

**NATIONAL
COMPREHENSIVE PrEP &
CONDOM PROGRAMMING
STRATEGY AND
IMPLEMENTATION PLAN**

**A Road Map for Key
populations**

2022-2026

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ABBREVIATIONS

<i>ARV</i>	<i>Antiretroviral drugs</i>
BBS	Bio-Behavioural Survey
BBSS	Bio-Behavioral Surveillance Studies
BSS	Bio-behavioural Surveillance System
CDC	Center for communicable Disease ControlCenter
COVID-19	Coronavirus disease-2019
CDP	Condom Distribution Programs
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
DMT	Decision-Making Tool
FGD	Focus Group Discussion
FSW	Female Sex Worker
FYDP	Five-year National Development Plan
GDP	Gross Domestic Product
GOI	Government of Iran
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HTP	Health Transformation Plan
IrMIDHS	Iran's Multiple Indicator Demographic and Health Survey
LMIC	Low- to-Medium Income Countries
MDA	Market Development Approach
MENA	Middle East and North Africa
MOHME	The Ministry of Health and Medical education
MSA	Market System Approach
MSM	Men having Sex with Men
NGO	Non-Governmental Organization
NSP	Needle-Syringe Programs
NSP	National Strategic Plan for Control of HIV/AIDS
OST	Opioid Substitution Treatment
PHC	Primary Health Care
PhD	Philosophy Doctorate
PLHIV	People Living with HIV/AIDS
PO	Prisoners Organization
PrEP	pre-exposure prophylaxis
PWID	People Who Inject Drug
RNA	Rapid Needs Assessment
SBCC	Social and Behaviour Change Communications
SIC	Supervising Implementation Committee
SPA	Service Provider Assessment
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TMA	Total Market Approach

<i>UHC</i>	Universal Health Coverage
<i>UMIC</i>	Upper-Middle Income country
<i>UN</i>	United Nations
<i>UNHCR</i>	United Nations Refugee Agency
<i>UNAIDS</i>	Joint United Nations Program on HIV/ AIDS
<i>UNDP</i>	United Nations Development Program
<i>UNFPA</i>	United Nations Population Fund
<i>VCT</i>	Voluntary Counselling and Testing Center
<i>WHO</i>	World Health Organization

EXECUTIVE SUMMARY

The success of the PrEP and condom program requires the cooperation and coordination of all sectors including government, the private sector, civil society and donor agencies working on HIV prevention. In supporting this effort, we employed a 10-Step Strategic Approach named Comprehensive Condom Programming (CCP) that encourages the participation of international agencies and at the top of them is UNAIDS, while placing ultimate responsibility for decision-making and implementation in the hands of national partners. The design of a condom program may vary from country to country depending on many factors, ranging from the local epidemiology of STIs/HIV and the condition of a country's health infrastructure to the cultural context of targeted areas and budgetary issues. However, the process of designing and implementing a SMART (specific, measurable, achievable, realistic and time-governed) strategy has many common features, which are described in this document.

This PrEP and condom program, the country's first national PrEP and Condom strategy plan for key populations, developed in the line of the 5th NSP of HIV/AIDS Control of Iran. For stakeholders across the country, the HIV Plan articulates goals, objectives, and strategies to prevent new infections via key populations, and better integrate and coordinate the efforts of all partners to achieve the ultimate targets for ending the HIV epidemic in Iran. The PrEP and condom program also establishes indicators to measure progress, with quantitative targets for each indicator and designates priority populations and key areas of focus.

VISION

- Iran will be a place where new HIV infections are prevented among key populations and their partners, every person have access to PrEP and high-quality condoms and lives free from stigma and discrimination.
- This vision includes all key populations and their partners, regardless of age, sex, gender identity, sexual orientation, ethnicity, religion, disability, geographic location, or socioeconomic circumstance

This vision is accompanied by two high-level goals, which frame the PrEP and Condom program's more specific objectives. Strategies are articulated for everyone to participate in working to achieve the goals through integrated individual-, community-, and structural-level responses. The order of goals, objectives, and strategies does not indicate any

prioritization, and many are intertwined. The two goals and associated objectives are as follows:

Goal 1: Prevent New HIV Infections through the use of key populations of male condoms

1. To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026
2. To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026
3. To increase access and availability of male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026

Goal 2: Prevent New HIV Infections through the Use of Target Populations of PrEP

1. To achieve the high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026
2. To increase awareness, adherence, and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026

Priority Populations

To focus efforts and resources for the greatest impact, the CDC Department of the MOHME and UNAIDS Country Office in Iran decided to cover Key Populations as populations disproportionately affected by HIV. Based on this protocol, the PrEP and Condom Program prioritizes efforts to reduce disparities and improve HIV outcomes among:

- Female Sex Workers (FSW)
- Men who have Sex with Men (MSM)
- People Who Inject Drug (PWID)
- prisoners
- Transgender (TG)
- PLHIV couples

Key Areas of Focus

This PrEP and Condom Program identifies key focus areas with the greatest potential to strengthen the national HIV prevention response and should be integrated across program design, implementation, monitoring and evaluation (M&E):

- a. **Adopt a Total Market Approach (TMA).** TMA aims to ensure that subsidy is targeted so that condoms for all population segments are available at affordable prices to varied market segments through effective coordination and collaboration between

government, NGOs, and private sector companies based on each sector's relative strengths and efficiency.

