In the Name of God

ISLAMIC REPUBLIC OF IRAN
COUNTRY REPORT

on Monitoring of the United Nations General Assembly Special Session on HIV and AIDS

DECLARATION OF COMMITMENT

Prepared by:
Office of the Under-secretary for Health, Ministry of Health and Medical Education, Centre for Diseases Management

January 2006
This report has been prepared in Cooperation with UNAIDS Iran and the Iranian Research Centre for HIV/AIDS

Iranian AIDS Research Center
Tehran Medical University

Joint United Nations Programme on HIV/AIDS
Acknowledgment

The development of the present report involved the active participation of various ministries, organizations, institutions, scholars and executives. We wish to express our gratitude in this regard, in the outset. This report would not have been possible without their invaluable assistance.

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2. Centre for Workplace Health Education and Research - Ministry of Labour and Social Affairs
3. Dispensary General of the Law Enforcement Forces
4. Drug Control Headquarters
5. Health Office – Ministry of Education
7. Iranian Blood Transfusion Organization
8. Islamic Republic of Iran Broadcasting
9. Maternal & Child Health Office - Ministry of Health and Medical Education
10. National Youth Organization
11. State Welfare Organization
12. NGOs active in the field of HIV/AIDS
13. Organization of Prisons and Punitive / Disciplinary Action (Prisons’ Organization)
14. Iranian Red Crescent Society
15. Substance Abuse Prevention and Treatment Office-Ministry of Health and Medical Education
16. Workplace and Environment Health Office – Ministry of Health and Medical Education
17. Universities of Medical Sciences and Healthcare Services (41 Medical Sciences Universities)
18. United Nations Population Fund (UNFPA) – Iran
19. United Nations Office on Drug and Crime (UNODC) – Iran

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Table of Contents

1. Acronyms
2. Introduction
3. Methodology
4. Status at a Glance
5. Overview of the HIV/AIDS Epidemic
   A. National Commitment and Action
      - Amount of national funds disbursed by governments
      - National Composite Policy Index
   B. National Programs
      - Most-at-risk populations: HIV testing
      - Most-at-risk populations: prevention programs
      - Life-skills-based HIV/AIDS education in schools
      - Workplace HIV/AIDS control
      - Sexually transmitted infections: comprehensive case management
      - Prevention of mother-to-child transmission: antiretroviral prophylaxis
      - HIV treatment: antiretroviral combination therapy
      - Blood safety
   C. Knowledge and Behaviour
      - Most-at-risk populations: Knowledge about HIV prevention
      - Sex workers: condom use
      - Men who have sex with men: condom use
      - Injecting drug users: safe injecting and sexual practices
      - Young people: knowledge about HIV prevention
      - Median age at first sex among young women and men
      - Higher-risk sex among young women and men
      - Young people: condom use with non-regular partners
   D. Impact
      - Most-at-risk populations: reduction in HIV prevalence
      - HIV treatment: survival after 12 months on antiretroviral therapy
      - Reduction in mother-to-child transmission
7. Major challenges faced and actions needed to achieve the goals/targets
8. Monitoring and evaluation environment
9. Support required from country’s development partners
10. Annexes
    ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS
    ANNEX 2: National Composite Policy Index Questionnaire
11. References
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC(s)</td>
<td>Antenatal Clinic(s)</td>
</tr>
<tr>
<td>API</td>
<td>AIDS Program Effort Index</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Surveillance Surveys</td>
</tr>
<tr>
<td>BTO</td>
<td>(Iranian) Blood Transfusion Organisation</td>
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<td>CDM</td>
<td>Centre for Diseases Management, MoH</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<tr>
<td>DCHQ</td>
<td>(Iranian) Drug Control Headquarters</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DoC</td>
<td>Declaration of Commitment</td>
</tr>
<tr>
<td>GO(s)</td>
<td>Government Organization(s)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDU/(s)</td>
<td>Injecting Drug Use/r(s)</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>IRIB</td>
<td>Islamic Republic of Iran Broadcasting</td>
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<tr>
<td>IRCS</td>
<td>Iranian Red Crescent Society</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health, Treatment and Medical Education</td>
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<td>MoL</td>
<td>Ministry of Labour and Social Affairs</td>
</tr>
<tr>
<td>MPO</td>
<td>Management and Planning Organization</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NA</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>NAC(s)</td>
<td>National AIDS Committee(s)</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>NGO(s)</td>
<td>Non-Governmental Organization(s)</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PO</td>
<td>The Prisons Organisation</td>
</tr>
<tr>
<td>SPA</td>
<td>Service Provision Assessment</td>
</tr>
<tr>
<td>STD(s)</td>
<td>Sexually Transmitted Disease(s)</td>
</tr>
<tr>
<td>STI(s)</td>
<td>Sexually Transmitted Infection(s)</td>
</tr>
<tr>
<td>SWO</td>
<td>(Iranian) State Welfare Organisation</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction

Today, the Islamic Republic of Iran is facing a critical phase of the HIV/AIDS epidemic because growing HIV/AIDS prevalence among IDUs has shifted the country from a low-prevalence state to one of concentrated prevalence over the past decade, giving rise to serious concerns about increased HIV/AIDS prevalence among IDUs as well as other most-at-risk populations. Extremely useful steps have been taken in delivery and expansion of HIV/AIDS services throughout the country in recent years. These have come about as a result of advocacy among policymakers and key decisions being made on harm-reduction strategies by high-level government officials as well as training the necessary skilled human resources base. Nevertheless, it seems that in spite of these steps, the continued qualitative and quantitative improvement of such services remains vitally important at this juncture.

While presenting the DoC core indicators, the present report is also intended to provide a general picture of the HIV/AIDS epidemic in Iran. Based on the DoC, the Islamic Republic of Iran and the other 188 UN member states pledged in June 2001 to control and prevent the transmission of HIV/AIDS.

The core indicators for monitoring DoC progress are significant on four grounds: first, they help to assess the effectiveness of our national response to the epidemic; second, they form a basis for monitoring the trend of the epidemic, related services and their outcomes; third, they show the level of each country’s commitment to the DoC; and fourth, they express the relative situation of each country in the global response to HIV/AIDS. It is for the very first time that Iran is reporting its DoC core indicators within the framework of UNAIDS guidelines and thus some shortcomings in the report are to be expected. Nevertheless, we hope that it constitutes a step towards controlling the spread of HIV in Iran.

Finally, given the need for collection of data on DoC core indicators for the next biennial report (due November 2007), with any research project whose findings might be useful in this regard, please inform the NAC secretariat (Fax ++98 21 88300444) or UNAIDS (Fax ++98 21 2285891, or iran@unaids.org) and ask the researchers to provide us with the full text of their paper, if at all possible.
Methodology

The present report was generated as a project implemented from mid-November to mid-December 2005. The project’s core team, working under the supervision of the Head of CDM comprised members of GOs, universities, UN agencies and PLHIV. In the absence of national surveys providing the values for the core indicators specified in UNAIDS guidelines, the required data was collected through a review of existing studies, monitoring of national programs and interviewing key informants. The study made use of databank searches in Irandoc, Google Scholar and Medline, as well as enquiries from medical universities, HIV/AIDS activist organizations and consultation with key individuals. The findings were examined by an epidemiologist, who extracted the data relevant to DoC core indicators. Activity-related data were acquired through written communication, and telephone and direct interviews with medical universities, GOs (e.g. DCHQ, PO, SWO, IRCS, BTO, MoE, IRIB, various military outfits and certain MOH-affiliated offices, including Substance Abuse Prevention and Treatment Office and the Office for Maternal and Child Health), and NGOs active in HIV/AIDS programs. Key informants selected from NGOs, GOs and PLHIV were interviewed according to the questionnaire included in UNAIDS guidelines. Interviews with experts were used to obtain missing information, verify and finalize data. In addition to information received through medical universities and key informants, the estimates of most-at-risk populations also made use of a study conducted by CDM and other related organizations in 2005. Upon categorization and summarization, the data was analyzed and used in ordinal presentation of core indicators. The draft report was circulated among a group of (individual as well as institutional) “readers” working on HIV/AIDS in Iran. The report was finalized following discussions and modifications during a consensus-building meeting on 23 December 2005, prior to publication.
### Status at a Glance

<table>
<thead>
<tr>
<th>National Commitment And Action Indicators</th>
<th>Total funding of IRR 118,992,046,000 (approximately US$ 14 million) for 2004-2005</th>
</tr>
</thead>
</table>

| National Composite Policy Index | 9.4% for 2004-2005 Source: Service delivery organizations and institutions |

