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An Evaluation of UNAIDS Joint Programme Country Envelopes: 2018–2022

Country case studies

Iran

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TABLE OF CONTENTS

Abbreviations and Acronyms **3**

1 Introduction and Context **4**

1.1 Purpose and scope of the case study 4

1.2 Approach/Methods/Limitations 4

2 National HIV Context and Programme Response **4**

2.1 Overview of the epidemic 4

2.2 National HIV policy and programmatic response 6

2.3 National response challenges and priority areas/gaps that need addressing 7

2.4 Financing of the national response 7

3 UNAIDS Joint Programme Strategic Orientation and Programme Approaches **8**

3.1 Joint Programme and Joint Plans 8

3.2 Overview of Joint Team Cosponsors Funding 9

4 Case Study Findings **14**

4.1 Evaluation Question Findings Related to Relevance and Coherence 14

4.2 Evaluation Findings Related to Efficiency and Effectiveness 15

4.3 Evaluation Findings Related to Results and Sustainability 19

5 Theory of Change **25**

6 Conclusions and Considerations Going Forward **28**

Annexes **30**

Annex 1 People/Groups Met and/or Interviewed **30**

Annex 2: Documents Reviewed and/or Referenced **32**

Annex 3: Evaluation Questions **35**

Annex 4: More Detailed Information **38**

Annex 5: 'Deep dive' **44**

Table of Figures

Figure 1: Country Envelope Funds Allocation per Annum, per Cosponsor 10

Figure 2: Strategic Domains 2018-2023 13

Figure 3: DSD Implementation Model in Selected VCT Centres 42

Table of Tables

Table 1: HIV and AIDS Estimates 5

Table 2: HIV Prevalence by Group 5

Table 3: HIV Transmission Pattern 5

Table 4: Links from CE Funds Allocation to NSP5 8

Table 5: Overview of Funding 9

Table 6: Allocation, Expenditure, and Absorption Data per Cosponsor in 2018 -2023 10
Table 7: Specific Overview of Country Envelope 11
Table 8: CE Funds Allocation to COVID-19 in 2020-2021 18
Table 9: Links from CE Anticipated Results/Outputs to UBRAF 21
Table 10: Theory of Change: Country Envelope Funding Model 25
Table 11: Challenges/Gaps of NSP4 38
Table 12: UN Agencies Financial Support to NSP4...38
Table 13: High Priority Areas of the Joint Programme on AIDS 38
Table 14: Country Envelope Allocation per Annum, per Cosponsor, per Strategy Result Area 39
Table 15: CE Funds Allocation by Anticipated Results 39
Table 16: Cosponsor Presence and Capacity for Implementation of 2022-2023 Joint UN Plans 41
Table 17: UNAIDS Technical Support Division of Labour 42
Table 18: Catalytic Character of DSD 48

ABBREVIATIONS AND ACRONYMS

ART	Antiretroviral Therapy
BUF	Business Unusual Funds
CDC	Centre for Disease Control
CE	Country Envelope
CSO	Civil Society Organization
DCHQ	Drug Control Headquarters
DIC	Drop-In-Centres
DSD	Differentiated Services Delivery
DoL	Division of Labour
EMTCT	Elimination of Mother-to-Child Transmission
EQ	Evaluation Question
FSW	Female Sex Worker
The Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIVHUB	HIV/STI Surveillance Research Centre
HMIS	Health Management Information System
HPV	Human Papillomavirus
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance
IRCHA	Iranian Research Centre for HIV/AIDS
JPMS	Joint Programme Monitoring System
JUNTA	Joint UN Teams on AIDS
KP	Key Population
MoHME	Ministry of Health and Medical Education
MSM	Men Who Have Sex with Men
NAP	National Aids Programme
NGO	Non-government Organization
NSP	National Strategic Plan
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-exposure Prophylaxis
PHC	Primary Health Care
PWID	People Who Inject Drugs
RTD	Rapid Test Device
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
S&D	Stigma and Discrimination
SWO	State Welfare Organization
UBRAF	Unified Budget Results and Accountability Framework
UCD	UNAIDS Country Director
UHC	Universal Health Coverage
UNSDCF	United Nations Sustainable Development Cooperation Framework
VCT	Voluntary Counselling and Testing

1 INTRODUCTION AND CONTEXT

1.1 Purpose and scope of the case study

The case study on Iran is part of a wider evaluation which aims to assess the relevance, coherence, efficiency, effectiveness, sustainability, and results of the UNAIDS country envelopes over the years 2018-2022, with a view to improving UNAIDS programming and results achieved through the United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The scope of this case study was defined by the following questions:

- Is Iran among the countries in greatest need of the country envelope (CE)?
- Does the CE address the priority gaps and needs of the national response?
- Does the CE contribute to a more strategic, prioritised and coordinated joint planning process?
- How efficient and effective is the CE funding mechanism?
- How are the results of CE funding contributing to UBRAF outputs and higher-level results, and
- Are there alternative allocation and disbursement models for joint funding?

1.2 Approach/Methods/Limitations

The case study on Iran focused mainly on qualitative analysis of Joint Team plans and the implementation and results of CE-funded activities. It was conducted in July and August 2022, through document review and meetings with different stakeholders (See Annex 1 and Annex 2). Altogether 12 interviews were conducted with staff of the UNAIDS Country Office and Cosponsors, and government ministries (involving 11 individuals) both face to face and using Microsoft Teams (due to the COVID-19 situation). Additionally, four separate group discussions were organized with Cosponsor focal points for HIV, members of the National AIDS Council, research institutes and academics, and KP-led networks and non-government organizations (NGOs). A separate meeting was held with the National HIV Care and Treatment Advisor to explore detailed information on Differentiated Service Delivery (DSD), one activity of strategic importance. The evaluation also included a visit to a comprehensive HIV health centre in Malard in Tehran province.

The UN Joint Team on HIV/AIDS in Iran has implemented a total of 46 activities funded through CEs from 2018-2022. These activities, in line with the global AIDS strategies, aimed to fast track progress towards reducing new HIV infections, discrimination and AIDS-related deaths to zero. During this period, 17 CE-funded activities focused on HIV testing and treatment and 23 of them on prevention of HIV. The other 6 activities mainly supported the national response to AIDS in terms of investment and efficiency based on reliable strategic information. Due to the limited time available to conduct the country study it was not possible to conduct an in-depth evaluation of each CE-funded activity. Yet, the collected evidence and answers to ten overarching evaluation questions (EQs) (see Annex 3) helped understand how the CEs in Iran have contributed to relevance, coherence, efficiency, effectiveness and sustainability and results.

2 NATIONAL HIV CONTEXT AND PROGRAMME RESPONSE

2.1 Overview of the epidemic

The total population of Iran is 84,533,127, of which 75.5 % live in urban areas.[1] The total sex ratio at birth is 103. The latest data on HIV and AIDS in Iran (Table 1) estimated that about 53,000 people are living with HIV (PLHIV). According to the most recent officially released data, 81% of PLHIV are men.

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[1] https://www.amar.org.ir/english (As retrieved on 07/20/2022)

Table 1: HIV and AIDS Estimates

Adults and children living with HIV	53000 [38000 - 140000]
Adult aged 15 to 49 HIV prevalence rate	<0.1 [<0.1 - 0.3]
Adults and children newly infected with HIV	2200 [<1000 - 13000]
HIV incidence per 1000 population (adults 15-49)	0.04 [0.02 - 0.25]
Adult and child deaths due to AIDS	3500 [2200 - 8800]
Orphans due to AIDS aged 0 to 17	34000 [25000 - 50000]

Source: Country Factsheets of Iran (Islamic Republic) for 2021

As seen above, HIV incidence among the general population is low. In other words, HIV in Iran is a concentrated epidemic, affecting certain groups that are at higher risk for infection. Table 2 gives the latest official data on these high-risk groups in the country.

Table 2: HIV Prevalence by Group

High Risk Groups	Population Size Estimate (#)	HIV Prevalence (%)
People who inject drugs	90000	3.1
Sex workers	138000	1.6
Prisoners	172000	0.82
Transgender people	10000	N/A

Source: Country Factsheets of Iran (Islamic Republic) for 2021

A historical review of the HIV prevalence in the country from 1980's up to date shows a shift in the mode of transmission. In the earlier years, people who inject drugs (PWID) that were using shared needles would spread the infection. Sexual contact and mother-to-child transmission (MTCT) were the next common mode of transmission. As shown in Table 3, the HIV epidemic among the general population, pregnant women and blood donors is considered to be lower than the first two categories.

Table 3: HIV Transmission Pattern

Route of Transmission	Cumulative Caseload (1986-2021)		Recent Pattern (Mar-Sep 2021)	
	#	%	#	%
Injecting Drug Use	25,068	57.3	-	16.1
Sexual Contact	10,757	24.6	-	55.3
Mother-to-Child	741	1.7	-	1.3
Blood and Blood Products	89	0.2	-	0.0
Unknown	7097	16.2	-	27.3
TOTAL	43,752	100.0	-	100.0

Source: Latest HIV Statistics for the Islamic Republic of Iran (Year Ending 31 Mar 2022). For public use.

Currently, the HIV incidence has decreased (Ameli, 2021) but concentrated more than ever among key populations (KP) with frequent unsafe injection and sex risk behaviours in PWID, men who have sex with men (MSM), as well as female sex workers (FSW) and their clients. Yet, a steady growth of sexual transmission of the virus is observed (UNAIDS, 2020; Hosseini-Hooshyar, 2021). It has been argued that the reason for the shift is because of popularization of stimulants in around 2010, leading to uncontrolled/unprotected sexual behaviours, especially among the youth (Tavoosi, 2004; Momtazi, 2010; MoHME, 2015; Leylabadlo, 2016; Sharifi, Shokoohi, 2016; 2017; Bagheri, 2018; Merghati Khoei, 2018; Darvishzadeh, 2019; Mohebbi, 2019).

Additionally, the ratio between infected women and men has undergone some changes. During 1987 to 2018, about 17% of the total infected KPs were reported to be women (SeyedAlinaghi S.A., et al.

2021). Recently, the epidemic burden is shifting from men to women. The HIV National Case Registry System reported that out of the total registered cases up to the end of 2019, 25% were women (UNAIDS, 2020). According to CDC, most women were infected through sexual contacts where the most common HIV transmission pattern among men is through injecting drug use. According to the same source, the prevalence of HIV among men and women aged 25-39 were the highest. (CDC, 2021)

The trend of HIV in different regions and provinces of the country has already been investigated to some extent (Lotfi, 2018; Musavi, 2018; Moradi, 2019; Nematollahi, 2021; Balooch Hasankhani, 2021;). Yet, many of these studies have resulted in different conclusions; hence the generalizability of the findings is undermined. Inadequate access to comprehensive and reliable data on burden of HIV/AIDS at local level and insufficient HIV case-finding skills in various locations limit the knowledge on trends in HIV incidence and prevalence by region or province or city.

2.2 National HIV policy and programmatic response

In 2003, seventeen years after the first case of HIV was reported in Iran, the Supreme Council for HIV/AIDS Prevention Planning was established and mandated by the Parliament of Islamic Republic of Iran to determine the policies of executive agencies and coordinate the stakeholders. It was also expected to develop plans for prevention and control of HIV/AIDS in the country. Accordingly, the first National Strategic Plan (NSP) for the period of 2002-2006 was developed and included programmes for public awareness, harm reduction for PWID, etc. In 2006, the council was integrated into the Health Supreme Council and Food Security. Since then the National AIDS Council, known in the country as the committee of Supervision of Implementation of HIV Programme (SIP) has formulated and implemented NSP to fight against the disease. The second (2007–2010) and third (2011–15) NSP included more specific training programmes for young people. The fourth one (2016–2020) focused on reaching the UNAIDS 90–90-90 goals by scaling up HIV testing and care services throughout the country and more tailored programmes for KPs.

The first technical consultation for development of the fifth NSP (NSP5) was held in 2019 with the participation of over 50 people, representing different sectors and organizations.[2] The NSP5 (2020-2024) is based on the changes in main factors and HIV epidemic pattern and will complement the previous plan by focusing on four thematic areas of prevention, diagnosis and treatment, support and empowerment, and monitoring and evaluation. The priority has been given to scaling up the HIV case-finding and linkage to care among general as well as KPs, including street children, prisoners, transgender people, MSM, FWS, and PWID. The NSP5 intends to achieve the following main objectives by the end of 2024:

- Prevalence of HIV Infection remains <0.15% among general population
- Prevalence of HIV Infection remains <5% among PWID
- Prevalence of HIV Infection remains <5% among people at risk for STIs
- Rate of HIV infection in alive babies born to HIV-infected pregnant women is reduced by 90%
- AIDS-related mortality decreases by 20%.

Iran provides universal and free access to antiretroviral therapy (ART) through a decentralised model of health delivery across 31 provinces via university hospitals, operating under the joint Ministry of Health and Medical Education (MoHME), providing uniform voluntary counselling and testing (VCT) services for HIV via sites such as Behavioural Disorders Consulting Centres, Drop-In-Centres (DICs), and mobile clinics. Furthermore, some services are offered by Positive Clubs and outreach teams. Behavioural Disorders Consulting Centres are the main sites responsible for providing treatment and

[2] https://www.undp.org/iran/news/three-day-consultative-meeting-held-develop-iran%E2%80%99s-5th-national-strategic-plan-hiv/aids

care for the PLHIV. Altogether, these are various settings in which the national HIV programmes are being carried out. The key service providers are the Centre for Disease Control and Prevention (CDC) of MoHME, State Welfare Organization (SWO) and Prisons Organization. There are also several other government organizations, all members of the SIP, that offer different types of assistance to targeted groups in above-mentioned settings.

The national HIV response by providing access to the above-mentioned services in various settings also contributes to reducing human rights and gender barriers. After Iran joined the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination in 2021, the number of activities to address the needs in this regard increased, including development of protocols for HIV services in humanitarian settings, training health workers to ensure provision of stigma and discrimination (S&D) free HIV services in emergency settings, offering standard training to at least 45% of the PWID on HIV prevention method and correct attitude toward HIV focusing on stigma reduction, adoption of HIV anti-discrimination bylaw for healthcare settings binding them to protect PLHIV and most at-risk populations from S&D, and establishment of HIV related services in legal medicine organization.

It should also be noted that three leading institutes for HIV research, training, and surveillance contribute to the development and implementation of NSP. These institutes are as follows: a) Iranian Research Centre for HIV/AIDS (IRCHA) that was established in 2005 and is a leading centre for HIV clinical management and research; b) HIV/STI Surveillance Research Centre (HIVHUB), which as a World Health Organization Collaborating Centre for HIV Surveillance, was established in 2009; and c) Shiraz HIV/AIDS Research Centre, affiliated to the Shiraz University of Medical Sciences, was established in 2009 with a focus on HIV prevention sciences and behavioural interventions.

