported using sterile injecting equipment the last time they injected</td>
<td>74% (2008)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Percentage of IDUs who report the use of a condom at last sexual intercourse</td>
<td>33% (2008)</td>
<td>38%</td>
<td>42%</td>
</tr>
<tr>
<td>Percentage of women at higher risk of HIV reporting the use of a condom at last sexual intercourse</td>
<td>57.1% (2010)</td>
<td>60%</td>
<td>70%</td>
</tr>
<tr>
<td>Percentage of prisoners who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>25%</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Discussion and lessons learned**

This assessment designed and carried out on behalf of CCM to measure achievements of phase 1 implementation and to provide CCM with an overall HIV/AIDS project performance, successes, challenges, lessons learned and to offer clear recommendations for the planning and implementation of the 2nd phase.

The results of the assessment showed that in general, HIV/AIDS project has succeeded in reaching the intended targets of phase 1 and have had a positive effect on underpinning the efforts of preventing and controlling of HIV/AIDS in the country. PR/SRs/SSRs and NGOs interactions, SCM, project stewardship and management, education of students, harm reduction services provided for IDUs, HVW and prisoners were acceptable and can be counted as examples of success.

Furthermore the strong political support on HIV/AIDS control program in Iran facilitates implementation of the GF HIV/AIDS project. In line with this, more involvement of project counterparts at highest levels of management will provide more support and better implementation environment.

Considering lessons learned in phase 1 and GF forthcoming policies on upper middle income countries besides global financial constraints, forces a gradual and systematic integration of the GFR8 project activities in current health services network to guarantee the sustainability of the system in place. Strengthening capacity of the health system in this regard is strongly suggested. In line with that it is recommended the project organogram be revisited and where possible implementation process be further aligned with national system. Defining standard minimum service packages, allocating ID number for DIC clients and harmonization of the harm reduction and educational activities among SRs/SSRs are non-negligible duties during phase 2 of the GFR8 project.
The major findings and improvement areas to be incorporated into Phase2 work plan are as following:

Main Strengths:
- Motivated and qualified project staff;
- Good coordination between PR/SRs/SSRs;
- Outstanding achievements in terms of output indicators;
- Timely delivery of supplies/goods/medicines and disbursement of funds by PR;
- Smooth running of project activities;
- Good Supply Chain Management.

Main Improvement areas:
- Technical errors in design of phase 1 work plan;
- Over/under- estimates of unit costs and targets;
- Performance variance among DICs / out-reach teams;
- The need for clearer guidelines for DIC/outreach/sleep-in centers operation;
- Concerns about the quality of service delivery;
- Weak data reporting and recording system;
- Inadequate project leadership/ownership in some settings;
- The need for regular monitoring and strengthening of the capacity of NGOs;
- Exhaustive paper work between PR,SRs, and SSRs;
- No evidence about cost efficiency/effectiveness of some interventions e.g. hotlines, after release MMT, male IDUs sleep in centers.

**Conclusion and recommendations**

According to the assessment team observations and findings, considerable improvement has been made through the GF Project implementation in Phase I. GFR8-phase 1 contributed to better implementation of NAP and the overall national response has been improved significantly. Additionally, good harmonization and a sense of cooperation have emerged among counterpart organizations resulting in a more systematic and effective response to HIV/AIDS countrywide.
According to the documents reviewed for the Q1 and Q2 period the Project performance has received an average rating of B1 while as per the Implementation Letter number 4, the Q4 and Q5 has been rated as A1. Considering the findings of the current assessment the overall A2 rating is recommended on the entire Phase I.

**Table 5: The GF suggested performance rating scale**

<table>
<thead>
<tr>
<th>A1</th>
<th>A2</th>
<th>B1</th>
<th>B2</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceeding expectations</td>
<td>Meets expectations</td>
<td>Adequate</td>
<td>Inadequate but potential demonstrated</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>&gt;100%</td>
<td>100-90%</td>
<td>60-89%</td>
<td>30-59%</td>
<td>&lt;30%</td>
</tr>
</tbody>
</table>

**Recommendations**

The followings recommendations are made according to the findings of this study:

- Providing more accurate estimation of unit costs and setting more realistic targets for the project outcome and coverage indicators.
- Improving the quantity and quality of harm reduction services which are provided through Drop-in Centers (DICs) and Outreach teams.
- Revise/update standard guidelines and operational procedures for Drop-in Centers, Outreach teams and Sleep-in Centers (SIC).
- Improve reporting and recording mechanisms and systems.
- Strengthen the sense of project leadership/ownership among parties especially Welfare Organization (WO).
- Undertake regular NGO capacity assessments.
- Focus on end user verification and define a solution to identify IDUs by an identification number to avoid service duplication and make sure that the IDUs are receiving required services continuously.
- Reduce paperwork especially in case of PR/SRs/SSRs financial transactions while maintaining the highest standards of accountability and integrity.
- Design studies on cost efficiency/effectiveness for Phase1 & 2 interventions (e.g. hotlines, after release MMT services, IRIB broadcasting, IDUs sleep in centers etc).