### INDICATORS OF NATIONAL PROGRAMS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results</td>
<td>9.4% for 2004-2005 Source: Service delivery organizations and institutions</td>
</tr>
<tr>
<td>Percentage of most-at-risk populations reached with HIV/AIDS prevention programs</td>
<td>At least 11.4% of IDUs were reached by preventive services. Source: Service delivery organizations and institutions</td>
</tr>
<tr>
<td>Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year</td>
<td>The figure is unavailable in percentage terms but there is a six-hour syllabus included in the ninth grade curriculum. Also in guidance (early secondary) schools a life-skills education program has been launched on a limited scale. Source: MoE</td>
</tr>
<tr>
<td>Percentage of companies that have HIV/AIDS workplace policies and programs</td>
<td>The figure is unavailable in percentage terms but workplaces with more than 25 employees are required to have workplace technical &amp; Health Committees for which HIV/AIDS education has been envisaged. Source: Enquiry from MoL Centre for Workplace Health and Safety Research and Training, and MoH Office for Workplace Health</td>
</tr>
<tr>
<td>Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated and counselled</td>
<td>The figure is unavailable in percentage terms for the whole country but a study in two districts showed that 47% of physicians had sufficient knowledge of STDs. Source: Study by Ali Beheshtian et al</td>
</tr>
<tr>
<td>Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission</td>
<td>6.8% based on the following figures: - Child deliveries in 2004-2005: 1,200,000 - HIV prevalence among pregnant women based on surveys over the same period: one out of 5440 cases - Estimates of pregnant women in need of ART to prevent MTCT: 220 in the same period - Number of women receiving ARV therapy for PMTCT: 15 cases Source: Vital Statistics Office/ Office for Maternal and Child Health/ CDM surveys</td>
</tr>
<tr>
<td>Percentage of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>12.7% based on the following figures: - ARV therapy recipients: 380 cases - Estimate of PLHIV in the advanced stage of the disease: 3000 persons Source: Centres providing ARV therapy and the estimate of the number of cases</td>
</tr>
<tr>
<td>Percentage of transfused blood units screened for HIV</td>
<td>100% Source: BTO</td>
</tr>
</tbody>
</table>
## KNOWLEDGE AND BEHAVIOR INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>No national-scale study is available but a study of IDUs has shown accurate knowledge of the role of condoms in prevention in 87%, of possibility of apparent health of infected persons in 30% and non-transmission through mosquito bites in 23% of respondents. A study of runaway girls and sex-workers showed that 50% and 46% had accurate knowledge of items 1 and 2 respectively. Source: Saman Zamani et al (2005) and Ali Ardalan et al (2002)</td>
</tr>
<tr>
<td>Percentage of female and male sex workers reporting the use of a condom with their most recent client</td>
<td>No national-scale study is available but in two studies 83.2% and 24% of female sex-workers were found to use condoms. Source: Mohammad Reza Jahani et al (2002) and Ali Ardalan et al (2002)</td>
</tr>
<tr>
<td>Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</td>
<td>No available data</td>
</tr>
<tr>
<td>Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid sharing equipment and use condoms in the last month</td>
<td>No national-scale study is available but in a study of IDUs in Tehran 19.8% had avoided shared injections in the last month and used a condom in their most recent sexual intercourse. Source: Saman Zamani et al (2005)</td>
</tr>
<tr>
<td>Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>No national-scale study is available but a study of 15-17 year old Tehran students found the level of accurate knowledge of the effect of condom use in prevention, non-transmission through food and non-transmission through mosquito bites to be at 96%, 87% and 67% respectively. Source: Anahita Tavoosi et al (2002)</td>
</tr>
<tr>
<td>Percentage of young people who have had sex before the age of 15</td>
<td>No national-scale study is available but a study of young men found that 27.7% had first had sex before the age of 18. Source: Mohammad Reza Mohammadi et al</td>
</tr>
<tr>
<td>Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months</td>
<td>No national-scale study is available but a study showed that 71.7% of 15-18 year-old sexually active young men (27.7% of the total sample population) had had more than one sexual partner. Source: Mohammad Reza Mohammadi, et al</td>
</tr>
<tr>
<td>Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner</td>
<td>No clear figures are available</td>
</tr>
</tbody>
</table>

## IMPACT INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Details</th>
</tr>
</thead>
</table>
| Percentage of persons in most-at-risk populations who are HIV-infected | Among IDUs: 5%-25%
In a study in Tehran: 15.2%
Source: Saman Zamani et al (2004) and reports by CDM |
| Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy | 93%  
Source: data from two major centres for service delivery to HIV patients. |
|---|---|
| Percentage of infants born to HIV infected mothers who are infected. | 24%  
Source: same as the eighth indicator |
First Episode

Overview of the HIV/AIDS Epidemic in Iran

This section presents the general state of the HIV epidemic in the Islamic Republic of Iran, based on data collected from cases reported to the MoH (source: medical universities, BTO and the Organization of Medical Jurisprudence), data from sentinel surveillance sites and other relevant studies.

The first case of HIV in Iran was reported in 1986. As of that date, the annual number of reported cases of HIV saw a gradual rise until 1995. An outbreak of HIV infection in a number of prisons across the country in 1995 led to a significant increase in the number of reported cases, which has been characterized by steady growth ever since. The first case of HIV transmission through (drug) injection was reported in 1992. Until 1995, 5 new cases of transmission through IDU were reported on average each year. With the discovery of the epidemic in 1995, suddenly the number of cases reported rose 30-fold as compared with the figures for the preceding year, making IDU the most common mode of transmission in Iran. IDU has continued to be the leading mode of transmission ever since. By September 26th, 2005, 12,556 persons had been reported as infected with HIV, of whom 631 had progressed to AIDS and 1,457 died. Some 5.4% of the reported cases were women.

The main route of transmission for reported cases remains shared injection equipment among IDUs. By the said date, 62.3% of all cases had been infected as the result of injecting drugs, 7.4% through sexual intercourse, 0.5% as the result of MTCT and 1.9% through infected blood products, with the mode of transmission being unknown in 27.9% of cases. Even though over the past few years the reported share of sexual transmission has remained fairly stable at 5-8%, the absolute figure has grown steadily from 50 persons in 2000 to about 200 persons in 2004. Furthermore, the proportion of reported cases where the mode of transmission is unknown has grown from 8.2% in 1998 to 28.1% in 2002. The assumption here is that these unknown cases can partly be attributed to sexual transmission, which remains under-reported due to the associated stigma. Also by September 26th, 2005, some 0.4% of all reported cases were four years old or younger, while 0.5% was aged 5 to 14. The majority of cases (40.8%) were in the 25-34 age group, followed by 29.7% in the 35-44 group. The distribution of the epidemic in the provinces is heterogeneous, with annual incidence varying from 2.3 per 100,000 to 103.6 per 100,000. It would seem that the inconsistency reflects variations in divergent local prevalence of HIV and its associated risk behaviours as well as uneven levels of surveillance and reporting.

Even the most prevalent mode of transmission is not the same across the country. That is, even though drug injection is the most common mode of transmission in the majority of provinces, there is one province where sexual transmission is as common a route of transmission as sharing injection equipment. The prevalence of HIV in different population groups, including most-at-risk populations, remains unknown and controversial. The bulk of existing information focuses on IDUs and pregnant women. In all surveys performed so far on pregnant women, with 5,456 individuals tested altogether, only one case of HIV has been reported. Also, in spite of the sharp increase in cases since 1995, all studies conducted up to the year 2000 had shown HIV prevalence among IDUs to be less than 1-2 percent. Yet every survey since 2003 has shown HIV prevalence among IDUs to exceed 5%. Since 2001, reported cases among spouses of HIV+ individuals have also risen from 6 cases in 2001 (0.5% of all cases in that year) to 76 cases in 2004 (2% of that year's total). HIV prevalence
among sex workers is also unclear, with reported rates ranging from zero to extremely high. It seems, however, that the highest reported prevalence rates among sex workers involved those who were also IDUs.

In Iran, as in other countries, the number of reported cases is only a portion of the total number of infections. The estimate for the total number of HIV-infected persons was 30-40 thousand in 2003 and has risen to 60-70 thousand in 2005\(^7\).
## A- National Commitment and Action Indicators

### First Indicator: Government Funding for HIV/AIDS

#### Purpose
- To track national HIV/AIDS budget allocations and analyze the budget from an HIV/AIDS perspective
- To compare the amounts of state and donor funding to HIV/AIDS activities
- To use allocations in the national budget as indicators of human rights achievements or violations

#### Definition
Amount of national funds disbursed by the government throughout the country

#### Measurement Tools
- Review of the 2004-2005 fiscal budget bill
- Review of MOUs among HIV/AIDS control programs in 2004-2005
- Enquiries about expenditure from ministry officials and other organizations with budgetary allocations for HIV/AIDS control activities.
- Enquiries about HIV/AIDS prevention and control expenditures from 40 medical universities

#### Value of Indicator
The 2004-2005 general budget allocations by the government of the Islamic Republic of Iran for the purpose of HIV/AIDS control, prevention and treatment were as follows:

<table>
<thead>
<tr>
<th>Item Description</th>
<th>IRR</th>
<th>USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Purchase of ARV medication</td>
<td>7,100,000,000</td>
<td>835,000</td>
</tr>
<tr>
<td>2- Funding provided to official staff of medical universities involved in HIV/AIDS control within the framework of logistic maintenance budget</td>
<td>6,480,000,000</td>
<td>762,000</td>
</tr>
<tr>
<td>3- Funding for all educational, preventive, control, counselling, care and treatment within the organizational structure of the MoH and medical universities</td>
<td>22,060,000,000</td>
<td>2,595,000</td>
</tr>
<tr>
<td>4- Funding for production and airing of mass media programs through IRIB</td>
<td>2,162,000,000</td>
<td>254,000</td>
</tr>
</tbody>
</table>
5_ IRCS spending on education, prevention and control | IRR 5,000,000,000 | USD 588,000

6- Funding allocated for procurement and provision of safe blood products by the BTO | IRR 45,000,000,000 | USD 5,294,000

7- Prisons' Organization expenditure for all HIV/AIDS education, harm reduction, prevention and control activities | IRR 6,648,650,000 | USD 782,000

8- SWO expenditure for education, prevention, harm reduction and delivery of care | IRR 4,094,460,000 | USD 482,000

9- Funding for the hospitalization of AIDS patients in public hospitals | IRR 1,488,000,000 | USD 175,000

10- Funding provided to MoH Substance Abuse Prevention and Treatment Office, purely for harm reduction interventions (Additional harm reduction-related funding has occurred under items 3, 5, 7 and 8 above) | IRR 12,550,000,000 | USD 1,476,000

11- Funding share of equipment and assets' expenditure by medical universities in the fiscal year 2004-2005 | IRR 1,488,000,000 | USD 175,000

12- Funding for informational/educational programs for students by MoE | IRR 1,525,156,000 | USD 179,000

13- Funding expended (by the armed force) for condom procurement and STD control | IRR 2,956,250,000 | USD 348,000

14- Funding expended by the armed forces for HIV/AIDS control and prevention | IRR 127,530,000 | USD 15,000

**Total Funding** | IRR 118,992,046,000 | USD 14,000,000

**Interpretation and Analysis**

In the Islamic Republic of Iran, the MPO draws up the budget bill by balancing various plans provided by government agencies and ministries on the one hand with estimated available funds on the other. The budget bill is then submitted to Parliament to be passed into law. DCHQ as a key national institution in drug control strategy development is active in funding harm reduction programs in a host of associated organizations and spheres. However, only figures for its operational cost centres have been obtained and double-checked with the DCHQ in order to insure accuracy and avoid overestimation. In the fiscal year 2004-2005 government's general (non-developmental?) budget constituted the main source of funding for activities to control the spread of HIV/AIDS. UN agencies also contributed a small amount to the effort (about USD 400,000 or 3% of government funding). Funding for HIV/AIDS activities was intended for all general population groups particularly prison inmates and most-at-risk populations. The funding foresaw no limitations in accessibility based on sex, race, creed, occupation or age. It is noteworthy that a safety injection component is being integrated into Iran's National Vaccination Program, the cost of which cannot be separated from the overall cost of inoculation interventions and thus is excluded from the above sum. Nevertheless, the measure fits in with HIV/AIDS prevention and control activities.