2.3 National response challenges and priority areas/gaps that need addressing

It is said that visible changes have occurred in HIV epidemiology regarding gender, modes of transmission, number of paediatric cases and density maps over time in the country, especially in big cities (Mirzaei, 2021; SeyedAlinaghi, 2021; Ameli, 2021;). Development and implementation of the plans that can appropriately respond to these changes have been challenging at times and have required precise targeting of HIV prevention and treatment programmes. One major challenge is reaching target groups, for instance sex workers and homeless PWIDs, that are highly stigmatized and currently illegal in Iran. The NSP4 formulated certain gaps/challenges (Table 11, Annex 4), some of which are still prevailing.

A number of individual HIV specialists and researchers have also categorized the gaps. Taking all these into account, there are certain challenges that the National Aids Programme (NAP) is tackling with. One of them is to overcome prevailing barriers for performing more KP testing to diagnose HIV. Another is the current low linkage and treatment uptake among KP. Mobilizing (peer) community workers as well as NGOs to ensure adherence and retention of KP is not easy when community participation is not as high as needed. Supply chain management is also an issue given the sanctions against Iran and current economic hardship for acquiring and managing essential resources and suppliers. The latter is also affecting HIV research and training programmes.

2.4 Financing of the national response

As the NSP4 and NSP5 documents demonstrate, budgeting the programme is an important and complicated process undertaken by the SIP and its technical working groups and sub-groups. First, certain standards for each activity of the annual plan are determined. Then, based on the needs of

each target group, a set of packages are defined to provide services for HIV/AIDS control, prevention, care and treatment. The next step is deciding upon the cost of required human resources, infrastructures, materials, equipment, etc., for each package of services per year. After specifying the quantitative annual objectives, contribution of each organization within SIP is made clear. The financial support by the UN agencies was indicated for each target group though the figure was not given (Table 12, Annex 4). It is to be noted that the available data on NSP4 and NSP5 do not specify individual UN agency financial support for each target group and set of activities.

3 UNAIDS Joint Programme Strategic Orientation and Programme Approaches

3.1 Joint Programme and Joint Plans

The United Nations Joint Programme on HIV/AIDS in Iran is composed of a Secretariat and 6 UNAIDS Cosponsors. The Joint UN Teams on AIDS (JUNTA) supports the National Programme on AIDS towards the achievement of the goals and targets of the 2021-2026 Global AIDS Strategy through the joint and individual work of the members. The Joint Plans are prepared in alignment with Global AIDS Strategy, UBRAF outcomes, national strategies, and community priorities. The UNAIDS Secretariat organizes joint meetings with focal points of cosponsor organizations and the national partners to ensure the global strategic priorities and the national response are integrated in biennial plans. As well, it takes part in SIP (Committee of Supervision of Implementation of HIV Programme) meetings and acts as technical specialists in SIP working groups. The most recent exercise for joint planning was led by the UNAIDS Secretariat to develop the 2022-2023 Joint UN Work Plan on HIV/AIDS with the collaboration of the JUNTA members, NAP representatives and community partners in 2021. Each group of stakeholders was requested to identify the most pressing needs and gaps regarding the HIV/AIDS programme, especially the ones that UN partners' intervention could possibly make a difference. Table 4 shows how the CE priorities for the recent biennial plans also emerged out of those broader discussion sessions.

Table 4: Links from CE Funds Allocation to NSP5

National Strategic Plan (2020-2024)	UN Joint Plan for 2022-2023 (CE Funds)		Cosponsors
	Strategy Result Area	Activities	
Treatment, care and support - ART	SRA 1- HIV Testing and Treatment	Evidence for Policy	WHO
		Harm Reduction for Iranian and refugee populations	UNDP
			UNHCR
TB/HIV	-		-
Prevention of Mother-to-Child Transmission	SRA 2- Elimination of Mother-to-Child Transmission	Prevention of sexual transmission	UNFPA
		HIV care for children/ adolescents	UNICEF
		COVID-19 resilience of ANC	UNODC[3]

[3] There appear to be discrepancies between data provided in the Joint Plan for 2022-2023 and the JPMS and the MoU between UNODC and UNAIDS. The table shows UNODC contribution to SRA 1. However, from the

<table>
<tr><td>Programmes for men at highest risk for HIV infection</td><td rowspan="6">SRA 3- Tailored HIV Combination Prevention Services for KPs</td><td rowspan="2">Differentiated Service Delivery</td><td rowspan="2">WHO</td></tr>
<tr><td>Programmes for women at highest risk for HIV infection and their clients</td></tr>
<tr><td>Programmes for people who inject drugs (PWID) and their partners</td><td rowspan="2">Harm reduction for PWID and people in prisons</td><td rowspan="2">UNODC</td></tr>
<tr><td>Programmes for transgender populations</td></tr>
<tr><td>Prevention programmes for other key and vulnerable population</td><td rowspan="2">Improving Linkage to Care</td><td rowspan="2">UNICEF</td></tr>
<tr><td>Other Prevention Programmes</td></tr>
</table>

3.2 Overview of Joint Team Cosponsors Funding

Each Cosponsor has got its own sources and strategies for fundraising for its HIV-related projects. Table 5 gives figures for the CE funds as well as other sources for each year after the CE mechanism was introduced in 2018. Since then, the global allocation of the CE funds to Iran has been US$ 300,000 per annum with no change. During this period, no Business Unusual Fund (BUF) was allocated to Cosponsors. In general, the CE funds have been 8.8% of the total funds received since then.

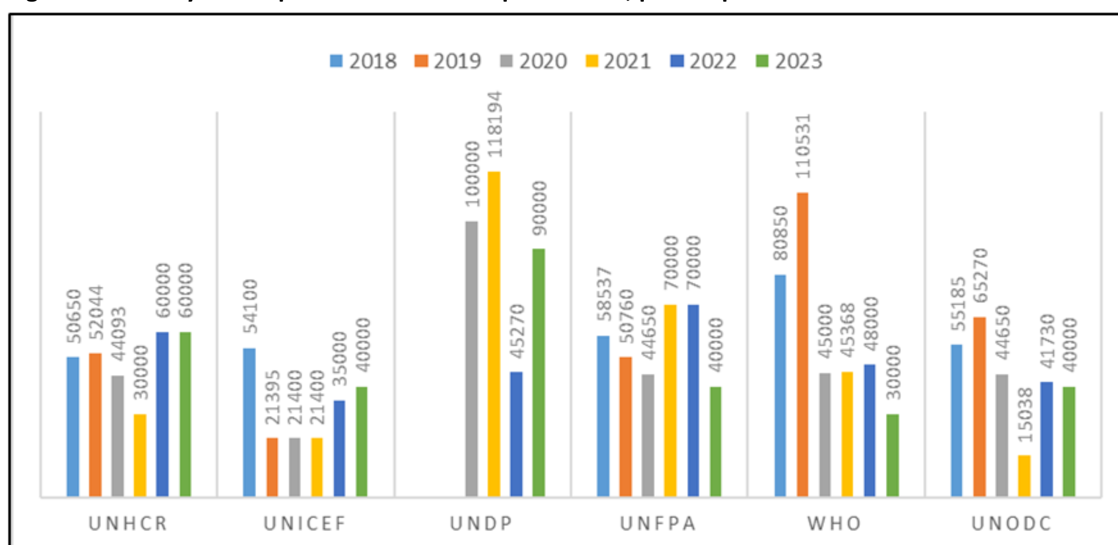
Table 5: Overview of Funding

Year	Country Envelope	Business Unusual Funds	Own/Other sources of Cosponsor funding for HIV	Total
2018	US$ 300,000	-	US$ 1,995,848	US$ 2,295,848
2019	US$ 300,000	-	US$ 169,344	US$ 469,344
2020	US$ 300,000	-	US$ 4,565,975	US$ 4,865,975
2021	US$ 300,000	-	US$ 3,932,273	US$ 4,232,273
2022	US$ 300,000	-	US$ 4,526,891	US$ 5,126,891
Total	**US$ 1,500,000**	**-**	**US$ 15,490,331**	**US$ 16,990,331**

Joint Team Cosponsors have used the CE funds to implement different activities during this period. Figure 1depicts each Cosponsor allocation by year. UNDP, as the principal recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), used to attend the JUNTA planning meetings but has now also started availing of CE funds since 2020. Its allocation on HIV-related activities from CE sources stands higher than other Cosponsors. WHO stands next to it, as Figure 1 displays.

JPMS and the MoU indicate CE funds are allocated for activities in support to RA 8 (in 2022) and RA 2 (in 2023). We were unable to validate this finding through the MoU so details have not been included in the table.

Figure 1: Country Envelope Funds Allocation per Annum, per Cosponsor



Source: UNAIDS (Summary CE and BUF Allocations 2018-2023 for Iran

Examining the balance between total allocation of CE funds and expenditure of Cosponsors throughout 2018-2021, it is known that Cosponsors have spent what was allocated to their plans via the CE mechanism (Table 6). The high absorption rate of WHO in 2020-2018 is due to its underspending in the previous biennial budgeting that was carried forward to the next fiscal year.

Table 6: Allocation, Expenditure, and Absorption Data per Cosponsor in 2018 -2023

Cosponsor	2018-2019			2020-2021			2022-2023	Total
	Allocation	Expenditure	%	Allocation	Expenditure	%	Allocation	
UNHCR	102,694	102,650	100	74,093	74,300	100	120,000	296,787
UNICEF	75,495	54,646	72	42,800	42,800	100	75,000	193,295
UNDP	-	-	-	218,194	193,521	89	135,270	353,464
UNFPA	109,297	65,323	59	114,650	115,587	101	110,000	333,947
WHO	191,381	119,903	63	90,368	161,794	179	78,000	359,749
UNODC	120,455	95,512	79	59,688	57,692	97	81,730	261,873
Total	**599,322**	**438,034**	**73**	**599,793**	**645,694**	**108**	**600,000**	**1,799,115**

Source: UNAIDS (Summary CE and BUF Allocations 2018-2023 for Iran)

Five Cosponsor agencies implemented 12 activities in 2018 and 11 activities in 2019 with the CE funds. Table 7 indicates that, in 2018-2019, UNFPA and UNHCR[4] developed activities that would eventually prevent HIV among key populations. Meantime, UNICEF focused on supporting activities that would prevent HIV transmission from mothers to children. During the same period, WHO also contributed to PMTCT-related interventions in addition to supporting projects that would help with HIV testing and treatment on one hand, and optimize the national health care system on the other hand. In 2020 and 2021, more Cosponsors were using the CE funds though less activities were implemented with the same amount of funds. During this period, UNFPA and UNHCR kept on

[4] UNHCR came on board in 2018 to address the HIV needs of Afghan refugees. It should be underlined that NSP4 not only considers refugees as one of the main KPs but also includes ‘migrants’ as key populations. The strategies adopted by the NSP4 calls for relevant stakeholders to modify activities for raising awareness as primary preventive measures and promotion of condom use as level 1 of preventive measures.

targeting key populations. UNICEF supported MoHME more strategically with PMTCT upscale and implementation of a Hard-to-Reach model. WHO, UNDP, and UNODC supported HIV testing and treatment by performing the activities noted in Table 7. UNODC also designed a gender-responsive programme that aimed to establish a network of Civil Society Organizations (CSOs) and to develop its capacity. Moreover, WHO based on the finding of an assessment of feasibility and acceptance for different key populations and variety of settings provided support to piloting Differentiated Service Delivery. It also continued supporting improved data generation processes.

Table 7: Specific Overview of Country Envelope

Year	Lead Agency	No. of Activities	Activities
2018	UNFPA	2	- Formulated guidelines and developed a comprehensive service package; - Provided youth-led and community-based SRH and HIV services in All-in Centres
	UNHCR	1	- Provided comprehensive harm reduction, including gender-based violence (GBV), and social protection services for vulnerable refugees
	UNICEF	2	- Conducted a formative assessment and evaluation study on the national PMTCT programme; - Improved linkage between private-sector and national/public sector data
	UNODC	2	- Adapted, tested and revised HIV testing guidance for use in short-term residential drug treatment; - Rolled out intensified, peer-led case-finding among key populations and locations
	WHO	5	- Hired an international consultant to contribute in in-depth review of PMTCT implementation in Iran; - Commissioned a consultant to conduct Mapping and Size Estimation of Key Populations; - Supported implementation of integrated bio-behavioural survey (IBBS) of FSW using respondent-driven samplings (RDS); - Conducted formative research about using HIV self-testing modalities in Iran; - Commissioned a consultant to assess Provider Initiated Testing & Counselling Integration in primary health care (PHC), universal health coverage (UHC)
2018 Total	*5 Agencies*	*12*	
2019	UNFPA	3	- Hired an international facilitator to conduct the above workshops - Organized two capacity building workshops for the personnel of the centres serving women and youth; - Arranged a training workshop for staff of centres for vulnerable women, peers and mobile clinics
	UNHCR	1	- Provided comprehensive harm reduction and social protection services for vulnerable refugees
	UNICEF	2	- Developed a roadmap to strengthen linkage between public and private sector on PMTCT; -Arranged workshops and consultation meetings between representatives of public and private sector