**Recommendation for Improved Measurement**

Implementation of National Health Accounts is recommended, if feasible. Otherwise it is desirable to at least see the implementation of National AIDS Accounts.
Challenges and Recommendations for Indicator Improvement

A) Challenges
Financial resources managers at high governmental levels do not allocate resources to HIV/AIDS programs based on the current NSP.
Absence of a specific budget line devoted to HIV/AIDS, from which all allocations are made – and can thus be tracked – to the relevant state agencies.
Absence of national monitoring mechanism for supervision of expenditure in terms of amount spent on HIV/AIDS programs as a ratio of total funding allocated to the purpose.
Absence of National AIDS Accounts and Health Accounts as well as failure in comprehensive implementation of operational budgeting at all levels of implementation.

B) Recommendations
1. Financial resources management at high governmental levels based on a strategic plan acceptable to different state agencies and confluent with a national monitoring plan
2. Implementation of National AIDS Accounts and National Health Accounts
Second Indicator: National Composite Policy Index

This indicator is calculated based on a UNAIDS questionnaire, which was completed using information provided by key informants as indicated (in) the section on methodology, above.

I- National Strategic Plan for HIV/AIDS Control and Prevention

Iran has drafted a National Strategic Plan (NSP) to control the spread of HIV/AIDS, which envisages intersectoral participation on a national scale. The plan covers the 2002-2007 period. While early steps to develop the NSP were taken by the MoH, other organizations, such as MoE, DCHQ, PO, IRCS, SWO, IRIB, ministry of culture as well as certain military outfits and various UN agencies in Iran contributed toward its finalization. Even though representatives of women's organizations as a sector were not present in the planning or management of the plan, nevertheless there are female staff members who have played important roles both in planning and in management of the NSP. The NSP concerns itself with areas of information and education, behavioural and epidemiological surveillance, universal precautions for healthcare workers, VCT, drug injection harm reduction for drug injection, social marketing and condom programming, STI prevention and treatment, blood safety, PMTCT, breastfeeding and provision of support and care for PLHIV and their families. Migration issues have not been included. Youth and most-at-risk populations have been considered as target populations. However, there is no explicit mention of women and girls as target populations. Participation of patients in the plan has been envisaged. The NSP includes an Action Plan with specific objectives but lacks a detailed budget or specified funding sources. Full participation and involvement of civil society failed to transpire at the planning stage, but civil society organizations have taken part in the plan indirectly. Iran's major HIV/AIDS control and prevention authorities and bodies have approved the plan.

HIV/AIDS prevention and control has been incorporated into Iran's Fourth Economic, Social and Cultural Development Plan. UN technical and financial aid to the Islamic Republic of Iran has continually existed. Iran's poverty reduction plan makes no mention of HIV/AIDS control. The NSP includes HIV prevention, and PLHIV care and support but does not address specifically issues of gender or income disparity. While there has been no examination of the economic consequences of HIV/AIDS until now, a study has been launched in this regard recently.

Regarding the armed forces, the NSP addresses the issue of prevention among military personnel but the issues of care, protection and voluntary HIV testing have been somewhat overlooked. There is no mandatory HIV testing for members of the armed forces.

All in all, HIV/AIDS activities within the NSP framework have made some headway during 2002-2004. The factors hindering full progress include:
Allocated funding falling short of requested budget
Lack of appropriate human resources at provincial and national levels
Insufficient NGO capacity building
Absence of functional M&E programs in line with NSP
Significantly lower intersectoral coordination on national scale than on provincial scale
Organizations involved in the framework of the NSP acting independently without necessarily addressing activities stipulated in the NSP
Novelty of the NSP and as such experience had to be gained gradually.

II- Political Support

The head of state and other high-ranking state officials speak of AIDS control programs with clarity and sympathy.

The High Council on AIDS has been created to coordinate intersectoral programmes at national level. The Council was established in 1988. In 2002, its organizational structure was reviewed and its guidelines approved by the council of ministers, leading to ratification of its legal status in 2003. The High Council on National Planning for HIV/AIDS Prevention and
Control operates under specified terms of reference and has a specific membership. Representatives from civil society, PLHIV and private sector have observer status. According to its guidelines, a national working group acts under the council, while provincial working groups are charged with organizing and implementing its decisions. Most of the Council's activities have been implemented by provincial work groups in 2004. The NAC and its relevant subcommittees and provincial committees are in charge of promoting interaction between the state, PLHIV, private sector and civil society. No national structure exists to coordinate the delivery of HIV services by civil society organizations.

In sum, political support for HIV/AIDS programs has seen relative improvement during 2002-2004. This is due to advocacy efforts influencing the highest levels of policy making.

**III- Prevention**

The NSP includes a strategy for promoting delivery of information and education on HIV/AIDS to the general public and certain programs have been implemented to promote dissemination of accurate information and reporting through the media. There is also a strategy to promote the provision of HIV/AIDS-related safe sex and reproductive health education among youth. However, there is no formal HIV education in primary and guidance (early secondary) level curricula. There is some educational content on the subject at high school and even guidance level, which has increased over the past year. The educational content is identical for girls and boys and is developed by the MoE. A strategy exists to promote the provision information, education and other preventive interventions among most-at-risk populations. For IDUs these interventions include information, education, harm-reduction, counselling, needle/syringe programs and condom distribution, detoxification treatment, substitution/maintenance treatment and rehabilitation programs. PO prevention programs for inmates—as one of the major most-at-risk populations in Iran, and identified as such in Iran's NSP—have seen significant expansion during 2002-2004. There are also some interventions envisaged for truck drivers. Interventions are also being developed for female sex workers. The program makes no mention of interventions for men who have sex with men, foreign immigrants and mobile populations. The issue of internally displaced populations does not apply to Iran. Certain approaches have been designated to increase access to basic prevention services for most-at-risk populations, which focus on increasing the number of services delivery points, harm reduction programs in prisons, outreach programs and utilization of NGO and private sector service providers. There are programs for blood safety, safe injection practices at PHC centres and antenatal syphilis screening. There is no scheme for the social marketing of condoms specifically for safer sex, although condoms are provided without any restriction or limitation throughout the national network of PHC clinics. Furthermore, during 2002-2004, PMTCT programs and universal precautions for healthcare workers have been implemented at service delivery points. During 2002-2004, there has been a relative improvement in support for, and implementation of, prevention programs, driven mainly by greater financial resources, political support, increase in the knowledge of service providers and planners, increased awareness among most-at-risk populations and the general public regarding the usefulness of prevention services, and the launching of outreach services and greater NGO involvement.

**IV- Care and Support**

The NSP has put in place a strategy for improving comprehensive HIV/AIDS care and support, which also addresses the usual obstacles against provision of such services to certain most-at-risk populations, such as IDUs. Iran runs programs in blood screening against HIV, universal precautions and post-exposure prophylaxis. For PLHIV there are programs for treatment of opportunistic infections, ARV therapy, contraceptive services, psychosocial support for PLHIV and their families, palliative care and treatment for common HIV-related infections, co-trimoxazole prophylaxis and TB diagnosis and treatment. Except for the publication of a booklet, no national-scale measure has been taken to provide
nutrition and home care. Nevertheless, some provinces have implemented certain home care activities.

There has been some improvement in the implementation of care and support programs during 2002-2004, which can be attributed to the points discussed under Prevention. There is no strategy or policy for responding to the HIV/AIDS-related needs of orphans and other vulnerable children, thus precluding any concrete effort in this regard. Nevertheless, the issue of street children has recently received intense attention. Executive guidelines for SWO service delivery have been approved and some services are being provided through it or through local municipalities. More recently, some limited action has also taken place. On the whole, no significant progress has been made in meeting the needs of orphans and other vulnerable children during 2002-2004.

V - Monitoring and Evaluation

Even though an M&E strategy has been envisaged in the NSP, there is at present neither a functional plan to monitor and evaluate activities nationwide nor a specific budget for this purpose. The relevant bodies have occasionally conducted their own M&E of activities. Also, there is currently no mechanism to insure that all major program implementers report to the Committee. There is no specific unit dedicated to M&E on a national scale nor has there been any training developed for this purpose at national or provincial level. The NSP's first M&E report was developed by CDM. Some provinces have also developed their own program monitoring reports. There is an M&E Committee, working under the National Committee, charged with development of an M&E plan. The plan is being developed and has not yet been approved by the relevant authorities. Also the M&E plans of individual organizations are not designed for the purpose of unifying M&E indicators nor are there representatives from civil society or PLHIV currently involved in developing the plan. The Committee has developed an M&E checklist for the NSP, which also monitors the performance of NAC provincial subcommittees. The checklists were piloted at one province in Sep/Oct 2004. The plan covers key issues such as data collection and processing, development of data collection instruments and compilation of a specific, standard set of indicators. On the whole, some steps have been taken to improve the state of M&E during 2002-2004.