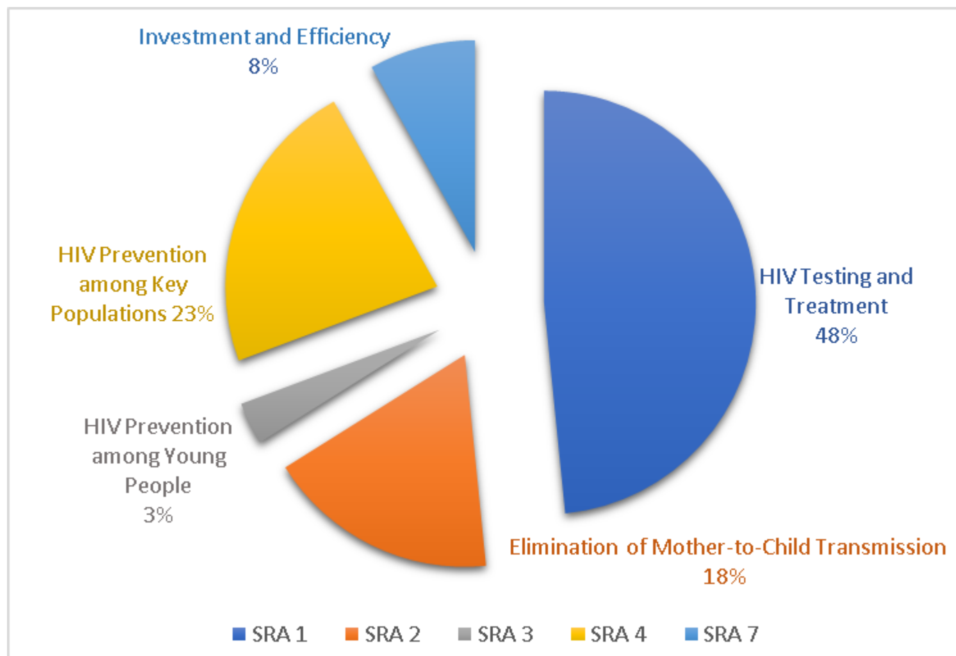
	UNODC	1	- Scaled up intensified, peer-led case-finding among key populations and locations to strengthen linkages
	WHO	4	- Organized a three-day training workshop for VCT centres staff; - Developed guidelines and Standard Operating Procedures for the provision of HIV testing and counselling (HTC) and ART services; - Supported implementation of IBBS of FSW using RDS; - Conducted 5 training workshops for approximately 150 outreach and facility-based providers
2019 Total	*5 Agencies*	*11*	
2020	UNDP	1	- Implemented Viral Load monitoring
	UNFPA	1	- Conducted a sexually transmitted infections (STI) surveillance
	UNHCR	1	- Provided harm reduction services for refugees
	UNICEF	1	- Developed and rolled out a three to five year roadmap for elimination of mother to child transmission (EMTCT)
	UNODC	1	- Promoted adherence to ART in closed settings
	WHO	2	- Provided technical support in developing and integration of people-centred, yet differentiated services, for HIV; - Improved mechanisms for timely information generation on communicable diseases and proper translation of research and evidence to policies and practices, via upgrading Health Management Information System (HMIS)
2020 Total	*6 Agencies*	*7*	
2021	UNDP	2	- Implemented Viral Load monitoring; - Procured HIV rapid diagnostic kits (G1 and G2 ELISA kits)
	UNFPA	1	- Procured Human papillomavirus (HPV) vaccines and condoms
	UNHCR	1	- Provided harm reduction services for refugees
	UNICEF	2	- Developed and rolled out EMTCT roadmap; - Scaled up PMTCT programme
	UNODC	2	- Conducted the following studies: * A brief qualitative review of access to selected harm reduction centres in the city of Tehran by utilizing a Dutch-based technical expertise and experience; * A rapid needs assessment on the emerging needs of women who use drugs with special emphasis on hard drug scenes - As a gender-responsive programming, established a network of civil society interlocutors in the field and planned for responding to identified needs and developing a Standard of Practice
	WHO	1	- Provided people-centred services (HIV Self-Testing Expansion)
2021 Total	*6 Agencies*	*9*	

All the activities that have been funded by the CE funds are linked to Strategy Result Areas (SRAs) in the 2016-2020 UNAIDS Strategy. Until now, Cosponsor agencies in Iran have allocated CE funds to five SRAs (Table 13 - Annex 4)[5]. As seen in Figure 2, the allocation for HIV testing and treatment from

[5] The Global AIDS Strategy for 2021–2026 adopted a new bold approach to close the gaps that are preventing progress towards ending AIDS. It defined 10 Result Areas at output level. The strategic domains for 2018-2023 are mostly aligned with Result Areas 1 to 3 and Result Areas 7 to 10.

CE sources is almost equal to the sum of all other allocations during 2018-2023. (For more details on the CE allocation by each Cosponsor to different SRAs, see Table 14 in Annex 4.)

Figure 2: Strategic Domains 2018-2023



The UNAIDS Joint Programme Division of Labour (DoL) defines the roles and responsibilities of the UNAIDS Secretariat and Cosponsors. Of course, this DoL is flexible according to the country context. In the case of Iran, six Cosponsor agencies are involved in delivering the Joint Plans. Table 17 (Annex 4) shows the detailed information on the UNAIDS technical support DoL in Iran.

As regards HIV prevention among key populations, young people, and women all six Cosponsors collaborate with each other. The leading agency for HIV services in humanitarian emergencies is UNHCR, and UNODC is responsible for harm reduction for PWID and people in prisons. According to the DoL, UNDP leads the planning and implementation of projects that address human rights and S&D. In case of Iran, the UNAIDS Secretariat plays this role more visibly but has called on UNDP to become more involved in work around S&D.[6] Besides, each Cosponsor as well as the UNAIDS Secretariat, depending on the nature of activities, determine which of their national partners (ranging from the government bodies, research centres, and individual specialists to CSOs/NGOs and peer groups) would perform the assignment.

[6] Minutes of JUNTA Meeting on 19 October 2021, p. 4.

4 CASE STUDY FINDINGS

4.1 Evaluation Question Findings Related to Relevance and Coherence

Relevance and Coherence of Country Envelope Allocation Model

In summary, the allocation of 87% of CE funds to Strategy Result Areas 1, 2, and 4 (testing & treatment, vertical transmission, and combination prevention) indicates the relevance of this mechanism (and the Joint UN Plan as a whole) to the National AIDS Programme, and linkage to NSP4 and NSP5. The CE allocation model, as a fixed regular funding mechanism, has increased the leveraging and advocacy capacity of the Joint Team with its national counterparts. Internally, the CE has encouraged greater collaboration among Cosponsors.

EQ 1: How well is the Country Envelope allocation mechanism working?
CE funds represent a small yet catalytic portion of the overall Joint Programme budget. In the case of Iran, the CE activities are part of the UN Joint Plan on HIV/AIDS and are well aligned with NSP5, the United Nations Sustainable Development Goals (SDGs), and the United Nations Sustainable Development Cooperation Framework (UNSDCF). The CE allocation mechanism has contributed to the mitigation of the simultaneous impact of the HIV and COVID-19 pandemics and accelerated the implementation of HIV-related interventions in certain high priority areas. The allocation of 48% of CE funds to HIV Testing and Treatment, 18% to EMTCT (with a focus on female KPs and their partners), and 23% to prevention of HIV among KPs indicate the significance of its contribution to HIV prevention, diagnosis, treatment, care and support programmes.

Group and individual key informant interviews (KIIs) with different stakeholders indicate that the catalytic nature of CE allocation mechanism is quite evident. It is true that prior to this mechanism JUNTA and its national partners were collaborating with each other to address the HIV-related needs of key populations. Yet, a fixed budget for three successive biennia has increased the functionality of the UN Joint Team to fill the gaps in NSP4 and then NSP5. It has also provided the UN Joint Team with the ability to leverage and advocate for implementation of activities for areas where less fund raising was possible within the national health system. These activities were mostly related to interventions that were either too innovative to invest in, socially and culturally a challenging process, or technically difficult to bring in necessary equipment and supplies (especially during the COVID-19 pandemic).

According to case study evidence, criteria for the CE allocation to Cosponsors were considered clear and transparent. As planning for each biennium is done collectively and decisions on spending the CE funds are taken jointly, the risk of overlapping interventions is minimized. The UNAIDS Secretariat leads the planning as well as project review sessions to ensure that Cosponsors fill in the gaps of each other. For instance, UNFPA and UNODC both undertake activities relating to PMTCT by means of the CE funds. But they are complementing each other because when UNFPA does not reach the pregnant women who use drugs, UNODC covers their needs in Drop-In-Centres. More importantly they both make use of CE funds to address the country needs as explicitly requested by SIP committee members and stated in NSP4 and NSP5.

As regards the allocation of CE funds to each Cosponsor on the basis of absorption capacity and/or reporting performance, it was argued that assessing the quality of performance would need appropriate tools and authorities that UNAIDS Secretariat is not equipped with. Currently, no system is in place to verify outputs and deliveries of CE-funded projects except the self-assessment and self-

declaration of Cosponsors. They report to their own system as well as Joint Programme Monitoring System (JPMS). It is assumed that the latter reports, as uploaded to the website, are short but clear enough to reflect the progress, achievements and challenges. Therefore, it was believed that ethically it would be improper to exclude any Cosponsor from the CE fund allocation.

It was also argued that in case of allocating CE funds only to those Cosponsors with high performance quality (measured by their absorption rate) creates a harmful competitive atmosphere among JUNTA members (and their national counterparts) on one hand and decreases the motivation of those one or two funded Cosponsors limiting themselves to CE funding instead of raising funds from other sources for their HIV-related activities. UNAIDS Secretariat in Iran has taken on another approach. Based on its previous experiences of participative leadership, it uses the leverage of CE funds to emphasize joint planning with the Cosponsors, SIP members and representatives of PLHIV and NGO/CSO networks to identify gaps that CE funds (i.e. yearly US$ 300,000) can possibly cover. Obviously, the identified gaps fit in with the mandates of one or two Cosponsors. After a joint decision on what the NAP gaps are, the Cosponsors develop narrative and budget proposals to be discussed in the JUNTA meetings. Thus, they get the financial support along with technical support by the UNAIDS Secretariat, if required.

4.2 Evaluation Findings Related to Efficiency and Effectiveness

Efficiency and Effectiveness of Country Envelope Allocation Model

In summary, the main gaps and needs of NAP are discussed and decided upon during the Joint Team meetings. Additionally, bilateral meetings/conversations between UNAIDS Secretariat and Cosponsors are organized to ensure the CE funded activities are performed as smoothly as required. The Cosponsors found the support offered by the UNAIDS Secretariat, in terms of providing guidance, templates, webinars quite useful.

The JUNTA, under the leadership of the UNAIDS Secretariat, has engaged government departments, CSOs/NGOs, PLHIV and KP groups, and other partners in planning processes and implementation of CE funds allocations. In recent years, it has also engaged the private sector. Despite the low level of NGO participation (as stated as a challenge in NSP4), it has been able to consult with the non-government bodies before developing interventions.

Case study evidence indicates that the CE allocation model was flexible and enabled reprogramming of funds during the COVID-19 outbreak. The CE budget for 2020-2021 plans was adjusted to the unexpected change in situation by assigning 39% of total CE funds to COVID-19 related activities. The Joint Team was able to advance national prevention coverage for KPs through supporting a range of activities run by the government partners, NGOs and CSOs, despite the delays caused by the coronavirus pandemic.

EQ 2: How well are the structures and processes to support the implementation of the country envelope model working in practice?

The CE helps with better prioritisation and addressing of the strategic country needs. Documentary and key informant evidence indicates that the main gaps and needs of NAP are discussed and decided upon during the Joint Team meetings in addition to bilateral conversations/meetings between UNAIDS Secretariat and Cosponsors. All funding requests are under pre-existing deliverables. In 2020, the requests the deliverable were expected to improve cascade performance (1st 90 among KPs; 2nd 90 in closed settings; 3rd 90 nationally) and support various elements of HIV prevention, including EMTCT. The NAP management and its community partners had assessed that it was vital to have Viral Load testing kits at hand to keep the abovementioned record and also push it

forward. By then, additional sanctions were re-imposed on Iran that curtailed access to the international financial system. It implied that implementation of NAP would face with supply chain gaps and could only provide the ART recipients with two recommended yearly VL testing. For that reason, the Joint Team provisionally agreed to support a portion of this request, subject to endorsement by the Quality Review team, that would prevent any significant decline in the country's 3rd 90 performance. UNDP (as the main recipient of the Global Fund funds) had already procured enough VL test kits to cover one full round of testing in 2020. So, it was encouraged to join the CE in the biennial Joint Team plans for 2020-2021.

In terms of current disbursement processes, they function well for Cosponsors. Yet, the arrival of funds (often in March) coincides with the Iranian New Year holidays, which usually leaves all Joint Programme activities (including CE funded ones) to be launched in April (at the earliest). The shortened implementation period for CE activities affects the process. Additionally, key informants considered the technical support of the UNAIDS Secretariat through offering guidance, providing templates, organizing webinars quite useful. It was said that reporting on CE had not been difficult (especially after receiving guidance) but burdensome for those UN agencies with staffing challenges. As well, the impact of sanctions on provision of needed supplies and logistic restrictions also caused delay in planned operations.

EQ 3: To what extent have country stakeholders (government, civil society, PLWH, key population groups, and other partners) been engaged in UN joint planning processes and implementation at country level?

As mentioned in previous sections, UNAIDS Secretariat has built and maintained strong working relations with the government bodies. Providing technical assistance to SIP committee (and sub-committee) members, especially by the UNAIDS Country Director (UCD), is an evident advantage for putting into practice the CE allocation model smoothly. The Cosponsors, and representatives of the government bodies, the NGO/CSO network, and the PLHIV community acknowledged that the collaborative interaction of UNAIDS Secretariat with different stakeholders has motivated them all to take part in UN joint planning processes.

Two distinct examples of such effectual relationship are observed in planning sessions for CE fund allocation for 2022-2023 and developing NSP5. In both cases the catalytic role of UNAIDS Secretariat, on the one hand, led to the integration of needs identified by different stakeholder in the new biennial CE fund plans and, on the other hand, made the inclusion of the UN and non-government stakeholders' requirements in the NSP5 possible. For instance, it was due to advocacy efforts of UCD and related UN agencies that EMTCT is now one of the strategies of NSP5. Furthermore, it was particularly acknowledged that because of participation of a number of PLHIV and representatives of NGOs/CSOs in planning sessions for the CE fund allocation (2020-2021) the Cosponsors could develop proposals that addressed the real needs of HIV affected people in a more realistic way. As UNAIDS is the only UN entity with NGOs in its governing body, it is possible to consult with them prior to planning and during implementation phase.[7]

Nevertheless, there are certain contextual barriers to engaging beneficiaries and non-government service providers in planning and implementation processes. Although NSP4 document admitted this gap as low level of NGO participation (Table 11, Annex 4) the engagement of non-government and HIV-affected communities faces restrictions. In the meeting with a number of PLHIV and NGO members, it was stated that despite the fact that the operating procedure of SIP committee requires the participation of NGO representatives, they are rarely invited (if invited at all) to planning and/or review sessions. Regarding the engagement of non-government stakeholders in implementation processes of the CE activities, it is noted that the private sector physicians have been recently

[7] https://iran.un.org/sites/default/files/2022-04/UNAIDS%20Iran%20Fact%20sheet%2017%20March%202022.pdf

involved in case finding processes run by VCT centres. Besides, as reported by the Cosponsors, a selection of non-government service providers is contracted every year to help with the implementation of plans. Yet, these organizations should be approved by their national counterparts. In the past, the UN agencies could sign an agreement with its non-government partners. The regulations have now changed. Given that the NAP budget is limited and working through NGOs (especially with the ones with an unwanted/sensitive background) is not given priority, the NGO members requested UNAIDS Secretariat to find a solution for their fund-raising problem.

Removing and/or reducing impediments for community participation in planning and leading HIV-related activities cannot be expected from the UN system though advocacy for more involvement of communities of PLHIV and peers in the HIV response and developing their capacity is possible and has been done so far. Table 15 (Annex 4) shows how the CE fund allocation model has contributed to addressing this issue (as expressed by the activities linked to UBRAF outcome 2).