VI - Human rights

There are some laws and regulations intended to protect PLHIV against discrimination. The vice-president has already issued a circular prohibiting pre-employment testing and dismissal of HIV+ employees (because of their HIV status). Furthermore, the Minister of Education has issued a circular making school enrolment of HIV+ children obligatory. A circular has been issued to detention facilities throughout the country that prohibits segregation of HIV-infected inmates. A law exempting prisoners with hard-to-cure illnesses from punitive action has been extended to inmates in the AIDS phase of the disease, of which judicial authorities have been duly informed. Certain articles in the Constitution of the Islamic Republic of Iran stress equality of all persons before the law, the state's responsibility in eliminating unfair discrimination against any person in all material and spiritual spheres, equal enjoyment of political, economic, cultural and human rights for all citizens and equality of access to health and treatment services. Regarding drug users, there is a law that precludes their arrest while receiving treatment. However, drug users are still considered criminals. Furthermore, in a circular issued last year the Head of the Judiciary instructed judges not to obstruct harm-reduction interventions. The NSP stresses patients' human rights, including the right to confidentiality. There is no gender disparity in access to prevention measures. There have been attempts to involve vulnerable populations but there is no specific plan in this regard. All HIV/AIDS research protocols involving human subjects must be examined and approved by ethics committees at local or national level. The committees include representatives of civil society and PLHIV.
Judicial authorities have received some training on issues that might arise regarding HIV/AIDS and human rights. There are certain programs in place aiming to change public attitudes towards HIV/AIDS-related discrimination and stigmatization and create a better understanding and acceptance of patients. On the whole, during 2002-2004, there have been relative improvements in policies, laws and regulations to enhance and safeguard the human rights of PLHIV as well as efforts to harmonize policy implementation with human rights. This is mainly due to greater advocacy efforts at higher levels of the Judiciary for policymaking and implementation at various executive levels.

VII- Civil Society Participation
Even though some civil society institutions have considerably expanded their activities in HIV/AIDS control over the last few years, yet civil society has not played a significant role in advocacy for HIV programs among political leaders and authorities, in drafting the National Plan, and in the development and funding of the current HIV/AIDS NSP. Nevertheless, the recent years have seen a growing interest at planning and service provision levels in utilization of NGOs in the delivery of HIV/AIDS services.
B-INDICATORS OF NATIONAL PROGRAMS:

Third Indicator: Most-at-risk populations: HIV testing

Purpose
To assess progress in implementing HIV testing and counselling among most-at-risk populations

Definition
Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results

Measurement Tool
Given the absence of any surveys on the above subject, program monitoring was used to measure the indicator.

Method of Measurement
The indicator value was arrived at by dividing the number of persons from most-at-risk populations who have been tested for HIV during the last 12 months and who know the results of their test (numerator) by the estimated size of the most-at-risk population (denominator)

1- VCTs administered for IDUs (numerator)
The numerator was arrived at through written enquiries sent to all centres that provide VCT services in Iran. These include 40 medical universities throughout the country, PO, IRCS, the BTO, SWO and NGOs.
Based on the results of the enquiries a total of 18826 IDUs received HIV counselling and testing in 2004-2005. The breakdown by organization is as follows: medical universities 7,890, IRCS 4,877, Prisons' Organization 5,056 and NGOs 1,003 persons. Note that figures for the BTO were not included to avoid overlaps.

2- Estimated number of IDUs (denominator)
The number of IDUs for 2004-2005 has been estimated at 200000 persons.

3- At present, no reliable figures are available on other most-at-risk populations on a national scale.

Value of Indicator
The indicator value for 2004-2005 amounts to 9.4% for IDUs. However, according to a rapid assessment of drug abuse conducted in 2004-2005, 21% of drug users (both IDUs and non-injectors) reported a history of HIV testing and awareness of the results at some point in their lives.

Interpretation and Analysis
By April 2005, 72 districts out of Iran's total of 328 (22%) had at least one VCT or behavioral counselling centre established by the network of medical universities. In addition, there were 44 prison-based triangular clinics (STI/ HIV/ Drug Abuse counselling) and 24 IRCS counselling centres, which provided VCT services. In 2004-2005, VCT services were also delivered by two NGOs. The services were also provided in the 31 BTO centres. Thus the total number of centres amounts to 173, which indicates some growth in the number of centres providing VCT services.
While such growth constitutes a valuable step, given the average number of test performed annually at each centre (about 100), the need to increase uptake of VCT services seems clear. Furthermore, there may be some overlap in the figures given above, given the distinct possibility that some persons may have received VCT at more than one centre.

**Recommendation for Improved Measurement**
Regular surveys of most-at-risk populations on the use of VCT services

**Strengths, Challenges and Recommendations for Indicator Improvement**

**A) Strengths**
Fairly even distribution of VCT services across the country.
Free delivery of prevention services including VCT services at the relevant centres.
Existence of a fairly well-trained human recourse base across the country.

**B) Challenges**
Insufficient access to most at-risk populations due to legal, social and cultural restrictions.
Absence of comprehensive private sector participation in provision of VCT services.
Lack of specific policy for certain most-at-risk populations such as MSM

**C) Recommendations**
Needs assessment for the promotion of VCT services
Launching systems for rapid testing in order to expand and facilitate access to VCT services.
Use of private sector capacity to enable 24/7 provision of VCT services
Sensitization of private and public healthcare providers to use every possible opportunity in assessing risky behaviour and making referrals to VCT centres.
Creating an enabling environment that encourages most-at-risk populations to seek VCT.
Fourth Indicator- Most-at-risk Populations: Prevention Programs

Purpose
To assess progress in implementing HIV/AIDS prevention programs for most-at-risk populations

Definition
Percentage of most-at-risk populations reached with HIV/AIDS prevention programs

Measurement Tool
Given the absence of any surveys on the above subject, program monitoring was used to measure the indicator

Method of Measurement
Written enquiries were sent out to 40 medical universities throughout the country, PO, IRCS, the BTO, SWO and NGOs working with most-at-risk populations. Private sector activities were reported by medical universities and SWO. The retrieved data was double-checked with information previously recorded at MoH Substance Abuse Prevention and Treatment Office, AIDS Control Office and key informant interviews.

Content of Enquiry
Enquiries concerned IDUs, sex workers, spouses of IDUs, street children and men who have sex with men. The services subject to enquiry included VCT, maintenance treatment and syringe/needle programs. Other services such as care and education/information services were excluded due to high overlaps with the services under consideration. Based on the responses received, some 18,826 VCTs had been administered to IDUS, 4300 IDUs had been covered by maintenance treatment and 3800 were covered by syringe/needle programs. In arriving at the numerator for the indicator, the figure for individuals in maintenance programs was dropped but the figure for syringe/needle programs was retained and added to the VCT cases, since the majority of maintenance treatment recipients are likely to have also volunteered for HIV counselling and testing, whereas this assumption seems less valid for needle/syringe programs (a total of 22,826 persons).

Estimated number of IDUs, sex workers, spouses of IDUs, street children and men who have sex with men: This task had already been addressed at meetings with various state officials. The data from these meetings and previously existing data have been adopted for the purpose of this report. The number of IDUs for 2004-2005 has been estimated at 200,000. At present, no reliable figures are available on other most-at-risk populations on a national scale.

Value of Indicator
Indicator value for 2004-2005 in the IDU population is 11.4%

Interpretation and Analysis
The actual coverage must exceed the recipients of the above services. This is because the number of individuals who have received education on HIV/AIDS should exceed those who accessed more specialized, costly services such as VCTs. Furthermore in 2004-2005 some 110,000 drug users sought treatment at SWO clinics. These were mostly admitted into abstinence-based treatments but also included in part maintenance treatment recipients. Since the proportion of IDUs in this group is unknown the item was excluded from indicator calculations. Yet even the alternative approach to the indicator would represent a significant gap between service coverage and desirable conditions. It is worth noting that countries considered success stories in controlling the epidemic among IDUs are those which, at the outset of the epidemic, covered between 20-30 percent of this population. Therefore, since
HIV prevalence exceeds the critical level of 5% among IDUs, coverage by effective HIV/AIDS prevention services clearly needs to exceed 20%-30%.

**Recommendation for Improved Measurement**
Launching regularly planned surveys for the target population

**Strengths, Challenges and Recommendations for Indicator Improvement**

**A) Strengths**
The existence of articles in the Fourth Development Plan Law obligating the government to undertake harm-reduction measures for drug users and vulnerable population groups, as well as involving the public, non-government sectors and requiring the provision of skills based education (Articles 86 and 97 of the Fourth Development Plan Law).
The existence of articles in the Fourth Development Plan Law obligating the government to license candidate service delivery points for most-at-risk populations (vulnerable women, street children and drug abusers), having duly examined the applications. (Article 26). This Article provides for private sector participation in such fields.
The increasing focus on harm reduction approaches by experts dealing with most-at-risk populations, which, together with policymakers' positive attitude, helps facilitate the implementation of relevant programs.

**B) Challenges**
In addition to the shortage of centres, there are also insufficient human and financial resources made available to the improved qualitative and quantitative coverage of services to vulnerable and most-at-risk populations.
The most-at-risk populations tend to be also the hardest to reach.

**C) Recommendations**
Legislation that protects most-at-risk populations in accessing service delivery points
Comprehensive support by policymakers and state officials for full implementation of the NSP to Control HIV/AIDS and the activities and objectives stated therein.
Fifth Indicator- Life-Skills-Based HIV/AIDS Education in Schools

**Purpose**
To assess progress towards implementation of life-skills-based HIV/AIDS education in all schools

**Definition**
Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year

**Measurement Tool**
Given the absence of any surveys on the above subject, program monitoring was used to measure the indicator

**Method of Measurement**
Written enquiry sent to the Health & Fitness Bureau of the Office of Deputy Education Minister for Physical Education and Health Affairs. The Bureau is responsible for HIV/AIDS programs at the MoE.

**Content of Enquiry**
Is HIV prevention a part of formal education at primary, guidance or high school level? If so, how many hours? Under which subject? And using which Syllabus?
For each of primary, guidance and high school levels, what percentage of schools have at least one teacher who has been trained in life-skills-based HIV/AIDS education over the last five years?
What percentage of students in the above schools have received regular education by such teachers over the past year?
If the above answer is not zero percent, how many hours of such education is provided on average at each grade per year?

**Value of Indicator**
Since there is no survey that answers these questions, the indicator cannot be directly calculated. According to program monitoring, there has been no formal HIV/AIDS education at primary or guidance (early secondary) levels. However, about 18% of guidance level boarding schools for girls have provided informal AIDS education within the framework of an Adolescent Health Improvement Project. Also, the ninth-grade curriculum includes six hours of HIV/AIDS education. 11.2% of all high schools have teachers trained on HIV/AIDS and 90% of all ninth-graders do receive the instruction.

**Interpretation and Analysis**
In practice HIV/AIDS education is limited to a single grade level, whereas such learning cannot take root unless it starts at early primary level and builds up over the years. The HIV/AIDS education that is provided at high school is based on traditional, didactic and is content-based. Some steps were taken last year towards development of life-skills-based HIV/AIDS education. These are continuing.

**Recommendation for Improved Measurement:**
Conducting special survey studies at school level

**Challenges and Recommendations for Indicator Improvement**

**Challenges**
Life-skills-based HIV/AIDS education requires planning and learning from kindergarten years, which is currently not done. There is reluctance against transparent presentation of certain learning material related to HIV/AIDS, especially as concerns prevention of HIV transmission in risky sexual behaviour. Skills-based (participatory) learning does not exist in schools

**B) Recommendations**
Inclusion of life-skills education for K-12
Advocacy for the full support of policymakers and government officials for complete implementation of life skills-based education at all levels of education.
Training for (volunteer) teachers of these skills and familiarizing them with participatory learning approaches.
Sixth Indicator - Workplace HIV/AIDS Control

Purpose
To assess progress in implementing workplace policies and programs to combat HIV/AIDS

Definition
Percentage of companies and factories that have HIV/AIDS workplace policies and programs

Measurement Tool
Given the absence of any surveys on the above subject, interview with key informants was used to measure the indicator

Method of Measurement
Interviews with the Director and Deputy-Director of the MoL Centre for Workplace Health and Safety Research and Training, and also the Director and Deputy-Director of the MoH Office for Workplace Health. Furthermore members of the faculty of occupational medicine at Tehran University of Medical Sciences were interviewed. No employers were interviewed.

Value of Indicator, Interpretation and Analysis
Based on interviews with key informants, there are currently few functional workplace implemented programs. Yet, the following workplace educational program has been implemented:
MoH workplace health policies are implemented through workplace technical safety committees. Production facilities with more than 25 workers must have a Workplace Health and Technical Safety Committee. Committee members have received two hours of training on HIV/AIDS in the workplace over the last two years.

Recommendation for Improved Measurement:
Conducting regular studies at places of work.

Strengths, Challenges and Recommendations for Indicator Improvement
A) Strengths
Appropriateness of technical committees for implementation of HIV/AIDS workplace policies
Completion of the preliminary steps for development of workplace HIV/AIDS education

B) Challenges
The vast majority of the labour force works in settings with fewer than 25 employees, where the organizational chart does not stipulate creation of technical committees.
Negative attitude of some employers and insurance companies towards hiring and retaining HIV+ individuals as employees.

C) Recommendations
Follow-ups for the implementation of the existing program
Utilization of non-government sectors in expanding workplace education, especially in shops with less than 25 employees.
Seventh Indicator- Sexually transmitted infections: comprehensive case management

Purpose
To assess progress in implementing universally effective STI diagnosis, treatment and counselling

Definition
Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated and counselled

Measurement Tool
Given the absence of any surveys on the above subject, interview with key informants was used to measure the indicator

Value of Indicator
Given the standardized methods and definitions specified in the guidelines, this indicator cannot be measured. However, a study of district reporting systems in Darehgaz and Bandar Abbas districts showed that 47% of physicians had sufficient knowledge of STDs.9

Interpretation and Analysis
An STD control program was launched by the Office for AIDS and STD Control at the Centre for Disease Management in 1998.
The clinical practice guidelines for STDs were developed in 2000-2001 and have since been revised. WHO guidelines emphasize syndromic management of STDs. The medications needed for the treatment of STDs are available. Yet some of the recommended medications are very costly. It is currently not possible to provide treatment for STDs free of charge. A large percentage of patients receive services from the private sector. However, the private sector does not cooperate sufficiently when it comes to surveillance and case reporting.

Strengths, Challenges and Recommendations for Indicator Improvement
A) Strengths
Appropriateness of the PHC network structure for integration of STD services as well as existence of the Triangular (HIV/STI/drug abuse) Clinic structure.

B) Challenges
Lack of coordination with the private sector, which treats the largest portion of STD patients.
Reluctance of clients and their sexual partners to seek medical help because of stigma
Lack of counselling abilities in many care providers

Recommendations
Following-up on implementation of the plan developed
Expansion of training programs
Inclusion of STI education in the curriculum of medical universities
Improving the knowledge of care providers

Recommendation for Improved Measurement:
Regular studies of physicians’ knowledge and performance.
Eighth Indicator- Prevention of Mother-To-Child Transmission: Antiretroviral Prophylaxis

Purpose
To assess progress in preventing vertical transmission of HIV

Definition
Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission

Measurement Tool
Program monitoring and estimates of the number of HIV+ mothers

Method of Measurement
1- Written enquiries sent to the public health departments of 40 medical universities. The medical universities are the sole providers of ARV treatment within the Iranian healthcare system. These universities provide with ARV treatment to prevent of vertical transmission of HIV. In 2004-2005, fifteen women received medication for this purpose.
2- Based on 2004-2005 estimates, the total number of deliveries was 1,200,000 while surveys of 5,440 pregnant women in the general population have shown only one case of HIV infection. Thus it can be expected that in 2004-2005 there must have been at least 220 HIV+ pregnant women in Iran.

Value of Indicator
Indicator value for 2004-2005 is calculated at 6.8%

Interpretation and Analysis
As the indicator shows, coverage of PMTCT treatment is low in Iran. Noting the 25% probability of MTCT, there is an urgent need to find appropriate ways of diagnosis and treating HIV+ mothers. Meanwhile, given that some 95% of pregnant women receive antenatal care at least once during pregnancy¹, and the wide coverage afforded by the current PHC system, human resources and free ARV treatment, it is imperative to develop proper policy and plans to upscale coverage of PMTCT services.

Recommendation for Improved Measurement
1- In the general population: Pilot studies in certain regions to ascertain HIV prevalence in pregnant women.
2- In most-at-risk populations: HIV prevalence in pregnant women in the most-at-risk populations, using studies and sentinel surveillance data
3- Steps to provide accurate estimates of populations of most-at-risk women of reproductive age

Strengths, Challenges and Recommendations for Indicator Improvement
A) Strengths
Adequate health infrastructure, skilled human resources and free ARV treatment in Iran
Near-universal ANC coverage in Iran and utilization of services by 95% of pregnant women

B) Challenges
A large portion of HIV+ women —especially pregnant HIV+ women— remain unidentified and are unaware of their infection. This will hold true for their children as well.

¹ Data from the Demographic and Health Survey (DHS) conducted in 2000
C) Recommendations
Provision of women-friendly VCT service to increase uptake of services
Needs assessment for various IEC methodologies to enhance awareness and motivation among most-at-risk women
Sensitization of care providers, including those in the private sector, to conduct HIV risk assessment in all patients.
Ninth Indicator- HIV Treatment: Antiretroviral Combination Therapy

Purpose
To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection

Definition
Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

Measurement Tool
1- Program monitoring
2- Estimation of HIV+ population and the percentage that has entered the advanced stage of the disease.

Method of Measurement
Written enquiries sent to the public health departments of 40 medical universities. The medical universities are the sole providers of ARV treatment in the Iranian healthcare system. NUMERATOR: Number of people receiving ARV treatment in 2004-2005 = 380. Assuming that 5% of the estimated 60,000 people in Iran who are HIV-positive have reached the advanced stage of the disease, some 3,000 persons should by now have entered the advanced stage.

Value of Indicator
The indicator equals 12.5% for the period 20 November 2004 – 20 November 2005.

Interpretation and Analysis
Procurement and distribution of ARV medication began in Iran’s healthcare network in 1997, when ARVs including Lamivudine, Zidovudine and Indinavir were included in the Iranian pharmacopoeia. Indinavir was subsequently replaced by Nelfinavir. Import licenses for Didanosine, Stavudine and Nevirapine were issued in 2004 and Stavudine and Nevirapine have been available from 2005. National guidelines for the clinical care of HIV/AIDS patients were developed in line with WHO guidelines, and include ARV therapy.

The aforementioned guidelines stipulate that ARV treatment is provided free of charge through MoH-affiliated behavioural disease counselling centres across the country. Until now the funding required to procure ARVs has been supplied by the government. The funding has not been subject to any restrictions in terms on number of patients or prioritisation on the basis of sex, age or social status. Over the past three years, the number of patients on ARV medication has almost quadrupled from 100 to 380.
Since there are an estimated 60-70 thousand persons living with HIV/AIDS in Iran, the actual number of AIDS patients requiring ARV therapy is bound to be significantly greater than the number reported. Furthermore, given the stage of the HIV/AIDS epidemic in Iran, about 5% of infected individuals should by now have entered the advanced stage of the disease. This means that the total number of patients requiring ARV therapy should be about 3,000.

There is a small group of patients currently requiring ARV therapy who receive treatment from the private sector. The size of this group is not known. However, according to the key informants interviewed, they account for less than 5% of the number covered by the public sector.
Over the last five years the government has taken steps to increase access to ARV treatment. By March 2005, 72 of Iran's 328 districts (22%) had at least one centre capable of providing ARV treatment.
Recommendation for Improved Measurement
Strengthening the existing clinical care system

Challenges and Recommendations for Indicator Improvement

A) Challenges
A significant portion of HIV+ persons in Iran remain unidentified.
Service delivery points face qualitative and quantitative constraints in expanding coverage of at-risk and most-at-risk populations.
Most-at-risk populations, which include the largest numbers of HIV+ persons in Iran, tend to be hard to reach.
Inadequate coverage of harm-reduction services, which constitute the link to unidentified HIV+ persons in most-at-risk populations
Limitations of various ARV therapies currently available
Low treatment compliance of IDUs, given that a majority of patients in Iran are in fact IDUs.