EQ4: To what extent have country envelope and BUF funding contributed to addressing gender equality, human rights and community-led responses?

With the limited role that persons affected by HIV play in the design, development and implementation of service delivery and research and policy making, the gender equality and human rights advocates have not had a direct recognizable voice that could potentially influence CE planning and implementation processes. Actually, JUNTA, under the leadership of UNAIDS Secretariat, takes on this role and ensures that certain mechanisms, such as the gender equality marker, is put in place to assess that activities meet the objectives of gender equality and women's empowerment. Other tools such as civil society and human rights markers are also used to ensure CE funds address human rights and community-led responses.

Examining the given scores for activities of CE funds during 2018-2023, it is known that activities either scored 1 or 2 for above criteria.[8] Yet, as the assessment and scoring are not conducted at the end of the implementation period, due to tight schedule for reporting, there is a need to explore ways to improve the process. It is true that some Cosponsors use their own agency guidelines (and indicators) to assess such criteria when they develop proposals. However, it has also happened to assess and score the markers during the joint meetings.

It has been quite complicated to operationalize gender mainstreaming strategy at the country level since mid-2010's.[9] As an example, supporting DSD at HIV risk hotspots (scored 2 for all three criteria) has been defined as a set of activities in the area of HIV prevention (linked to UBRAF outcome 1 rather than UBRAF outcome 2) and covers the needs of those PLHIV that are most discriminated and stigmatized and exposed to gender-based violence. In other words, JUNTA develops and implements plans that implicitly include socially and structurally marginalized groups of FSWs, MSM, TG, refugees and poverty-stricken people. Even conducting studies among them is not easy and requires taking certain measures to protect the study population. Researchers usually acknowledge that individual-level data on risk behaviours are sensitive data.[10]

This indirect cautious approach to mainstreaming GEWE strategies, and strategies related to human and civil society rights, that find an appropriate cultural fit within the national context has helped CE

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[8] The range of scoring for the markers start from zero (which means the activity does not contribute to needs from that specific perspective) to three (that implies the activity meets the principal objective).

[9] For instance, the term 'gender' is not used in the United Nations Development Assistance Framework (UNDAF) for 2017-2021.Though the document refers to 'women' three times. Furthermore, Islamic Republic of Iran has not ratified the Convention on the Elimination of All Forms of Discrimination against Women, which justifies restrictions faced by the UN system to push persistently for gender mainstreaming.

[10] As mentioned in a survey paper funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria and Iran Ministry of Health in 2018: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0207681

fund allocation mechanism to respond the above-mentioned issues. Yet, increased knowledge and sophisticated analytic skills of HIV-related staff of UN agencies on GEWE, human rights and community-based interventions may possibly strengthen the current links between CE fund plans and UBRAF outcome 2, without being obliged to develop specific directly associated interventions on sensitive issues.

EQ 5: To what extent have country envelope and BUF funds supported the adaptation of HIV programming during the COVID-19 pandemic in a flexible and timely way? How has COVID-19 impacted on the implementation of country envelope activities?

In February 2020, the first confirmed cases of COVID-19 were reported in Iran. Soon the infection began spreading in the country. The Joint Team contributed at various levels to the national COVID-19 response, mobilising resources and working with national partners to strengthen surveillance systems, bridge procurement gaps, and generally maintain essential health services for PLHIV in the country. At that time CE funds mechanism was in its second biennium, starting to implement agreed Joint Plans. But, with the outbreak of the disease, the activities funded by CE had to be revisited to ensure they address the specific needs of target groups affected by COVID-19. Key informant evidence indicated that the CE allocation model was flexible enough to reprogramme the funds during the COVID-19 outbreak, if they required. Actually, they got to know about the option for reprogramming/ rescheduling the activities with under 50% changes by a round of emails sent by the UNAIDS Secretariat. For instance, UNODC adjusted its plan to use CE funds to provide required personal protective equipment (PPE) for prisoners and homeless PWID.

Despite the challenging context of COVID-19, the Joint Team in Iran was able to advance national prevention coverage for key populations through a range of activities working with government partners, NGOs and CSOs. Due to the close partnership of the UNAIDS Secretariat and national AIDS directors and HIV experts, who were drawn into COVID-19 advisory committees and management teams, the JUNTA could support the national planning and decision-making bodies for COVID-19 responses. Accordingly, the CE budget for 2020-2021 plans was adjusted to the unexpected change in situation by assigning 39% of total CE funds to COVID-19 related activities. Contribution of UNDP to these activities, by procuring PCR and DSM kits for VL monitoring in addition to G1 and G2 ELISA kits (through the Global Fund) was the highest among the Cosponsors (50%). Next to it, was the contribution of UNFPA (30%) through HPV vaccines and condoms. WHO contributed (19%) to expand HIV Self-testing during that period (Table 8).

As the COVID-19 pandemic was not yet over when the Joint Plans for CE funds allocation for 2022-2023 were being developed, it was decided to support CDC to build further resilience in managing emergencies such as the COVID-19 outbreak. UNICEF has procured rapid diagnostic test (RDT) kits to improve the access of pregnant women especially services for hard-to-reach pregnant women, especially from vulnerable and key populations, in provinces with high declining in PMTCT programme in 2022, using 12% of total annual CE funds for the period.

Table 8: CE Funds Allocation to COVID-19 in 2020-2021

High Priority Area	Deliverable	Activity	Details	UN Agency	Budget (US$)	%
HIV Testing and Treatment (Testing Gap)	Scale up and diversify HIV testing services	Procurement of HIV rapid diagnostic kits	Procurement of G1 and G2 ELISA kits	UNDP	5,725	2
	Customise T&C guidelines	People-centred services	HIV Self-Testing Expansion	WHO	45,368	19

	ART capacity development	Viral Load monitoring	Procurement of 73 PCR and 146 DSM kits for VL	UNDP	112,469	48
	Pre-exposure Prophylaxis and condom programming	Procurement of Condom	Procurement of HPV vaccine and condom	UNFPA	70,000	30
TOTAL					**233,562**	**100**

Undeniably, the COVID-19 pandemic impacted the national HIV response mainly by disrupting uptake and delivery of HIV services.[11] It was also reported that the critical situation caused logistic delays in delivering overall planned services. For instance, WHO could not put into operation its plans for expansion of HIV self-testing and DSD (both being CE funded activities) until early August 2020. The reason was that CDC, its key national partner, was simultaneously involved in COVID-19 duties. Therefore, the 2020 implementation deadline was altogether extended to end of August 2021.

Other significant delays, due to the combination of sanctions and COVID-19, were procurement and availability of rapid diagnostic tests, ELISA, CD4 and viral load monitoring kits. Disruption of services and care, due to the COVID-19 situation, put key populations at risk of not receiving their medications and services on time. To some interviewees, even before the COVID-19 outbreak, the NAP was lagging behind the global 90-90-90 targets by 2020. So, given the challenges caused by the pandemic, those targets seemed more unreachable.

Yet, there were some lessons learned from supporting COVID-19 related HIV programming. First of all, concerted efforts guaranteed timely and more streamlined procurement of essential HIV medicines and commodities. Besides, skills in conducting rapid needs assessments help with appropriate service delivery at critical times. So the COVID-19 Preparedness Plan can be a model for other health emergencies that might affect PLHIV. More significantly, building and maintaining strong partnerships with the PLHIV community and functional NGOs/CSOs are essential in reaching KPs and ensuring their accessibility to services and adherence to treatment.

4.3 Evaluation Findings Related to Results and Sustainability

Results and Sustainability of Country Envelope Allocation Model

In summary, though it seems too early to confirm that invested inputs through CE funds have led to tangible results, certain outputs have been reached and reported. The COVID-19 outbreak that affected the routine progress of CE funded activities is one reason for not achieving intended outputs.

The anticipated results of the CE allocation model are contributing to UBRAF outcomes 1, 2, and 3. Most of the CE funded activities are relate to outcome 1. This mechanism has positively affected the JUNTA members and furthered transparency and collaboration, as the Cosponsors get to know what each agency is doing and if needed, they cover each other's gap.

The main helping factor in this process is the reliable working relations amongst the UNAIDS Secretariat, the Cosponsors, the CDC managers, the SIP committee members and the national HIV

[11] According to Country Spectrum Estimates, 2021 (quoted in the Country Report for 2020), there was an increase of 1.06% in the number of new adult infections in 2020.

specialists. Regularity of CE funding mechanism and productive joint planning are other helping factors.

Yet, achievement of results is mainly hindered by external factors such as sanctions against Iran, current economic hardship, and changing conditions. Internally, there is a need to invest more in human resources and to increase their capacities.

EQ 6: To what extent have the country envelope and BUF funds achieved country envelope outputs/results as intended?

In the opinion of the Cosponsors and representatives of the SIP committee, research institutes, PLHIV community and NGO/CSO networks, the well-structured process of consultation with stakeholders for allocating CE funds helped with achieving most of the intended outputs of the first biennium plans. Yet, some of the outputs were difficult to attain. For instance, in 2018, the outputs that meant to improve the KP routine data and linkage with integrated HIV surveillance were difficult to attain because access to quality data proved to be too time-consuming that caused delays and extensions of the original contract. Regarding the second biennium plans, many outputs could have possibly been achieved timely and fully if there were not the COVID-19 outbreak. As this evaluation was taking place in the middle of the third biennium plan, it was only hoped to achieve intended outputs.

One output from CE processes has been the reduction of fragmentation of the Joint Team. A good example of reduced fragmentation of Joint Team plans and Cosponsor activities is observed in their efforts in supporting the National PMTCT programme. As Table 14 displays UNICEF and WHO have both contributed to this result in 2018-2021. The focal points of both UN agencies stated that group meetings of CE funds were an appropriate platform to plan, discuss, review and report the progress and/or challenges of the activities. In this regard, the UNAIDS Secretariat admitted that this mechanism was not only disbursing financial resources among Cosponsors but it is a ‘strategic fund’.

UCD asserted that the engagement of UNAIDS Secretariat in the whole process, from assessing the needs in collaboration with national partners, joint planning for required activities, developing two-year proposals (which he should present and convince decision makers for funding at regional level) to overseeing the reporting of CE funded activities ensures improved accountability of UN Joint Plans. During the process, many vague propositions and inferences are double checked using multiple sources. The fact that the CE funds model defines deliverables for a two-year period (not very long so that changes in conditions affect the attainability of objectives and not very short to be undoable) is an advantage that simplifies the complexity and uncertainty of actions on HIV/AIDS. In terms of using CE funding model in a more strategic manner, it was stated that being recently initiated it would be unrealistic to expect more of it. Taking into consideration that the CE fund allocation corresponds to 0.2% of the national spending on the AIDS response and 1% of the HIV resources in the country, it is valued more as being catalytic rather than anything else.

EQ 7: What results have been generated through country envelopes and how are country envelopes contributing to the achievement of UBRAF outputs and higher-level results?

By reviewing the list of activities given in Table 7 and Table 15 (Annex 4), it is possible to categorize activities implemented in 2018-2021 into certain anticipated results. Table 9 displays the links from these results to UBRAF results. It should be noted that there are internal documents that link activities to UBRAF outcomes and outputs. In so doing, detailed description of certain activities relates them to more than one outcome.

Table 9: Links from CE Anticipated Results/Outputs to UBRAF

Country Envelope Result/Output	UBRAF Outcome Area and Results
National PMTCT/EMTCT programme is supported. CE funds contributed to the initiation of EMTCT for key populations in 2018 and this service has been integrated into a package of essential services targeting female SW etc.	Outcome 1- People living with, at risk of and affected by HIV obtain equitable access and reap equitable benefits from HIV prevention, treatment, care and support services
Key populations are assisted through community-based interventions. Integrated services targeting KPs have been scaled up since 2020 and are now in place in 3 VCT centres. Besides, vulnerable Afghan refugees have been provided with comprehensive harm reduction and social protection services.	
Key populations gain better/more access to required supplies. Since the COVID-19 outbreak, KPs have been provided with essential kits (G1 and G2 ELISA, 73 PCR and 146 DSM) for VL, HPV vaccines and condoms.	
Capacity of NGOs/CSOs and peer groups are developed. Financial assistance has been provided for NGOs to provide harm reduction programmes for PWID and their families in three provinces. A network of CSOs has been established and supported to plan for responding to identified needs of PWID, especially women drug users.	Outcome 2- Communities of people living with, at risk of and affected by HIV, including key populations, women and young people, are empowered, enabled and effectively resourced to lead HIV service delivery, advocate for and enjoy their right to health, and social and structural drivers of the HIV epidemic are removed
National research capacity is strengthened. The CE funds have contributed to strengthening the capacity of the national AIDS research agency through training staff in research methodologies valuable for KP modelling exercises and supporting innovative research that is informing and shaping the delivery of services.	Outcome 3- Increased availability of effective, equitable and sustainable systems to achieve and maintain the 2025 targets, through robust financing for national budgets and community responses, greater service integration for people-centred delivery, expanded HIV service access in emergency settings, and effective pandemic preparedness and responses
Better-quality data are produced. Hardware for HMIS was provided for the use in SWO centres and surveillance systems of HIV, STI and integrated bio-behavioural survey of FSW using RDS have been developed and/or upgraded.	
Guidelines, standard procedures, etc. are developed. The CE funds have supported the development of PMTCT guidelines for the private sector and guidelines and Standard Operating Procedures for the provision of HTC and ART services in "other" settings.	
National capacity is increased through training. Several training workshops have been organized for the personnel of facility-based and outreach service providers that address the needs of vulnerable women, peer groups and youth on various topics such as reproductive health, the use of guidelines, and the use of PAS e-monitoring mobile application.	

To give one example of how CE funds allocation has helped progression towards UBRAF outputs, a set of related activities, known as Differentiated Services Delivery (DSD), is briefly examined here. (For detailed information see, Annex 5).

The idea of supporting a pilot project on DSD in Iran through CE funds was put into practice in 2020 with a focus on key populations. As the DSD model was commended by the WHO Regional Office for the Eastern Mediterranean, WHO in Iran became the lead agency. In 2018 WHO had used the CE funds to conduct formative research regarding HIV self-testing (HIVST) modalities in the country. Based on this research, there was an opportunity for JUNTA to complement the WHO's HIVST and DSD work. On the other hand, national HIV specialists and CDC experts had already found out that there was a need to increase the capacity and knowledge on networking among HIVST providers and introduced differentiated HIV testing that was based on five pillars of partner notification testing, key population testing, HIV testing in high-risk locations, symptom-based HIV testing, and intensified PMTCT that could improve the situation.

The regular interaction among the UNAIDS Secretariat, the Cosponsors and SIP committee members resulted in developing a set of activities that brought in WHO (responsible for HIVST expansion), UNICEF and UNFPA (responsible for supporting PMTCT/EMTCT and integration of services with maternal, new-born and child and reproductive health programmes) using the CE funds. The interventions have been initiated in the most appropriate settings for provision of such services in the country, i.e. Behavioural Disorders Consulting/VCT centres). According to CDC, the DSD programme has already finished its first piloting period and entered the second phase before being scaled up in all VCT centres. As reported and observed during the field visit, differentiated ART delivery by means of a health care worker-managed group, client-managed group, facility-based individual, and out-of-facility individual is improving the situation in the pilot sites, where VCT centres are located. Though in its pilot phase, DSD is contributing to provision of more equitable benefits to PLHIV, especially less privileged KPs (Figure 3, Annex 4). The strong CDC ownership of the programme gives hope to its sustainability.

EQ 8: To what extent have country envelopes enhanced and changed the capacity of Joint Teams and supported the mobilisation of resources (human, financial, technical) at country level?

The fact that the CE funds are received and managed at country level and tied to specific deliverables, has given the Cosponsors an opportunity to address the gaps that their own resources would not cover. Much of their own resources respond to the direct request of their national partners but with CE funds they find a chance to support activities that because of their novelty and uncertain probability of results the NAP would not give it a priority. However, when such an activity is defined in collaboration with the UN Joint Team as a pilot, it is welcomed and put into practice. This success has been gained collectively and therefore affects positively the way the JUNTA members work together. The process of CE funds allocation has also brought further transparency and collaboration. The Cosponsors get to know what each agency is doing and when a gap is identified, agencies can cover the remaining needs, if their mandates allow. For instance, UNDP as a Global Fund PR steps in to procure condoms when UNFPA cannot do it, due to recently raised sensitivities against it.[12] Another example is the collaboration of UNHCR, WHO and UNICEF to procure COVID-19 vaccines for refugees in 2021.

The country respondents referred to insufficient funding as a challenge. They argued that, compared to the country's need, the CE funding was limited. Although this mechanism was mostly used to

[12] Article 51 of the newly ratified law of "Youthful Population and Protection of the Family" prohibits the free distribution of contraceptives such as condoms across the country's healthcare network. As UNFPA is known for its support to family planning and ensuring the reliable supply of a full range of modern contraceptives, procurement of condoms (though for other purposes rather than family planning) is not welcomed.

develop pilot interventions the funding constraints would sometimes impose difficult choices between budgeting for human resources or programmes. Regarding DSD as a novel intervention, it was believed that mobilization of international financial resources for another round could result into faster scale-up. Uneven capacities of the Cosponsors were also referred to as a challenge that affected reporting to some extent.

It was stated that to be able to use the resources more strategically, the link between quality performance, reporting, reprogramming/re-budgeting should be defined more clearly. It was suggested that to improve the quality of performance and narrative reports a more comprehensive section on indicators could be added to show progress annually. Some references were also made to insufficient attention to social indicators during phases of developing proposals and monitoring.

EQ 9: What are the main factors helping or hindering the achievement of results?
The main helping factors include, but are not limited to, the reliable working relations that have been built and maintained amongst the UNAIDS Secretariat (especially UCD), the Cosponsors, the CDC managers and SIP members as well as the national HIV specialists. Additionally, the regularity of CE funds has resulted in a successful planning process. As the joint planning for the CE funds is based on evidence and gap analysis, activities complement partners' efforts. Given that there is a limited number of Cosponsors in Iran, fragmentation is avoided to a remarkable extent. Other contributing factors are a well-established JUNTA that has reinforced the UNAIDS Secretariat, to address well the national programme gaps using CE allocation model as well as the political support of the UN Country Team (UNCT) for its operation.

Nevertheless, there are certain constraints that hinder the operations as planned (or wished). From a human resources perspective, the overall capacity of JUNTA is limited. In this regard, two different points were found out, one of which is the gap between senior and junior staff of Cosponsors, in terms of their knowledge and skills as well as the time they spend on HIV work. In any case, several staff are usually performing many other duties but also act as the focal points of HIV/AIDS in JUNTA (and CE-related) meetings. This weakness gets more visible when there is a need to negotiate with the counterparts in SIP meetings. As Table 16 (Annex 4) shows, the staff with higher grades spend less percentage of their time on HIV-related activities, though UNDP and UNODC are exceptions. It is true that many G and P grades prove to be very efficient in their work regarding HIV-related programmes, but here the question is how to keep the balance between inputs invested by each Cosponsor to ensure the CE funded activities can contribute to UBRAF outcomes. Some respondents believed that more specific knowledge and skills regarding HIV/AIDS related issues are needed within the team. This is also true regarding the response to EQ4, that if reaching UBRAF outcome 2 is to be pursued, investing in related human resources on the topics and good practices of GEWE[13], human rights of PLHIV and community-led interventions, might be helpful.

Evidently, there are some external hindering factors that affect not only the CE funds allocation model but the Joint Programme overall. These external/contextual factors can hardly be managed or positively influenced. From time to time, changes in the political conditions (such as changes within the cabinet and/or administration) lead to changes in polices and cause restraints. When a programme or a process is flexible enough, the implementation of activities may not be interrupted. For instance, those Cosponsors responsible for procurement of required supplies with the CE funding already know that there are complicated customs clearance processes in Iran. So they normally take into account such contextual problems that have been deepened by the sanctions against Iran. Another example was given by a CDC expert that stated, due to recent changes in the administration, the term "unintended pregnancy" has to be removed from guidelines. It seems that those in CDC

[13] A first step might be use of current capacities, such as the UN Gender Working Group by maintaining regular interaction with.

who are in charge should either stop using those guidelines or publish a new edition of them. Yet, it is not always possible to solve such problems easily, especially if something is going to be adjusted to changes in a much bigger scale. As an example, when the community participation is low, taking on a people-centred approach throughout the programme is hard though the joint planning for CE funds allocation improved prioritization and helped the JUNTA to further focus on results for people as the anticipated deliverables demonstrate.

Over and above, it is to be reminded that when the CE fund mechanism was operationalized the SIP committee and CDC welcomed its support to pilot innovative intervention strategies, and tend to adopt and expand effective models. Now, it is not known if the new administration, which took office in 2021, is as keen as before and if it remains committed to implementing NSP5 (It was reported as a challenge in Report 2018-2021).

EQ 10: What other models exist as potential alternatives for incentivising UN joint planning and funding at country level?

Prior to introducing the CE funds allocation model, some of the Cosponsors had access to UBRAF core funds and mobilized funds from their own sources to respond to HIV-related needs in Iran. Now, this mechanism provides them an additional source for funding. The country respondents suggested no other mechanism that could address the gaps better than CE funds. However, the effectiveness of CE funds could be strengthened in terms of making the role and responsibilities of UNAIDS Secretariat and the Cosponsors less vague and less complex. As the Secretariat should not be perceived as a donor and should not act as one, its catalytic responsibility regarding issues around appraisal of performance requires being better understood, defined and appreciated.

5 THEORY OF CHANGE

Table 10: Theory of Change: Country Envelope Funding Model

Activities/ Outputs	Assumption Met	Description
RELEVANCE AND COHERENCE (DESIGN)		
Inputs		
Joint Team members at country level	YES	UNAIDS Secretariat staff and six Cosponsors (UNDP, UNFPA, UNHCR, UNICEF, UNODC and WHO) are in charge of implementation of 2022-2023 Joint UN Plans. Altogether, there are 35 staff, out of which 13 are full time. Except for UNAIDS Secretariat and UNDP, other UN agencies have got no full-time personnel. Trustworthy professional relationships among JUNTA members help the work get done.
Resources: CE and BUF funding (US$)	YES	2018-2019 (US$ 600,000); 2020-2021 (US$ 600,000); 2022-2023 (US$ 600,000)
Guidance: Joint UN Planning guidance 2017 (for CE alignment); CE mechanism guidance and templates; Guidance on use of BUF funding; Guidance on use of CE funds for COVID-19 response.	YES	Timely shared by UNAIDS Secretariat which shares the guidelines and templates with Cosponsors and organizes workshops and webinars for further clarification. It also holds meetings to provide other technical support and consultation.
CE mechanisms and processes (EQ1, EQ2, EQ3, EQ9)		
1. Allocation formula for Iran is updated annually as new/relevant data emerges.	YES	One example is DSD-related activities for which WHO received different funds.
2. Country envelope guidance, including for COVID-19 clarifies the intentions of CE funding and is available in time for start of the annual planning processes.	YES	All Cosponsors receive guidance and instructions on the CE funds allocation, disbursement and priority areas. The flexibility of the CE allocation model enabled reprogramming the funds during the COVID-19 outbreak.
3. Joint Team processes and plans are inclusive of key stakeholders, based on country needs, and align to UBRAF Results Areas.	YES	The case study evidence indicates that the JUNTA engages the representatives of government and non-government organizations, PLHIV, and private sector in planning for the CE funds allocation and implementing the activities. There is regular strong collaboration between JUNTA and NAP management. Processes and plans are also aligned with UBRAF Result Areas.
4. Allocation of CE funds to Cosponsors, and submission of proposals for CE funding is timely and aligned to guidance.	YES	Allocation of CE funds is discussed and decided in several Joint Team meetings, based on UNAIDS guidance and instructions in a timely manner. Based on inputs from NAP and consultation with CSO/NGO network and PLHIV community, Cosponsors develop proposals considering the stated needs and gaps.

Activities/ Outputs	Assumption Met	Description
5. QA, approval and CE funding disbursement processes are timely and aligned to guidance.	YES	The COVID-19 outbreak affected the timely disbursement of the CE funding, in terms of having extended the 2020 implementation deadline to August 2021. Otherwise, the funding disbursement processes were timely and according to guidance, done once QA was complete.
6. Reporting on implementation of CE funding and deliverables takes place in a timely manner and results of funding are tracked and documented.	YES/ Partly	Reporting on implementation of CE funding and deliverables takes place in a timely manner. However, there is no standard template to be used for reporting. Each Cosponsor is using their template and often report on the entire programme and indicators (not only activities implemented with CE funds) which makes it difficult to separate work done under CE.
7. Joint Teams capacity assessments are conducted and findings addressed.	YES	Country capacity assessment (including the composition of the team based on available resources) for 2018-2019 (with linkages to SRAs) and for 2022-2023 (with linkages to Joint Programme Result Areas), specific source of fund for personnel or specific linkage to the CE funds model, is not clear.
EFFICIENCY AND EFFECTIVENESS (IMPLEMENTATION)		
Expected outputs from CE allocation mechanisms and processes (EQ1 EQ2, EQ3, EQ4 , EQ5, EQ6, EQ8, EQ9)		
1. UBRAF core funds allocated and disbursed through the CE mechanism to Cosponsors are prioritised and used strategically based on country needs.	YES	The CE funds allocation is aligned with SDGs, UBRAF SRAs, with UNSDCF. In accordance with the National Strategic Plans, it addresses the country needs.
2. CE funding mechanisms strengthen Joint Team internal and external collaboration, strategic planning processes, and coherence of UN support around country priorities.	YES	The Joint Team involves the key national stakeholders (including the SIP members, HIV/AIDS Researchers, CSOs/NGOs and PLHIV networks and private sector) in planning and implementation of the CE funded activities. Alternately, under the leadership of the UNAIDS Secretariat, it supports SIP and CDC experts in developing national plans
3. QA processes reinforce transparency and Joint Programme accountability at country and regional levels.	YES	At country level all activities and budgets are uploaded into JPMS once QA is complete.
4. Joint Programme is able to mobilize additional resources through the catalytic and innovative effect of CE funding.	YES	There is a strong consensus that the CE funding model acts as a catalyst helping Cosponsors as well as their national counterparts to cover the gaps and run pilot projects that, otherwise, might not get adequate budgets from other sources. Regards novel activities, for instance People-centred Services, when pilot projects supported by the CE allocation funds successfully end, there is a strong chance that national resources get allocated for their scale-up.
5. CE funding supports activities that address Gender Equity, Human Rights, community responses.	YES/ Partly	There have been multiple interventions funded through the CE to support GEWE, S&D, and community-led responses.
6. CE funds are used to strengthen national responses to COVID-19 in the context of HIV.	YES	The CE funds allocation model was flexible enough to address the dual HIV/COVID-19 pandemic needs of KPs. One major contribution of the Cosponsors to sustaining treatment services for PLHIV during this period was procurement of required kits through this mechanism.

<table>
<tr><th>Activities/ Outputs</th><th>Assumption Met</th><th>Description</th></tr>
<tr><td>7. CE funds and joint planning processes support strengthened Joint Team's capacity (technical & managerial), including effective stakeholder engagement.</td><td>YES</td><td>The regular biennial funding basis of the CE model has increased the motivation of JUNTA and SIP to engage more energetically in the joint planning and implementation processes.</td></tr>
<tr><td colspan="3">SUSTAINABILITY (RESULTS)</td></tr>
<tr><td colspan="3">UBRAF Outcomes through Results Areas 2022-2026 (EQ7, EQ8, EQ9, EQ10)</td></tr>
<tr><td>Joint programme outcome 1 and results:
1. Prevention: capacity strengthened to scale up combinational prevention services
2. Treatment: capacity strengthened to scale up treatment and care services
3. Paediatric AIDS, vertical transmission: capacity strengthened to ensure access to services to eliminate vertical transmission
• (Strategic Results Areas 1, 2, 3,4)</td><td>YES</td><td>The fact the allocation of 48% of the CE funds to HIV Testing and Treatment (SRA1), 18% to EMTCT (SRA2), and 23% to covering the needs of KPs (SRA4) indicate the contribution of this model to UBRAF outcome 1.</td></tr>
<tr><td>Joint programme outcome 2 and results:
4. Community led responses: community empowered to address needs of marginalised and key populations
5. Human rights: political commitment built to improve legal/policy environment, removal of stigma and discrimination
6. Gender equity: capacity strengthened to promote gender equality and end GBV
7. Young people: capacities to implement multi-sectoral responses for young people (health, education, HR, protection)
• (Strategic Results Areas 3, 5, 6)</td><td>YES/ Partly</td><td>The CE funds allocation model has defined activities throughout all three biennia that implicitly address SRA5 and SRA6. Yet there have been interventions that addressed gender-based-violence while providing harm reduction services. As regards of human rights, studies supported by the JUNTA reveal persistent cases of HIV-related stigma and discrimination in healthcare facilities and other community settings. So, reducing S&D within healthcare settings and empowering the PLHIV community has been targeted in 2022-2023 plans. The CE funds allocation for this period has addressed this gap by developing a number of community-led responses for the youth and harm reduction activities among Iranian and migrant Afghan KPs</td></tr>
<tr><td>Joint programme outcome 3 and results
8. Funded response: capacities built to develop and implement sustainable responses
9. Integration and social protection: increased access to integrated health services and social protection mechanisms
10. Humanitarian settings and pandemics: fully prepared HIV response that protects PLWH from impact of pandemics.
• (Strategic Results Areas 7, 8)</td><td>YES/ Partly</td><td>To improve the quality of strategic information and smart investments for the national response, technical assistance and financial support have been provided through revising national HIV estimates; size estimations of key populations; impact evaluations of the HIV services among vulnerable women; a formative evaluation of services for vulnerable men; cost-effectiveness of harm reduction services; assessment of antiretroviral treatment service delivery among people living with HIV in closed settings; and evaluation of HIV prevention, care and treatment services in prisons.</td></tr>
</table>

6 CONCLUSIONS AND CONSIDERATIONS GOING FORWARD

Summary Conclusions

The CE allocation model, as a fixed regular funding mechanism, has increased the leveraging and advocacy capacity of the UN Joint Team in interaction with its national counterparts. Internally, CE allocation model has provided a more collaborative partnership among the Cosponsors.