B) Recommendations
Legislation to support and improve access to treatment for most-at-risk populations
Advocacy for the full support of policymakers and government officials for complete implementation of the NSP and the activities and objectives therein.
Availability of a greater variety ARVs, in order to increase choice and, therefore, patient compliance as well as coverage of patients requiring special regimens.
Expansion of methadone maintenance treatment in IDUs in order to improve compliance with ARV treatment.
**Tenth Indicator- Blood Safety**

**Purpose**
To assess progress in screening transfused blood units for HIV

**Definition**
Percentage of transfused blood units screened for HIV

**Measurement Tool**
Program monitoring

**Method of Measurement**
Enquiry sent to BTO, which is the country's sole blood donation, processing and transfusion service.

**Content of Enquiry**
What percentage of donated blood units are screened for HIV in accordance with the National Protocol?

**Value of Indicator**
100% of the blood units are screened against HIV by the ELISA method.

**Interpretation and Analysis**
HIV screening of donated blood was introduced in 1989. Recent years have seen greater efforts in selecting donors. One example is the elimination of the requirement for blood replacement against transfused blood. Hence, donors are now being selected on the basis of very precise criteria for the prevention of blood-borne diseases. Furthermore, all blood products are processed in accordance with international standards.
Eleventh Indicator- Most-At-Risk Populations: Knowledge about HIV Prevention

Purpose
To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations

Definition
Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Measurement Tool
Given the absence of any surveys on the above subject, other studies in this regard were used to give a picture of the indicator

Method of Measurement
Use of studies which include special surveys of most-at-risk populations and which have recorded responses to the following questions:

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

The indicator requires that the portion of respondents giving correct answers to all questions as well as to each individual question be determined. Given the significance of injecting drug use in Iran, data on necessary knowledge for preventing the transmission of HIV through injection has also been included.

Value of Indicator
At present, there are no national-scale surveys of most-at-risk populations to evaluate their level of awareness of HIV prevention essentials. There are scattered studies of most-at-risk populations; the following are the most relevant findings:

Injected Drug Users: In a study conducted in 2005 in three Tehran neighbourhoods, of which two had ongoing needle and syringe programs, 600 IDUs (all male) were surveyed. 521 (87%) answered correctly to question two, 139 (23%) to question four, and 183 (30%) to question three. 165 (27.5%) responded correctly to both questions two and three while the number of correct responses to both questions two and four was 125 (21%).

Sex workers: A survey of a small sample of runaway girls/sex-workers in Tehran found that from the 54 persons asked, questions two and three received 27 (50%) and 25 (46%) correct responses, respectively.

Inmates: A study involving 350 prison inmates, conducted in 2001 in the city of Kermanshah, found that questions one, three, four and five received 84.3%, 95.2% 51.7% and 72.5% correct responses, respectively. The same study showed that 95.2% of the inmates knew that sharing syringes and needles could transmit the infection.
There are no studies focusing on men who have sex with men.

**Interpretation and Analysis**
These studies do not reflect conditions nationwide, yet it seems that the level of awareness is lower than desirable among most-at-risk populations.

**Recommendation for Improved Measurement**
Regular surveys of the target population

**Strengths, Challenges and Recommendations for Indicator Improvement**

**A) Strengths**
The existence of articles in the Fourth Development Plan Law obligating the government to undertake harm-reduction measures for drug users and vulnerable population groups, as well as involving the public, non-government sectors and requiring the provision of skills based education (Articles 86 and 97 of the Fourth Development Plan Law).
The existence of articles in the Fourth Development Plan Law obligating the government to license candidate service delivery points for most-at-risk populations (vulnerable women, street children and drug abusers), having duly examined the applications. (Article 26). This Article provides for private sector participation in such fields.
Existence of a circular issued by Iran's Head of the Judiciary backing syringe/needle programs for IDUs.
Implementation of harm-reduction interventions in Iran's prison facilities.

**B) Challenges**
Absence of pervasive programs to educate most-at-risk populations, which tend to be hard-to-reach.

**C) Recommendations**
Changes in legislation on most-at-risk populations in order to facilitate service delivery including education.
Advocacy for policymakers and government officials to fully support implementation of the NSP and the activities and objectives therein.
Twelfth Indicator- Sex Workers: Condom Use

**Purpose**
To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients

**Definition**
Percentage of female and male sex workers reporting the use of a condom with their most recent client

**Measurement Tool**
Given the absence of any surveys on the above subject, other studies were used to give a picture of the indicator

**Value of Indicator**
At present there are no national-scale studies of this indicator. However, in a cross-sectional study of 149 female sex workers in police custody, 124 (83.2%) reported regular use of condoms. Another small-scale cross-sectional study of 54 runaway sex-worker girls showed that 24% of them used condoms in over 95% of their sexual contacts.

**Interpretation and Analysis**
As can be seen the indicator calculated here is somewhat different from the indicator intended by the guidelines. Furthermore the populations of the two cited studies cannot be considered representative of the sex worker as a whole.

**Recommendation for Improved Measurement**
As part of a BSS in most-at-risk populations, regular studies of sex workers need to be designed and implemented. In addition to behavioural research, studies are needed to estimate the size of sex workers populations in different regions.

**Recommendations for Indicator Improvement**
Increased access to sex workers through cooperation of NGOs
As part of positive prevention programs, HIV+ individuals should be encouraged to use condoms through proper counselling
Thirteenth Indicator- Men Who Have Sex with Men: Condom Use

**Purpose**
To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

**Definition**
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

**Value of Indicator**
Since there have been no randomised trials or cohort studies in this regard, no data is available on the subject.

**Recommendation for Improved Measurement**
Despite strong stigma and social taboos, there are indications from various sources that some men have sex with men either regularly or occasionally. Implementing small-scale concentrated studies can help further identify these individuals while reducing sensitivity against wider studies.
Existing surveillance sites across the country can include questions about MSM and MSM practices so that the data gathered could be used as the basis for further activities.

**Recommendations for Indicator Improvement**
Current centres that deliver harm-reduction, STD and VCT services need to be made more proactive regarding MSM by asking clients about such potential behaviour and providing the necessary information in this regard.
Fourteenth Indicator- Injecting Drug Users: SafeInjecting and Sexual Practices

Purpose
To assess progress in preventing IDU-associated HIV transmission

Definition
Percentage of IDUs who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid sharing equipment and use condoms in the last month

Measurement Tool
Given the absence of any surveys on the above subject, studies that addressed questions pertinent to the indicator are used to give a picture of the indicator.

Method of Measurement
Use of studies which include special surveys of IDUs and which have recorded responses to the following questions:
Have you injected drugs at any time in the last month?
If the answer is “yes:” Have you shared injecting equipment at any time in the last month?
Have you had sexual intercourse in the last month?
If the answers to questions 1 and 3 are both “yes:” Did you or your partner use a condom when you last had sex?

Value of Indicator
At present there are no national scale surveys on the subject. However, in a study conducted in 2005 in three neighbourhoods in Tehran, 589 IDUs (all male) were surveyed who had a history of at least one injection in the one month period prior to the study. 23.1% (136 persons), 26.4% (156 persons) and 25.6% (40 persons out of 156) gave affirmative responses to questions 2, 3 and 4, respectively. 156 cases had both injected drugs and had sexual intercourse over the previous month. Of these 19.8% had both avoided shared injection over the previous month and used condoms in their last sexual intercourse.

Interpretation and Analysis
These studies do not reflect conditions nationwide, as two out of the three neighbourhoods were sites of harm-reduction interventions. Yet it seems that more effort is needed to promote condom use and encourage avoidance of shared injection equipment among IDUs.

Recommendation for Improved Measurement
As part of a BSS in most-at-risk populations, regular studies of IDUs need to be conducted.

Strengths, Challenges and Recommendations for Indicator Improvement
A) Strengths
The existence of articles in the Fourth Development Plan Law obligating the government to undertake harm-reduction measures for drug users and vulnerable population groups, as well as involving the public, non-government sectors and requiring the provision of skills based education (Articles 86 and 97 of the Fourth Development Plan Law).
The existence of articles in the Fourth Development Plan Law obligating the government to license candidate service delivery points for most-at-risk populations (vulnerable women, street children and drug abusers), having duly examined the applications. (Article 26). This Article provides for private sector participation in such fields.
The increasing focus on harm reduction approaches by experts dealing with most-at-risk populations, which, together with policymakers' positive attitude, helps facilitate the implementation of relevant programs.
B) Challenges
In addition to the shortage of centres, there are also insufficient human and financial resources made available to improve qualitative and quantitative coverage of vulnerable and most-at-risk populations.
The most-at-risk populations tend to be also the hardest to reach

C) Recommendations
Legislation that protects most-at-risk populations’ access to service delivery points
Comprehensive support by policymakers and state officials for full implementation of the NSP to Control HIV/AIDS and the activities and objectives stated therein.
**Fifteenth Indicator - Young People: Knowledge about HIV Prevention**

**Purpose**
To assess progress towards universal knowledge of the essential facts about HIV transmission

**Definition**
Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

**Measurement Tool**
Given the absence of any surveys on the above subject, studies that addressed questions pertinent to the indicator are used to give a picture of the indicator

**Method of Measurement**
Use of studies which include special surveys of most-at-risk populations and which have recorded responses to the following questions:
1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?
The indicator requires that the portion of respondents giving correct answers to all questions as well as each individual question be determined.

**Value of Indicator**
At present there are no national surveys of the subject in this age group. However a number of studies have been conducted in this regard in Tehran and a number of other cities. In a 2003 study of 1,172 15-65 year-olds in Tehran—half males and half females—28% under the age of 24, 92%, 65.4% and 53% of respondent gave correct answers to questions one, three and four, respectively. Questions two and five were not specifically asked but 86.9% and 68.9% of the respondents, respectively, knew that the infection cannot be transmitted through shaking hands or coughing and sneezing. Results did not vary on basis of gender. A 2002 study of 15-17 year-old high-school students in Tehran found that out of a total of 4,641 persons 96%, 96%, 67% and 87% responded correctly to questions one, two, four and five, respectively. Question three was not asked.