The JUNTA's solid collective experience in the HIV response and its well-established relationships with key partners have contributed to the functionality of CE funds model, and vice versa, CE funding allocation has leveraged joint action.

The CE funds allocation, based on evidence and gap analysis, helps the Cosponsors complement other partners' efforts. The joint planning and review meetings have improved the prioritization of needs and gaps of NAP and helped the JUNTA members to address those needs more efficiently.

The Cosponsors found the support offered by the UNAIDS Secretariat, in terms of providing guidance, templates, webinars quite useful. They also stated that current disbursement processes function well enough.

Under the leadership of the UNAIDS Secretariat, the government departments, CSOs/NGOs, PLHIV and KP groups, and other partners are engaged in planning processes and implementation of the CE funds allocation. In recent years, due to this mechanism, partnership with the private sector was also promoted.

The Cosponsors admitted that the CE allocation model was flexible enough to reprogramme the funds during the COVID-19 outbreak. The CE budget for 2020-2021 plans was adjusted to the unexpected change in situation by assigning 39% of total CE funds to COVID-19 related activities. The Joint Team was able to advance national prevention coverage for KPs through supporting a range of activities run by the government partners, NGOs and CSOs. However, the COVID-19 outbreak affected the routine progress of CE funded activities and is one reason for not achieving intended outputs.

It seems too early to confirm that invested inputs through CE funds have led to tangible results, or that certain outcomes have been reached and reported. Yet, the anticipated results of the CE allocation model are directly (or indirectly) contributing to UBRAF outcomes. The main helping factor in this process is the reliable working relationships amongst the UNAIDS Secretariat (especially UCD), the Cosponsors, the CDC managers, the SIP committee members and the national HIV specialists.

Despite the low level of NGO participation (as stated as a challenge in NSP4), it has been possible to consult with the non-government bodies before developing interventions. In a very complicated context, the CE funds model has been able to attend to issues of gender equality and women's empowerment, human rights and community-led responses. By adopting the most possible appropriate cultural fit within the national context, several activities (assessed by certain markers) have been developed to address the needs of KPs.

Shrinking financial resources, due to sanctions and recent economic hardship, make the CE funds allocation more imperative than before.

All in all, the CE funds have been able to maximise the comparative advantage of UN agencies, and despite challenges around policy dialogue and little articulation of the UN system role and comparative advantage, the Cosponsors have been largely able to focus on upstream work.

Considerations for strengthening Country Envelope funding model and operations at country level

Strategic Considerations:

- The CE funding model needs to be more flexible, i.e., permit rapid re-programming of funds and activities, in a volatile implementation setting, like Iran.
- Understanding and acting upon social enablers could integrate the basic programme activities, such as PMTCT/EMTCT, condom promotion and distribution, HIV testing, treatment and care services, especially for KPs at higher risk, in a better manner into UHC and PHC. It can be useful to increase the capacity of the Joint Team with respect to the concept and practical use of 'social

enablers' in HIV/AIDS planning (as explained by the UNAIDS consultative group in Montreux, Switzerland in 2019).

Operational Considerations:

- As limited capacity can affect the work of the Joint Programme, certain ways for investing in human resources are to be explored. This can vary from increasing the knowledge and skills of current staff, bringing in new staff with relevant knowledge and skills on HIV/AIDS related programming and monitoring and/or revising the current percentages of time of higher skilled/experienced persons.
- Due to the negative effect of COVID-19 on the quality of implementation, some key informants pointed out the whole Joint Team should spend more energy and time to cover the gaps, i.e., a sort of re-energizing spirit/outlook was requested.
- As mentioned by several focal points, an assessment of mainly 2022 activities was needed prior to starting the activities of 2023. To conduct such an internal assessment may require updating the monitoring skills of the Joint Team and/or modify some more coherent indicators for monitoring, etc.

Annexes

Annex 1 People/Groups Met and/or Interviewed

Organization	Name	Position
UN Agencies		
UNAIDS Secretariat	Fardad Doroudi	Country Director
	Ali-Reza Vassigh	Strategic Information Adviser
UNDP	Claudio Providas	Representative
	Hedieh Khaneghahpanah	Project Manager (JUNTA Focal Point)
	Ali-Reza Tajlili	Monitoring and Evaluation Consultant
UNFPA	Sathya Doraiswamy	Representative
	Monire-Therese Bassir	Head of Health Cluster
	Zahra Mirniam	Programme Associate (JUNTA Focal Point)
UNHCR	Fumiko Kashiwa	Assistant Representative
	Ruben Barbado	Senior Protection Officer
	Zarrin Eizadyar	Senior Programme Assistant (JUNTA Focal Point)
UNICEF	Gilles Chevalier	Deputy Representative
	Mohammad Eslami	Head of Health Cluster
	Zahra (Mojan) Majdfar	Health & Nutrition Officer (JUNTA Focal Point)
	Golfam Seif	Adolescent Development and Participation Officer
UNODC	Alexander Fedulov	Representative
	Kaveh Moradi	Deputy Representative
	Gelareh Mostashari	National Programme Officer and Senior Expert in Drug Demand Reduction (JUNTA Focal Point)
	Morvarid Javidi	Programme Assistant
WFP	Negar Gerami	Representative
WHO	Mikiko Senga	Deputy Representative
	Omid Zamani	National Professional Officer (JUNTA Focal Point)
Government Partner Organizations		
National AIDS Council	Mohammad Mehdi Gouya	Manager and Director General of CDC (MoHME)
	Hengameh Namdari	HIV Prevention Focal Point and the Head of national HIV M&E Task Force (MoHME)
	Katayoun Tayeri	National HIV Care and Treatment Advisor (MoHME)
	Naser Soleymani	Prisons Organization

	Seyed Ebrahim Ghoddousi	Prevention and Vulnerability Reduction Department (MoHME)
	Fariborz Ahmadi	Drug Control Headquarters (DCHQ)
	Mehdi Ghambari	Psychosocial Health Office (MoHME)
	Hamed Safari	AIDS Control Office (MoHME)
	Majid Kazemi Asl	Deputy Department of Ministry of Cooperatives, Labour and Social Welfare
	Sedigheh Kalanaki	Management Centre (MoHME)
	Kambiz Mahzari	SWO
	Shahnaz Sheibani	SWO-HIV Focal Point
	Malihe Molavi	Secretariat of Health Supreme Council
	Nasrin Goudarzi	Ministry of Interior
	Taktom Khojasteh	Prevention and Vulnerability Reduction Department (MoHME)
	Maryam Rahan	Deputy Department of Health (MoHME)
	Parviz Gorji	AIDS Control Office (MoHME)
Hazrat Abbas VCT (Malard, Tehran)	Golimohammadi	CDC
	Gholamipoor	HIV/AIDS Specialist (University of Medical Science of Iran)
	Mohammdzadeh	VCT Manager
Non-government Partner Organizations/Persons		
NGO/CSO/Peer Group Network	Fatemeh Bahramabadian	Chair of the Board at Chatra NGO
	Nasrin Kordi	Technical Manager of the Tehran Positive Club
	Amir-Reza Moradi	Executive Director, of Iranian Positive Life
	Mehdi Asadi	Director of Green Thoughts Association
Research Institutes/ HIV Specialists	AliAkbar Haghdoost	Professor of Epidemiology, Department of Biostatistics and Epidemiology, Faculty of Public Health and Senior Researcher of HIVHUB
	Hamid Sharifi	Professor of Epidemiology, Department of Biostatistics and Epidemiology, Faculty of Public Health and Senior Researcher of HIVHUB
	Seyed Ahmad SeyedAlinaghi	Associate Professor and Research Deputy of IRCHA
	Ghobad Moradi	Professor (Social Determinants of Health Research Centre, Research Institute for Health Development) Kurdistan University of Medical Sciences
	Froozan Akrami	Senior Researcher at Shahid Beheshti University of Medical Sciences
	Akbarpour	Tehran University of Medical Sciences
	Ghaderi	Kurdistan University of Medical Sciences

ANNEX 2: DOCUMENTS REVIEWED AND/OR REFERENCED

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ANNEX 3: EVALUATION QUESTIONS

Strategy and Design (Relevance and Coherence)

Evaluation Question 1: How well is the Country Envelope allocation mechanism working?

- How well does the global allocation formula ensure resources are directed to regions and countries most in need? What factors help or hinder this resource allocation?
- How dynamic is the global allocation model (e.g. in responding to changing epidemic data and needs)?
- What drives decision making for how country envelope funds are allocated between Cosponsors at the country level? Are transparent criteria in use to ensure the right allocations are going to the right Cosponsors, based on country needs?
- How far is 'performance based' allocation (absorption capacity and reporting performance) being used to decide how to allocate funds to Cosponsors at country level? How appropriate is this?
- What is the rationale and vision for country envelopes in 2022-2023 now BUF funds have been subsumed?
- How successful have BUF funds been and why?
- How can the allocation model be improved to ensure resources are targeting countries most in need?

Implementation (Efficiency and Effectiveness)

Evaluation Question 2: How well are the structures and processes to support the implementation of the country envelope model working in practice?

- How far is country envelope allocation and planning integrated into annual Joint Planning processes?
- How are country envelopes helping to prioritise and address strategic country needs? Examples?
- How user friendly is Secretariat guidance and templates? Is guidance widely used/adhered to by Joint Teams?
- How efficient are country envelope disbursement processes? Were the actual funds received, the same as planned? How are disbursement processes affecting the potential to achieve results?
- What has been your experience of reporting on country envelope and/or BUF funds – easy/intuitive or difficult/burdensome? Please provide examples.
- In your opinion, does the volume of country envelope funding merit the time and effort spent programming and reporting on the funding (transaction costs)?
- To what extent are quality assurance processes improving the relevance and accountability of country envelope funds and actions e.g. have country allocations increased/decreased as a result of regional QA processes; have QA processes improved the strategic focus of funds? Please provide examples.
- What factors help or hinder the timely implementation of country envelope funds?
- How can the efficiency of country envelope processes be improved (e.g. is annual cycle appropriate, what processes be further streamlined?)

Evaluation Question 3: To what extent have country stakeholders (government, civil society, PLWH, key population groups, and other partners) been engaged in UN joint planning processes and implementation at country level?

- To what extent are country partners engaged and influencing UN joint planning processes? Please provide examples.
- To what extent are country partners implementing activities funded through country envelopes?
- How is engagement with country partners strengthening the relevance and alignment of UN Joint Plans and country envelopes to country needs and priority gaps? Please provide examples.
- How are country envelopes leveraging partner support for the national response?
- What factors help or hinder greater engagement of country stakeholder and beneficiaries in UN planning, implementation and accountability processes.

Evaluation Question 4: To what extent have country envelope and BUF funding contributed to addressing gender equality, human rights and community-led responses?

- How are gender, human rights and community leaders being engaged and influencing country envelope planning and implementation processes?
- How are country envelope and BUF funds directly supporting gender equality, human rights, and community responses? Please provide examples.

- Considering the totality of the Joint Plan/s in any given year, to what extent are country envelopes investing in gender equality, human rights and community responses, compared to other areas such as treatment, prevention, EMTCT etc.? Are there any trends?
- What factors are helping or hindering the use of country envelope funds to support gender, human rights and community responses e.g. any guidance or processes that could be strengthened in this respect?

Evaluation Question 5: To what extent have country envelope and BUF funds supported the adaptation of HIV programming during the COVID-19 pandemic in a flexible and timely way? How has COVID-19 impacted on the implementation of country envelope activities?

- How are country envelope funds supporting the adaptation of HIV programming during the COVID-19 pandemic – what does this support look like?
- How flexible and nimble is the country envelope allocation model for the reprogramming of funds to support resilient HIV responses - timely guidance, feedback, and approval processes for reprogramming country envelope funds?
- How flexible and responsive has Joint Team capacity been to support the reprogramming of funds during COVID-19?
- How did COVID-19 impact on the implementation and performance of the Joint Plan and country envelope funded activities?
- What are the main lessons learned from supporting COVID-19 related HIV programming that could provide useful learning for other countries?

Evaluation Question 6: To what extent have the country envelope and BUF funds achieved country envelope outputs/results as intended ?

- To what extent have country envelope and BUF funds strengthened the prioritisation and strategic use of UN funds, based on country needs/gaps? Please provide examples.
- How have country envelopes reduced fragmentation of Joint Team plans and Cosponsor activities?
- How far are Joint Team members aware of each other's work and country envelope plans/activities?
- To what extent have country envelope funds boosted joint team working, coordination and collaborative action and with what results? Please provide examples.
- How have country envelopes enabled better joint working, coordination, and collaboration with external partners and with what results? Please provide examples.
- Did CE funds fill a gap or catalyse and with what results? Would the same results be achieved without the country envelopes?
- How have country envelopes improved the accountability of UN Joint Plans and activities and with what results?
- What factors have helped or hindered the strategic use of and accountability of country envelope funds?

Evaluation Question 7: What results have been generated through country envelopes and how are country envelopes contributing to the achievement of UBRAF outputs and higher level results?

- What kind of results are country envelopes generating? Please provide examples.
- How have country envelope and BUF funds catalysed action and helped progression towards UBRAF outputs 1-10? Please provide examples.
- How have/are country envelope and BUF funds generating results and contributing to:
  - more equitable access to HIV services
  - breaking down barriers to achieving HIV outcomes
  - sustaining efficient HIV responses which are integrated into health, social protection and pandemic responses?
- What factors have helped or hindered the achievement of results through use of country envelopes?

Evaluation Question 8: To what extent have country envelopes enhanced and changed the capacity of Joint Teams and supported the mobilisation of resources (human, financial, technical) at country level?