**Interpretation and Analysis**
These figures do not reflect conditions nationwide. Yet it seems that knowledge about the sexual transmission of HIV has reached acceptable levels. However, in rejecting misconceptions about HIV, particularly the idea that one could tell who is infected by their appearance, further education is clearly needed.

**Recommendation for Improved Measurement**
Launching regularly planned surveys of the target population

**Strengths, Challenges and Recommendations for Indicator Improvement**

**A) Strengths**
A national literacy rate that exceeds 80%

**B) Challenges**
The fact that Iran's population is relatively young
Negative attitudes of some key decision-makers and policymakers on sexual education

C) Recommendations
Introduction of skills-based education as defined under the fifth indicator
Utilization of mass media
Regularly planned information mobilizations
Sixteenth Indicator- Sex before the Age of 15

Purpose
To assess progress in increasing the age of first sexual contact in young people aged 15–24

Definition
Percentage of young people who have had sex before the age of 15

Measurement Tool
Given the absence of any surveys on the above subject, studies that addressed questions pertinent to the indicator are used to give a picture of the indicator

Method of Measurement
Youth respondents were asked whether they had ever had penetrative sex; if they answered “yes”, they were asked at what age they had first had sex.

Value of Indicator
There is no nationwide study in this regard for this target group. However a 2003 study of 15-18 year old Tehran boys revealed that 27.7% had already had sex. That is, about 30% of young men under the age of 18 have a history of sexual activity.

Interpretation and Analysis
The study does not reflect conditions nationwide but does reflect that at least in Tehran age at first sex is alarmingly low.

Recommendation for Improved Measurement
Launching regularly planned surveys of the target population

Challenges and Recommendations for Indicator Improvement
A) Challenges
Reluctance of some authorities in accepting the concept of sexual education.
Denial by some authorities regarding some of the critical problems facing Iran's youth.
The fact that Iran's population is relatively young

B) Recommendations
Introduction of skills-based education as defined under the fifth indicator
Utilization of mass media
Regularly planned information campaigns
Seventeenth Indicator- Higher-Risk Sex among Young Women and Men

Purpose
To assess progress in reducing the percentage of young people aged 15–24 who have higher risk sex

Definition
Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months

Measurement Tool
Given the absence of any surveys on the above subject, studies that addressed questions pertinent to the indicator are used to give a picture of the indicator

Method of Measurement
Survey studies of youth were used in which respondents were asked about their marital status and their last three sexual partners within the preceding 12 months. For each partner, details need to have been taken of cohabiting status as well as duration of the relationship, condom use and other factors.

Value of Indicator
At present there is no national-scale study on the subject for this age group. However one study were conducted in Tehran in which questions relevant to the indicator were asked. In a 2003 study of 15-18 year old boys in Tehran 27.7% were found to have had sex at least once. Of these 71.7% had had more than one sexual partner.

Interpretation and Analysis
These figures do not reflect conditions nationwide, yet it seems that high-risk sexual behaviour in at least some segments of Iran's youth has alarming dimensions.

Recommendation for Improved Measurement
Launching regularly planned surveys of the target population

Strengths, Challenges and Recommendations for Indicator Improvement
A) Strengths
A national literacy rate that exceeds 80%

B) Challenges
1. The fact that Iran's population is relatively young
2. Widespread negative attitudes throughout the country on sexual education.

C) Recommendations
1. Introduction of skills-based education as defined under the fifth indicator
2. Utilization of mass media
3. Regularly planned information campaigns
4. Expansion of educational programs in smaller groups using peer education.
Eighteenth Indicator- Young People: Condom Use with Non-Regular Partners

**Purpose**
To assess progress towards preventing early-age exposure to HIV through unprotected sex with non-regular partners.

**Definition**
Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner.

**Measurement Tool**
Given the absence of any surveys on the above subject, studies that addressed questions pertinent to the indicator are used to give a picture of the indicator.

**Method of Measurement**
Survey studies of youth were used in which respondents were asked if in the past 12 months they had had sexual intercourse with a non-regular partner who was neither a spouse nor someone they were living with and also asked about condom use the last time they had sex with their most recent non-regular partner. Indicator value is the ratio of respondents that reply affirmative to both questions (numerator) to the number of respondents that have had non-regular sexual partners (denominator).

**Value of Indicator**
Due to lack of required data based on surveys of young people the value of the indicator cannot be ascertained.

**Interpretation and Analysis**
Based on the statistics available for 2004-2005, the population of Iran's 15-24 year olds was estimated at 17 million, which constituted 24.4% of total population of 70 million. Taken together with the increase in mean age at marriage (DHS2000), indications are that non-regular sexual relationships occur frequently among Iran's youth. Yet, due to socio-cultural (and ethical) restrictions on behavioural surveys in this age group, the necessary data regarding youth sexual health, high-risk behaviour and social norms is not available.

**Recommendation for Improved measurement of the Indicator:**
Periodic surveys of the youth.

**Strengths, Challenges and Recommendations for Indicator Improvement**

A) **Strengths**
Potential capacity of a number of institutions with wide coverage across the country to implement HIV prevention programs for young people aged 15-24.

B) **Challenges**
The fact that Iran's population is relatively young
Various barriers to provision of sex education
Inadequate participation of institutions involved in youth affairs in HIV/AIDS prevention

C) **Recommendations**
Implementation of skills-based educational programs for youth, especially in schools
Implementation of harm reduction programs for high-risk sexual behaviours through:
Efforts to delay sexual debut
Efforts to reduce the prevalence of high-risk sexual behaviour
Ease access to condoms for young people and social marketing of condoms
Sensitization and involvement of youth institutions in HIV/AIDS control issues
**D- IMPACT INDICATORS**

**Nineteenth Indicator- Most-at-Risk Populations: Reduction in HIV Prevalence**

**Purpose**
To assess progress on reducing the HIV prevalence rate among most-at-risk populations

**Definition**
Percentage of persons in most-at-risk populations who are HIV-infected

**Measurement Tool**
Serologic Surveys

**Method of Measurement**
Examinations of studies based on serologic surveys

**Value of Indicator**

**Most-at-Risk Populations: Reduction in HIV Prevalence**

There is, at present, no national study of most-at-risk populations aiming to find the prevalence of HIV infection. Nevertheless, the following relevant studies were available:

In a 2003 study of 165 IDUs referred to three drug addiction treatment clinics, the prevalence of HIV among injecting drug users was found to be 15.2%. Data from other studies and surveys throughout the country indicate that the prevalence of HIV varies considerably from region to region, ranging from 5% to 25% among IDUs.

Two small-scale studies in Tehran placed the prevalence of HIV among female sex workers at zero. Even though some reports suggest much higher HIV prevalence among female sex workers, such reports usually refer to sex workers who are also IDUs.

At present, it is not possible to make any calculation about prevalence among other most-at-risk populations.

**Interpretation and Analysis**

The findings of the study on IDUs cannot be extrapolated to the country as a whole. The sample population was based on admissions to a single clinic and cannot be considered a fairly random sample of the entire IDU population. Nevertheless the figure seems to indicate that the prevalence of HIV in the population under study has passed the critical phase.

**Strengths, Challenges and Recommendations for Indicator Improvement**

**A) Strengths**
1. The existence of articles in the Fourth Development Plan Law obligating the government to undertake harm-reduction measures for drug users and vulnerable population groups, as well as involving the public, non-government sectors and requiring the provision of skills based education (Articles 86 and 97 of the Fourth Development Plan Law).
2. The existence of articles in the Fourth Development Plan Law obligating the government to license candidate service delivery points for most-at-risk populations (vulnerable women, street children and drug abusers), having duly examined the applications. (Article 26). This Article provides for private sector participation in such fields.
3. The increasing focus on harm reduction approaches by experts dealing with most-at-risk populations, which, together with policymakers' positive attitude, helps facilitate the implementation of relevant programs.

**B) Challenges**
1. Most-at-risk populations, which include the largest numbers of HIV/AIDS patients in Iran, tend to be hard to reach
2. Existence of laws that lead to repeated imprisonment of drug users, thus increasing the risk of the associated harms. (Fortunately, many of these laws are in the process of being amended).

3. Strong negative attitudes of some authorities towards sex workers, which often makes the very mention of the subject difficult.

C) Recommendations
1. Legislating laws to support most-at-risk populations to facilitate service delivery, including IEC, in order to limit the harms associated with high-risk behaviour.
2. Comprehensive support by policymakers and state officials for full implementation of the NSP to Control HIV/AIDS and the activities and objectives stated therein.
Twentieth Indicator- HIV Treatment: Survival after 12 Months on Antiretroviral Therapy

Purpose
To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy

Definition
Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

Measurement Tool
Program monitoring

Method of Measurement
Enquiry sent to HIV/AIDS treatment centres

Content of Enquiry
Number of individuals receiving treatment in March 2004
Number of persons receiving ARV therapy in March 2004 who were still alive in March 2005
Number of persons receiving treatment in March 2004 who were not retained by March 2005 for reasons other than death
Number of persons receiving treatment in March 2004 who died over the following year

Value of Indicator
Value of the indicator for 2004-2005 was 93%

Interpretation and Analysis
Enquiries were sent two major centres in Tehran with the greatest experience and history in HIV/AIDS services. Therefore it is likely that survival rates may be lower at other centres across the country.