- What are the main capacity related challenges (financial, human, technical) faced by the Joint Team? How is the recent capacity assessment planning to address these challenges?
- How have the country envelopes enhanced or changed the capacity of the Joint Team at country level?
- How have the country envelopes helped Joint Teams mobilise and leverage more resources at country level e.g., with Global Fund, PEPFAR, domestic government resources, and with what results? Please provide examples.

How can the Joint Programme use its resources more strategically to achieve more results?

Evaluation Question 9: what are the main factors helping or hindering the achievement of results?
▪ What factors and helping or hindering the achievement of results of the country envelopes? ▪ Capacity and resource related issues (human; financial; technical) ▪ Internal guidance, disbursement, reporting processes ▪ What has gone well that may provide useful learning for other contexts? ▪ Have there been any unintended consequences arising from the country envelope experiences and funding model? ▪ What recommendations do you have for strengthening the country envelope funding model to deliver results?
Evaluation Question 10: What other models exist as potential alternatives for incentivising UN joint planning and funding at country level?
▪ How do country envelopes differ to previous allocation and disbursement models used by UNAIDS i.e. how did Cosponsors get country funds before country envelopes? ▪ How does the country envelope allocation model and processes compare to other models e.g. MDTF for COVID-19, other? ▪ Are there better ways to allocate and strategically use funds compared to country envelopes? Please explain. ▪ Based on your knowledge and experience of working with other models, what recommendations would you make to strengthen the country envelope funding model?

ANNEX 4: MORE DETAILED INFORMATION

Table 11: Challenges/Gaps of NSP4

Challenges/Gaps
Significant gap between identified/registered and estimated cases of HIV
Limited access of women infected by HIV to training, counselling services, voluntary tests and reproductive health care
Incomplete integration of HIV-related services in PHC and UHC
Insufficiency of current services for PWID
Limited knowledge and information on MSM and TG, due to social and cultural restrictions
Inadequate number of DICs and insufficient services for high-risk women
Not enough attention to the prevalence of HIV among street children
Not enough support to peer groups and mobile clinics engagement in outreach activities
Low level of NGO participation
Increasing prevalence of HIV among the youth, with the probable unprotected sexual relations among them
Inadequate responsiveness to S&D and insufficient supportive laws and regulations to protect PLHIV
Prevalence of stimulant use among the youth
Insufficiency of financial support beyond public resources for implementing HIV prevention and control plans
Unsatisfactory activity level of the Positive Clubs for fulfilling the needs of PLHIV and their intimates
Inadequacy of current health care services, ART, psychological counselling services, home-based health care and social-economic protection for people with AID
Not enough attention to geographical distribution of HIV/AIDS in Iran for selecting the priority areas

Table 12: UN Agencies Financial Support to NSP4

Name of Organization	Target Group	Source of Funds								
		Organizational Operating Budget	DCHQ	The Global Fund	UNHCR	WHO	UNODC	UNFPA	UNICEF	Others
SWO	PWID	✓	✓	✓						
	Street Children	✓							✓	
	Wives/ Partners of PWID	✓					✓			
MoHME	Venereal Patients	✓					✓			
	Refugees	✓			✓					
	Adolescents	✓							✓	
	High Risk Women	✓					✓			
	PWID	✓		✓	✓					
	Non-injecting Drug Users	✓			✓					
	People Who Use Stimulants	✓			✓					
	Wives/ Partners of PWID	✓					✓			

Table 13: High Priority Areas of the Joint Programme on AIDS

High Priority Areas
Strategy Result Area 1- Children and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment
Strategy Result Area 2- New HIV infections among children eliminated and their mothers' health and well-being is sustained
Strategy Result Area 3- Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV
Strategy Result Area 4- Tailored HIV combination prevention services accessible to key populations including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants
Strategy Result Area 5– Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Strategy Result Area 6- Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed
Strategy Result Area 7- AIDS response is fully funded and efficiently implemented based on reliable strategic information
Strategy Result Area 8- People-centred HIV and health services are integrated in the context of stronger systems for health

Table 14: Country Envelope Allocation per Annum, per Cosponsor, per Strategy Result Area

Area	2018	2019	2020	2021	2022	2023	Total
SRA 1							***870,727***
WHO	29,960	32,100	23,000	45,368	30,000	30,000	190,428
UNDP			100,000	118,194	45,270	90,000	353,464
UNODC	55,185	65,270	44,650		41,730		206,835
UNHCR					60,000	60,000	120,000
SRA 2							***318,275***
WHO	14,980						14,980
UNICEF	54,100	21,395	21,400	21,400	35,000	40,000	193,295
UNFPA					70,000	40,000	110,000
SRA 3							***58,000***
WHO					18,000		18,000
UNODC						40,000	40,000
SRA 4							***406,063***
UNFPA	58,537	50,760	44,650	70,000			223,947
UNHCR	50,650	52,044	44,093	30,000			176,787
UNICEF							0
UNODC				5,329			5,329
SRA 7							***146,050***
WHO	35,910	78,431	22,000				136,341
UNODC				9,709			9,709
Grand Total	**299,322**	**300,000**	**299,793**	**300,000**	**300,000**	**300,000**	**1,799,115**

Table 15: CE Funds Allocation by Anticipated Results

Year	Result/Output	Activity	Cosponsor
2018-2019	National PMTCT programme is supported	Conduct formative Assessment and evaluation study on the National PMTCT programme	UNICEF
		Strengthen the health sector information system for monitoring cases of MTCT	
		Development of roadmap to strengthen linkage between public and private sector on PMTCT	
		International consultant to contribute in in-depth review of PMTCT implementation in Iran	WHO
	Better-quality data is produced	Improve linkage between private-sector and national/public sector data	UNICEF
	National research capacity is strengthened	Support implementation of IBBS Integrated Biological and Behavioural Surveillance of female sex workers using RDS	WHO
		Support implementation of integrated bio-behavioural survey of female sex workers using RDS	
		Conduct formative research about using HIV self-testing modalities in Iran	

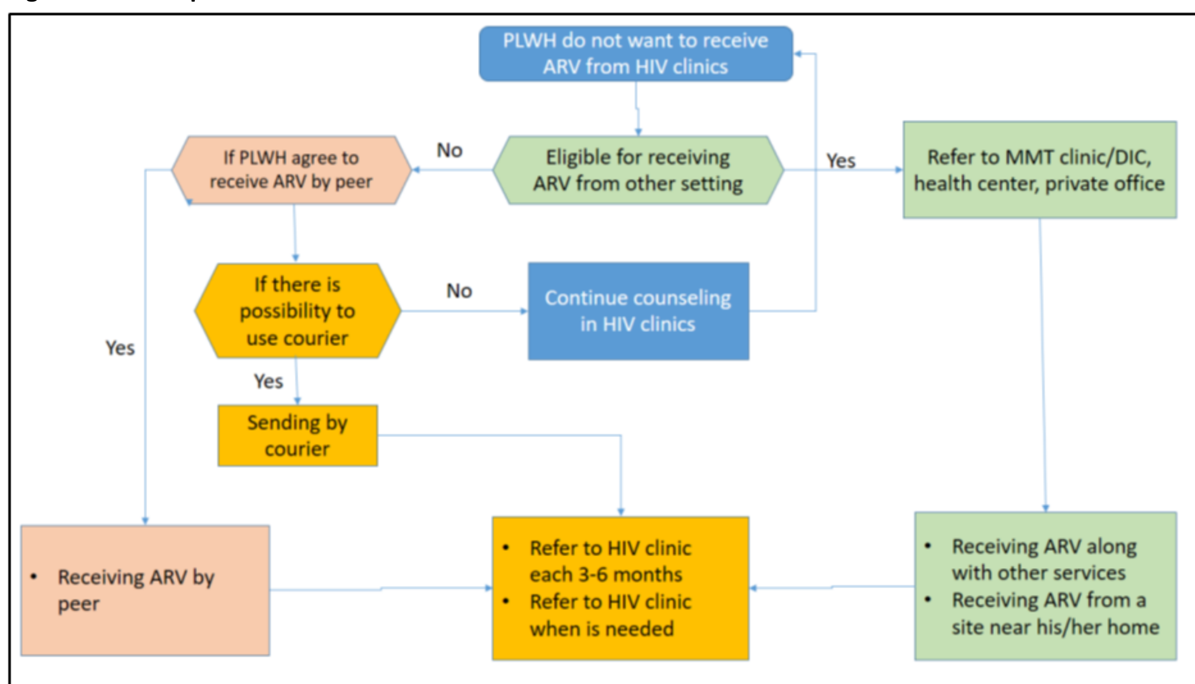
Year	Result/Output	Activity	Cosponsor
		Consultancy to assess Provider Initiated Testing &Counselling Integration in PHC , UHC	
		Consultancy to conduct Mapping and Size estimation of Key Populations	
	Key populations are assisted through community-based interventions	Roll out intensified, peer-led case-finding among key populations and locations	UNODC
		Provision of comprehensive harm reduction & social protection services for vulnerable refugees	UNHCR
		Youth-led and community-based SRH and HIV services in All-in Centres	UNFPA
	Guidelines, standard procedures, etc. are developed	Formulate guidelines and comprehensive service package	UNFPA
		Adapt, test and revise HIV testing guidance for use in short-term residential drug treatment	UNODC
		Develop guidelines and Standard Operating Procedures for the provision of HTC and ART services	WHO
	National capacity is increased through training	One 3-day training workshop for physicians of the above centres	WHO
		Conduct 5 training workshops for approximately 150 outreach and facility-based providers	
		Workshops and consultation meetings between representatives of public and private sector	UNICEF
		One training workshop for staff of centres for vulnerable women, peers and mobile clinics	UNFPA
		Hiring of international facilitator to conduct planned workshops	
		Two capacity building workshop for the personnel of the centres serving women and youth	
2020-2021	National EMTCT/PMTCT programme is supported	Development and rollout of EMTCT roadmap	UNICEF
		PMTCT scale-up	
	Key populations gain better/more access to required supplies	Viral Load monitoring	UNDP
		Procurement of HPV vaccines and condoms	UNFPA
	Key populations are assisted through community-based interventions	People-centred HIV services	WHO
		Promotion of adherence to ART in closed settings	UNODC
		Harm Reduction for Refugees	UNHCR
	National capacity is increased through training	HMIS upgrades	WHO
		STI surveillance	UNFPA
	Capacity of NGOs/CSOs and peer groups is developed	Brief qualitative review of access to selected harm reduction centres in the city of Tehran by utilizing Dutch-based technical expertise and experience	UNODC
		Conduct a rapid needs assessment on the emerging needs of women who use drugs with special emphasis on hard drug scenes	
		Establish a network of civil society interlocutors in the field and plan for responding to identified needs and developing a standard of practice	

Table 16: Cosponsor Presence and Capacity for Implementation of 2022-2023 Joint UN Plans[14]

Agency	Position	Staff Grade	Time %
UNAIDS Secretariat	Country Director	NO-D	100
	Strategic Information Adviser	NO-C	100
	Project Consultant	NO-A	100
	Project Associate	G5	100
	Driver	G4	100
UNDP	**HIV Project Manager (NOB) - GF**	**NO-B**	**100**
	Procurement Analyst (NOA) - GF	NO-A	50
	Procurement Associate (GS6) - GF	P6	100
	Finance Associate (GS7) - GF	G7	100
	HIV Project Associate (G6) - GF (2)	G6	100
	HIV Project Associate (G6) - GF	G6	100
	HR Assistant (GS5)	G5	25
	Driver (GS2) - GF	G2	100
	HIV Monitoring and Evaluation Specialist - GF	Consultant	100
	Operation Clerk (UNV) - GF	UN Volunteer	100
	UNDP Health Team HQ	Other	10
UNFPA	Assistant Representative	NO-C	5
	HIV/AIDS Regional Advisor	P5	5
	HQ Technical Specialist	P3	5
	Programme Associate	**G7**	**80**
UNHCR	Regional Public Health Officer	P4	3
	Senior Programme Officer	P4	4
	Programme Officer	P3	5
	Programme Associate	**G6**	**25**
UNICEF	Health specialist	NO-C	20
	Health and nutrition officer	**NO-B**	**50**
	Adolescent development officer	NO-B	30
	Adolescent and HIV specialist-regional office	P3	100
	Program assistant	G5	20
UNODC	**DDR/HIV Programme Coordinator**	**NO-B**	**30**
	HQ, Senior Expert, Portfolio Manager	P5	3
	HQ, Expert, Monitoring and Evaluation	P4	3
WHO	**National Professional Officer**	**NO-B**	**25**
	Program Assistant	G5	25
	Regional HIV adviser (multiple)	Other	5

[14] Each Cosponsor's Focal Point in the JUNTA meetings is highlighted

Figure 3: DSD Implementation Model in Selected VCT Centres



Source: CDC Report on People-Centred Services

Table 17: UNAIDS Technical Support Division of Labour

UBRAF OUTCOME	Joint Programme Results Areas Outputs	Sustainable Development Goals	Primary Contributing Organizations
OUTCOME 1: People living with, at risk of and affected by HIV obtain equitable access and reap equitable benefits from HIV prevention, treatment, care and support services.	1: HIV Prevention	SDG 2, SDG3, SDG 4, SDG 5, SDG 10, SDG 11, SDG 17	All Cosponsors and UNAIDS Secretariat
	2: HIV Treatment	SDG 2, SDG3, SDG 4, SDG 5, SDG 10, SDG 11, SDG 17	UNICEF, UNODC, WHO, UNAIDS Secretariat
	3: Paediatric AIDS, Vertical Transmission	SDG 2, SDG3, SDG 4, SDG 5, SDG 10, SDG 11, SDG 17	UNICEF, UNFPA, WHO, UNAIDS Secretariat
OUTCOME 2: Communities of people living with, at risk of and affected by HIV, including key populations, women and young people, are empowered, enabled and effectively resourced to lead HIV service delivery, advocate for and enjoy their right to health, and social and structural drivers of the HIV epidemic are removed	4: Community-led responses	SDG 1, SDG 3, SDG 5, SDG 8, SDG 10, SDG 16, SDG 17	All Cosponsors and UNAIDS Secretariat
	5: Human Rights	SDG 1, SDG 2, SDG 3, SDG 4, SDG 5, SDG 8, SDG 10, SDG 11, SDG 16, SDG 17	UNDP, UNFPA, UNODC, UNAIDS Secretariat
	6: Gender Equality	SDG 1, SDG 2, SDG 3, SDG 4, SDG 5, SDG 8, SDG 10, SDG 11, SDG 16, SDG 17	All Cosponsors and UNAIDS Secretariat
	7: Young People	SDG 1, SDG 3, SDG 4, SDG 5, SDG 8, SDG 10, SDG 11, SDG 17	UNICEF, UNDP, UNFPA, WHO, UNAIDS Secretariat

OUTCOME 3: Increased availability of effective, equitable and sustainable systems to achieve and maintain the 2025 targets, through robust financing for national budgets and community responses, greater service integration for people-centred delivery, expanded HIV service access in emergency settings, and effective pandemic preparedness and responses.	8: Fully funded HIV Response	SDG 1, SDG 2, SDG 3, SDG 5, SDG 10, SDG 11, SDG 17	UNICEF, UNDP, UNFPA, WHO, UNAIDS Secretariat
	9: Integration and Social Protection	SDG 1, SDG 2, SDG 3, SDG 4, SDG 5, SDG 8, SDG 10, SDG 11, SDG 16, SDG 17	UNICEF, UNDP, UNFPA, UNODC, WHO, UNAIDS Secretariat
	10: Humanitarian Settings and Pandemics	SDG 2, SDG 3, SDG 5, SDG 8, SDG 10, SDG 11, SDG 17	UNHCR, UNAIDS Secretariat

ANNEX 5: 'DEEP DIVE'

Differentiated Services Delivery (DSD)

Background, rationale and alignment of activity

Cosponsor agency: WHO

Implementer: Centre for Disease Control (CDC) of Ministry of Health and Medical Education

Biennium: 2018-2019; 2020-2021; 2022-2023

Name of activity funded by country envelope or BUF funds:

2018-2019

- Conducting formative research about using HIV self-testing modalities in Iran.