Recommendation for Improved Measurement
Strengthening the existing clinical care system while emphasizing annual data collection

Challenges and Recommendations for Indicator Improvement
A) Challenges
Limitations of various ARV therapies currently available in Iran
Reduced survival because of greater mortality rates in IDUs, who account for the majority of HIV/AIDS patients in Iran, compared with the general HIV+ population

B) Recommendations
1. Further diversification of ARV medications, despite recent improvements, in order to make a greater variety of regimens available, increase patient compliance and coverage of patients requiring special regimens.
2. Directly observed treatment for some patients.
Twenty First Indicator- Reductions in Mother-to-Child Transmission

Purpose
To assess progress in towards eliminating mother-to-child HIV transmission

Definition
Percentage of infants born to HIV infected mothers who are infected

Measurement Tool
Estimates based on program coverage

Method of Measurement
Use of the following equation:

\[ \text{Indicator score} = \{T \ast (1-e) + (1-T)\} \ast v \]

where

- \(T\) = proportion of HIV-positive pregnant women provided with antiretroviral treatment
- \(v\) = MTCT rate in the absence of any treatment
- \(e\) = efficacy of treatment provided

Based on indicators calculated in the present report \(T = 6.8\%\).
Given the lack of studies on the values of \(e\) and \(v\) these variables are assumed to be 25% and 50%, respectively, as recommended internationally.

Value of Indicator
Indicator value for 2004-2005 equals:
\[ \{0.0217 \ast (1-0.50) + (1-0.0217)\} \ast 0.25 = 0.24 \]

Interpretation and Analysis
As the indicator values shows, since coverage of PMTCT programs is low in Iran, consequently the rate of MTCT would be high.

Recommendation for Improved Measurement
In the general population: periodic (biennial) studies to ascertain the prevalence of HIV among pregnant women in the general population.
Among most-at-risk populations: Prevalence of HIV among pregnant women in the most-at-risk populations must be determined using studies and establishing Sentinel sites.
Necessary steps must be taken to provide an accurate estimate of the total population of most-at-risk women of reproductive age.

Recommendations for Indicator Improvement
A) Strengths
Adequate health infrastructure, skilled human resources and free ARV medication in Iran
Widespread access to ANC in Iran and utilization of services by 95% of pregnant women

B) Challenges
A large portion of HIV+ women —especially pregnant HIV+ women— remain unidentified.

C) Recommendations
Improvement of VCT centres in order to facilitate utilization by women
Needs assessment for IEC material to enhance awareness and motivation among most-at-risk women
Sensitization of care providers, including those in the private sector, to conduct risk assessment in all patients
Recommending VCT to the spouses and sexual partners of all men infected by HIV
Major Challenges Faced and Actions Needed

The major challenges and recommended corrective actions as follows:

1- Implementation of the 5-Year NSP for HIV/AIDS Control

Challenges
A) Limited funding for complete implementation of the NSP and absence of a separate funding program for HIV/AID control in Iran's fiscal budget law.
B) Absence of national level coordination in the implementation of the NSP
C) Disparity between current human resources capacity and that stipulated by the plan.
D) Absence of a National M&E Plan to oversee the activities of all sectors involved
E) The taboo associated with high-risk behaviour and thus the difficulty in reaching most-at-risk populations
F) Insufficient support from policymakers for implementation of HIV/AIDS control programs
G) Insufficient civil society participation in the development and implementation of policies.

Actions Needed
A) Clarifying the negative economic, social and cultural consequences of the epidemic for policymakers, and advocacy for:
   1. Sufficient resource allocation for equipment, human resources and funding
   2. Legislating laws that support and protect PLHIV
   3. Legislating laws needed for further facilitation of access to most-at-risk populations.
B) Review of the 5-year NSP in order to develop the next strategic plan, based on prioritization of activities and services within the framework of existing capacities and potentials.
C) Re-activation of the NAC in order to achieve unified macro-management of activities envisaged in the NSP
D) Development and implementation of the National M&E Program for oversight of activities and achievement of time-bound objectives
E) Preparing an environment conducive to active participation of civil society in policy development and implementation.

2- Service Delivery to Most-at-Risk Populations

Challenges
A) Inaccessibility of the IDU population (despite positive achievements in this regard as a result of policies adopted in recent years).
B) Limited nature of services provided for other most-at-risk populations such as female sex-workers and MSM, due to lack of access to these populations
Actions Needed
A) Increased coverage of harm reduction services particularly by utilization of peers within most-at-risk populations
B) Advocacy among policymakers in order to amend legislation, to the extent possible, in order to facilitate access and delivery of services to most-at-risk population

3- Young People, especially given the key significance of this population in controlling the HIV/AIDS epidemic and given the fact that the Islamic Republic of Iran has a young population

Challenges
A) Absence of developed life-skills education curriculum at schools
B) Inadequate knowledge of young people's behaviour and level of awareness
C) Prevailing social and cultural restrictions against sexual education and public information campaigns in this regard.
D) Failure of some adolescents and youth to complete secondary (guidance and high school level) education

Actions Needed
A) Setting up regular, periodic and scientific surveys to obtain sufficient knowledge of the level of awareness and behaviour of youth as well as the harms that target this population.
B) Implementation of pilot projects to determine and develop the most appropriate means for education and information in order to achieve widespread interventions on a national scale in the shortest time possible.
C) Advocacy among policymakers regarding implementation of skills-based education and sexual education, in particular given the successful advocacy among policymakers and political leaders for implementing harm reduction programs for IDUs). With proper planning and clarification of dangers resulting from ignoring sexual education this task should be possible to achieve.
It is noteworthy that religious texts also tend to be candid is discussing sexual issues.

4- Private Sector Service Delivery

Challenges
A) Lack of private sector involvement in the delivery of HIV/AIDS prevention and control services despite its widespread presence throughout the country.
B) Lack of knowledge regarding guidelines, activities and objectives of the NSP among certain segments of private sector leading to some private sector activities that fall outside the planned framework.

Actions needed
A) Development and implementation of IEC programs for the private sector in order to familiarize it with guidelines and activities for prevention of more-or-less unacceptable behaviours.
B) Discovering the existing potentials in the private sector and guiding them towards HIV/AIDS control and prevention services.
C) Advocacy among policymakers

5- NGO Service Delivery

Challenges
A) Limited number of NGOs
B) Limited number of NGOs capable of delivering HIV/AIDS services
C) Absence of a network to connect the existing NGOs across the country
D) Weakness of ties between GOs and NGOs
**Actions Needed**

A) Government facilitation of:
   1. Formation of new NGOs,
   2. Stronger relations between the government and NGOs
   3. NGO capacity building in the delivery of HIV/AIDS services

B) Laying the grounds for increased NGO participation in HIV/AIDS service delivery

C) Foster cooperation between NGOs throughout the country

D) Advocacy among policymakers
Monitoring and Evaluation Environment

The National M&E Committee was established in 2003 pursuant to the Council of Ministers' approval of the bylaws for the High Council for Planning HIV/AIDS Prevention. Committee members comprise mainly representatives of medical universities. Other sectors engaged in HIV/AIDS control are not represented.

The Committee has failed to develop and implement a comprehensive plan for the evaluation of the activities undertaken thus far but is in the process of developing a plan for M&E of such activities. Its objectives are roughly defined along three levels of structural, process and outcome evaluation. Monitoring of HIV/AIDS prevention and control programs in Iran has heretofore focused on data produced through the activities of medical universities, for the most part, as well as those from PO, SWO, BTO and IRCS. However no specific unit is charged with the responsibility of implementing the decisions of the National M&E Committee or with the task of program M&E generally for all sectors throughout the country.

Nevertheless members of the Committee have compiled M&E checklists based on the NSP to monitor the performance of subcommittees at province level. The checklists were piloted in one province as of September 2004.

Over the recent past, M&E activities have included regular serologic surveys at a specific time of the year, annually. Over 80 survey posts have been set up for this purpose, of which 75% are located inside prison facilities and the rest collect data on pregnant women, truck drivers and clients of STD clinics. The collected data is conveyed to the MoH for program monitoring.

The following actions are recommended for improvement of the program M&E environment:

1. Training human resources and utilization of international experience
2. Participation of all bodies active in HIV/AIDS control measures in the National M&E Committee
3. Development of a national M&E plan
4. Development of guidelines for implementing M&E.
5. Development of the major and minor indicators to provide for activity evaluations that make outcomes comparable with those of other sectors and other countries.
Fifth Episode

Support Required from Iran's Development Partners

- Provision of financial resources: So far the share of Iran's development partners has been insignificant in financing the funds needed for the prevention and control of HIV/AIDS
- Provision of technical and logistical support for implementation of HIV/AIDS control activities
- Facilitation of Iran’s access to ARV medication at discounted rates
- Development of international training courses for Iran’s HIV/AIDS planners and service providers
- Facilitating experience exchanges for countries with similar social, economic and geographical conditions.
- Evaluation of activities implemented by international consultants and recommendation of appropriate solutions to any weaknesses found.
- Provision of software applications useful in the implementation of activities
- Assisting the formation of competent regional networks of NGOs active in the delivery of HIV/AIDS services
- Sensitization of states with HIV prevalence at—or on the verge of—the critical stage
- Encouraging leading global producers of consumer goods to promote the prevention and control of HIV at least in their products for adults (shaving equipment, cigarettes, etc.)
- Coordination among NSP stakeholders and HIV/AIDS prevention and control affairs.
References

1. Center for Disease Management, Annual Table of Identified HIV Cases by Gender and Means of Transmission, 2005, (unpublished)
2. Center for Disease Management, Latest HIV Figures in Iran 2005 Q4, Dec 30th 2005
4. HIV/AIDS prevalence Map for Different Provinces by the Number of Reported Cases, 2005, (unpublished)
Appendices

Appendix 1: Consultation/preparation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1. Which institutions/entities were responsible for filling out the indicator forms?
   a) NAC or equivalent  
   b) NAP  
   c) Others

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<td>NAC or equivalent</td>
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<tr>
<td>NAP</td>
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2. With inputs from Ministries:

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<td>Foreign Affairs</td>
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<tr>
<td>Others</td>
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</tbody>
</table>

   Including DCHQ, Prisons Organization, academia, PLHIV, NGOs, UN agencies, SWO, BTO, IRCS

3. Was the report discussed in a large forum?  
   Yes  No

4. Are the survey results stored centrally?  
   Yes  No

5. Are data available for public consultation?  
   Yes  No

Appendix 2: National Composite Policy Index Questionnaire (through CRIS)

Appendix 3: National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)