2020-2021

- People-centred Services:
  a) Technical Support in Developing and Integration of People-centred Differentiated Services for HIV;
  b) HIV Self-Testing Expansion.

2022-2023

- People-centred Services:
  a) Technical Support in Developing and Integration of People-centred Differentiated Services for HIV;
  b) HIV Self-Testing Expansion;
  c) Implementation of DSD models for KP (NC).

How will expected outputs or deliverables of the activity contribute to addressing the country need/gap?

People-centred Differentiated Service will enhance access to HIV self-testing, build linkage to treatment (ART), and strengthen adherence to treatment. Therefore, it will improve the quality of care, increase patients' satisfaction, and realize outcomes of NAP by responding the specific challenges and barriers for provision of appropriate services that were stated in the NSP4.

Back in early 2018, WHO supported conducting a formative research on using HIV self-testing (HIVST) modalities in the country. The researchers assessed the feasibility and acceptance for different key populations and variety of settings. The findings revealed that there was a need to introduce differentiated HIV testing based on five pillars of (1) partner notification testing, (2) key population testing, (3) HIV testing in high-risk locations, (4) symptom-based HIV testing, and (5) intensifying PMTCT. Moreover, it was known that adoption and application of DSD approach required capacity development for staff in testing facilities since level their skills for appropriate recording test results, data duplication, client tracing, and targeting of HIV testing services towards hard-to-reach high risk groups was low.

These findings (and suggested ways for improvement) matched the findings of other studies conducted by the CDC and national HIV research institutions. The experts had already come to the conclusion that the heterogeneity of the HIV epidemic required differentiated models for HIV prevention and control. According to the national estimation, more than 60% of diagnosed HIV cases lived in six cities/provinces by 2018. The same assessments had stated that the key high risk populations were MSM, FSW, and PWID. These populations were considered as hard-to-reach target groups. They had also noted that there was a need to increase the capacity and knowledge on networking among HIVST providers. Taking all these factors into consideration, the CDC, WHO and the UNAIDS Secretariat agreed that it was time to move away from the routine one-size-fits-all model and try an alternative approach that would better serve the needs of PLHIV and optimize the available resources in health systems.

Based on findings of this research, WHO developed a proposal to support people-centred services by means of HIV self-testing expansion and implementing DSD models for KPs in 2021. The people-centred services for PLHIV and their intimates have been supported for another round, with a focus on developing and integrating the differentiated HIV-related services in national primary health care (PHC) system and increased universal health coverage (UHC).

Activity is aligned to which UBRAF results area and outcome:

Outcome 1; Outcome 3; SRA 1

Supporting which strategic priority area (Global AIDS Strategy):

Result Area 1; Result Area 3

Budget and timeline for country envelope activity:

2018 (US$ 14,980); 2020 (US$ 23,000); 2021 (US$ 45,368); 2022 (US$ 18,000)

Implementation

Nature of activity and participation:

In this project, a model was designed to provide differentiated services to increase the access of high risk KPs to ART and its related services. The model fell into four categories: healthcare worker-managed group; peer-managed group; facility-based individual; and out-of-facility individual. It was decided that a number of physicians, healthcare personnel, nurses, pharmacy manager, social workers and patient/peer groups/family members would be trained and assigned to provide not only antiretroviral drugs but also monitor patients, support the adherence to medications, conduct laboratory tests, and evaluate the opportunistic infections of MSM, FSW, PWID and TG populations. By 2021, five comprehensive health centres were providing the services. Four of them, located in Tehran province, were affiliated to Iran Medical University and one, located in Isfahan province, was linked to Isfahan Medical University. Moreover, several other family physicians and VCT centre experts in Sistan and Baluchestan province were trained for this approach. Two private offices in Tehran, in addition to several Methadone Maintenance Therapy clinics and Drop-In-Centres were also putting this approach into practice. According to the national protocols, HIV/AIDS-related services can be provided in such settings to a degree

under certain conditions. Throughout the time, numerous relevant documents (including policies, procedures guidelines, protocols, training materials, and templates for data collection and reporting) were drafted and shared with different implementing bodies and service providers. For increasing the capacity of each group of involved persons, appropriate training modules were created and a range of related training courses were offered.

Date in annual cycle when funds were received by Cosponsor for activity:

According to CDC, funds were received timely. Yet, WHO could not put into operation its plans for expansion HIV self-testing and DSD until early August 2020. The reason was that CDC experts were simultaneously involved in COVID duties.

Activity implemented (on time, on budget and as intended):

After the 2020 implementation deadline was extended to end of August 2021, the activities intended to be done in the second biennium were performed on time as budgeted.

Evidence of implementation:

Expenditure to date: Up to now, a total amount of US$ 101,348 has been allocated to above-mentioned activities.

Reporting to date: The CDC has submitted, at least, seven narrative reports, two of which are in English. The last one, dated 2021, mentions the project implementation challenges along with suggestion for solutions. These are in addition to WHO project regular reports in 2018, 2020 and 2021. The report for 2022 will be submitted by the end of the year.

Challenges, bottlenecks, unintended consequences experienced:

The outbreak of COVID-19 adversely affected the project, especially the activities that the peer groups were expected to perform. The epidemic conditions of the COVID-19 disease caused the mobilized peer groups in pilot sites not to access the high risk KPs as frequently as planned. In some cases, the service recipients were reluctant to see them, especially during the peak periods. In general, the peer groups could not encourage the target groups to go to the VCT centres for counselling services and other required services. Besides, the training of the personnel as well as project monitoring tasks were all delayed for three months.

Other main challenges included the selection of peer groups. In case of Isfahan, the number of eligible persons for receiving ART services outside the VCT centres were few. Besides, they were living far from each other and from the VCT centre. Given the insufficient numbers of peer group members, it was difficult to provide all identified cases with such services. Financially speaking, in addition to the transportation costs of the peer groups, the daily payment of peer groups was also a serious issue.

Moreover, the engagement of peer groups in the implementation process revealed that different high risk KPs required the involvement of specific peer groups, i.e. FSW, MSM, PWID, and TG populations had to be contacted by their own peer group. Otherwise, peer groups did not feel safe and secure enough to find cases among different KPs. Women members of peer groups were especially concerned about it.

The personnel of healthcare centres were concerned about the sustainability of the intervention. They thought that if such community-based interventions could not continue, the existing patients would feel discouraged and stop referring to the counselling centre.

It was observed that in some cases the diagnosed KP were reluctant to receive services from the peers. They preferred to be in direct contact with physicians, nurses and healthcare workers.

Results

The first pilot project of People-centred DSD, has already been completed. The second phase the project is now under way in 10 more sites. Based on the success stories and lessons learned the model will be revisited and if the funding does not limit its expansion the DSD approach will be taken on a national scale.

Although some argued that it was too early to confirm that invested inputs through CE funds in promoting DSD have led to substantial results, case study evidence indicates that differentiated ART delivery by means of a health care worker-managed group, client-managed group, facility-based individual, and out-of-facility individual is improving the situation in the pilot sites and contributing to provision of more equitable benefits to PLHIV, especially less privileged KPs.

To explain how the activities undertaken in 2021 contributed to a chain of results, it is noted that the project was prioritised based on the country needs and the CE funding allocation in all three years was used strategically. It has also provided a potential opportunity to strengthen the Joint Team internal and external collaboration, as the example of performing of PMTCT with a DCD approach shows. Given other assumptions of the ToC, the project contributed to the national responses to COVID-19 I the context of HIV. During the COVID-19 outbreak, the peer groups mobilized in all five pilot sites could deliver ART and PPE packages to selected KPs as far as possible. According to the project, selected target groups could choose to receive ART service by postal delivery. So, when face-to-face contact became unsafe during the peak period the pandemic, the project activities were sustained to some extent.

As of its linkage to the Joint Programme Outcome and Results, the whole project was designed and implemented to address UBRAF outcome 1 and SRA1. Moreover, it also began developing the capacity of peer groups that was a new type of intervention, compared with building outreach teams affiliated to the VCT Centres, who were not obliged/mandated to mobilize peer groups to reach out KPs. In this sense, it also contributed to the UBRAF outcome 2. Offering numerous training courses to different groups on how to manage ART and self-testing processes strengthened the national capacity, which consecutively was in line with UBRAF outcome 3. In terms of its contribution to the National Strategic Plan (2020-2024), the DSD project has been targeting the same hard-to-reach PLHIV that the NSP5 has identified as KPs.

Catalytic Character of People-centred Differentiated Services:

As Table 18 shows that the catalytic role of the CE funds to introduce and implement the CDC approach in pilot sites ranges was most notable in developing the capacity of human resources to address low level of case findings among hard-to-reach KPs.

Table 18: Catalytic Character of DSD

Green	Regular updates of protocols, according to the latest WHO treatment guidelines, and subsequent training of physicians, nurses and healthcare workers	Strongly catalytic: Improved; multiplier; accelerated Technical support and regular consultation of UNAIDS Secretariat and WHO regarding training, training materials, consultation services have built confidence that the new approach is applicable in 4 pilot sites.	Exceeds expectations (notable catalytic effect)
Amber	Covering the needs of those PLHIV that were neglected by the previous routine methods	Catalytic: Innovative; multiplier UNAIDS country envelope activities made it possible to reach out to those MSM, FSW, TG and PWID that would not refer to the VCT centres. Therefore, the number of diagnosed patients increased in the pilot sites. There was also an increase in the number of ART recipients and adherence to treatment among those reached out by the peer groups.	Meets expectations (catalytic effect is as expected)
Red	Optimizing the potential of peer support	Less catalytic: Interventions based around peer support and social networks still need to be supported in terms of training and mobilising resources to reduce challenges the project is facing in this regard.	Less than expected (no notable catalytic effect).

The CDC experts were especially taken with the innovative ways of DSD in normalizing HIV test among FSW as well as pregnant women. They also found DSD approach as a platform for strengthening national stakeholders but also increasing the collaboration and coordination of the UN agencies. They believed that once the DSD approach was understood and put into practice, it opened up the scope of their work in VCTs. As an example, when they were running a PMTCT project with the support of UNICEF, the health workers that had learned through DSD training to reach out women outside the VCTs had found 420 cases by extending their operation to a park in the neighbourhood.

Scale of the expected result:

It was anticipated that the DSD model, once extended to the national level, would enhance the quality of PLHIV's life, improve the provision of ART services qualitatively and quantitatively, support the *Treat All* policy, and eventually achieve *90-90-90 goals*. Although the latter has not been achieved and the approach has yet to be scaled up in the coming years, the case study evidence (including the field visit observations) indicated that more PLHIV were diagnosed and more of them received ART services (compared with the figures recorded for the previous year in the same VCT centres).

Role of UNAIDS in following up activity and results:

WHO introduced the DSD model, which was commended by the Eastern Mediterranean Regional Office (EMRO) of WHO. Consequently, the CDC experts started modifying the model and guidelines so that it fits to the situation in Iran.

Innovative initiatives:

Prior to applying DSD approach into healthcare centres and Behavioural Disorders Consulting Centres, the idea of using social marketing in HIV prevention was unknown to most healthcare personnel. At best, it was rarely practiced (UNAIDS, 2015). Though the support given by the Joint Programme to promoting social condom marketing was not via the CE funds allocation, the special services to FSWs relied on this initiative and the staff of health facilities greatly appreciate and attribute it to DSD pilot projects.

Critical success factors which help explain the results:

Implementation of DSD, though in a limited scope, has been opening the debate on possibility of integration of the National AIDS programme into the primary healthcare system (Farahbakhsh, 2019). Given the stigma and discrimination against PLHIV and the impossibility of covering all their healthcare needs as well as HIV/AIDS-related services in one place, a collaborative integrated model such as DSD seems more appropriate. The achievements and learnings of the current DSD pilot projects in five locations can feed into this process.

The strong CDC ownership of the programme gives hope to its sustainability.

The project contributes to GEWE significantly, as one component is based on community-led interventions that in case of expansion can contribute to reduction of gender inequalities and S&D.

The regular interaction among the UNAIDS Secretariat, the Cosponsors and SIP committee members resulted in developing a set of activities that brought in WHO (responsible for HIVST expansion), UNICEF and UNFPA (responsible for supporting PMTCT/EMTCT and integration of services with maternal, new-born and child and reproductive health programmes) through CE funds model. The interventions have been initiated in the most appropriate settings for provision of such services in the country, i.e. VCTs.

Lessons learned:

The differentiated service delivery is a dynamic approach that is based on cross-sectional/time needs and also capacity of each healthcare centre. Yet, it is necessary to strengthen structure of each centre.

The unexpected consequences of COVID-19 outbreak taught that how important it is to provide services at a right time and have alternative solutions when disruptions happen.

Raising patient expectations should be avoided. Otherwise, the periodic nature of some interventions might cause disappointment.

Patients do not need to benefit from only one method for treatment and the methods can be changed at different times according to the individual's needs.

PMTCT and harm reduction programmes can be integrated if the basic structure and human resources of primary health care are redefined. It implies to differentiate between 'integration' and 'linkage' within the PHC system.

The mobile sort of service provision facilitated the access to the marginalized PLHIV. Adopting the DSD approach helped address the inconsistency VCT centres working hours with the presence of high risk KP in the neighbourhood.

Since the initiation DSD-based activities, part of the pilot projects has been implemented by peer groups. After selection they receive tailored training. Members of peer groups are paid by the VCT centres to ensure that they take the tasks seriously though it was found out that criteria for their selection should include personality traits, social and behavioural attitude, familiarity with HIV/AIDS and HIV treatment in addition to the candidate's economic status.

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