- b. **Use data and evidence about the total market and users to design interventions.** It is critical to understand patterns of condom use in different segments of the key populations and the dynamics of the total market, including user perceptions and motivations, prior to designing interventions.
- c. **Put the user at the center of the interventions.** Interventions should seek to understand and then focus on the specific needs of priority populations and ensure equitable access to condoms. Interventions should be designed with the understanding that user choices – such as choosing different types of condoms or other HIV prevention options – can influence how and when condoms are used.
- d. **Align within the context of broader HIV prevention and treatment strategies.** The challenge is to develop condom programming that accounts for evolution in treatment and prevention programs, without losing the focus required to increase condom use among populations who still need them, especially given the slow scale-up of PrEP as well as ART adherence challenges in some settings or among some populations (e.g., youth or men not seeking treatment). This PrEP and Condom Program is in line with Iran's 5th NSP of HIV/AIDS Control.

The vision, goals, objectives and other components of the PrEP and Condom Program were developed with input from numerous and varied stakeholders in the UNAIDS and CDC Department of the MOHME. The PrEP and Condom Program is designed to be useful for a broad audience, including people working in public health, health care, government, community-based organizations, research, and academia. It serves as a roadmap for stakeholders from all sectors of society to guide development of policies, services, programs, initiatives, and other actions to achieve the nation's vision of ending the HIV epidemic. The PrEP and Condom Program focuses on two areas that will have the greatest impact on the health of the nation: preventing new HIV transmissions using condoms by key populations and their sexual partners; and HIV prevention using PrEP drug by target populations.

The PrEP and Condom Program includes indicators for measuring progress and quantitative targets for each indicator. To ensure implementation and accountability, an operational plan that documents the specific actions that different partners will take to achieve the PrEP and Condom Program's goals and objectives will be released subsequent to the PrEP and Condom Program.

FOREWORD

Iran has a concentrated HIV epidemic with a low prevalence of less than 0.1% in the general population and PLHIV was reported about 59,000 (33,000-130,000) by the end of 2019, which is the highest number of PLHIV in the Middle East and North Africa (MENA) region.¹ Iran has been one of the active countries fighting against HIV/AIDS in the MENA region during the last decades. Moreover, there is a strong push to strengthen the national health management system concerning HIV prevention and control. In Iran, HIV/AIDS has its unique features, from changes in modes of transmission to improvement in treatment and care programs. Although Iran is one of the pioneers in implementing applicable and appropriate policies in the MENA region, including harm reduction services to reduce HIV incidence, people with substance use disorder continue to be the majority of PLHIV in the country. In line with other nations, the programs in Iran aim at the UNAIDS 90-90-90 targets and to eliminate mother-to-child HIV transmission. However, in the context of Iran, data for 2018 show that the projected goals have not been achieved and 36%, 57% and 82% of the 90-90-90 goals have been achieved, respectively.²

Globally, an effort to plot the future course of the HIV response has developed a set of interim targets for 2025 that need to be achieved to reach the Sustained Development Goals HIV targets within the Sustainable Development Goals. In line with this global effort, the Iran's 5th National Strategic Plan (NSP) of HIV/AIDS for the period of 2020-2024 has also been approved. Priorities of the 5th NSP in the continuum of the 4th NSP, are limiting prevalence rates among key populations and scaling up HIV prevention, care and treatment services for high-risk groups.³

CHAPTER 1. INTRODUCTION

1.1. Why Condom

Preventing new HIV infections is central to ending the AIDS epidemic. Several methods and interventions have proved highly effective in reducing the risk of, and protecting against, HIV infection, including male and female condoms, the use of antiretroviral medicines as pre-exposure prophylaxis (PrEP), behaviour change interventions to reduce the number of sexual partners, and the treatment of people living with HIV to reduce viral load and prevent onward transmission. It should be noted that female condoms are not part of the condom programming in Iran and are only available to key groups in certain public centers across the country, which are provided by international organizations. The Global HIV Prevention Coalition have endorsed a detailed road map to provide the basis for a country-led movement to scale up HIV prevention programs to meet targets to end AIDS as a public health threat by Sustained Development Goals.⁴ In line with primary prevention targets, HIV prevention responses need to be organized around five central pillars, depending on country context:

¹ UNAIDS. <https://www.unaids.org/en/regionscountries/countries/islamicrepublicofiran#:~:text=In%20the%20Islamic%20Republic%20of,of%20all%20ages%20was%200.05>. [Accessed 9.8.2021].

² UNAIDS data 2019. <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data> [Accessed 1.8.2021].

³ UNAIDS.

file:///D:/UNAIDS/PrEP/Papers/Threeday%20consultative%20meeting%20held%20to%20develop%20Iran%E2%80%99s%205th%20National%20Strategic%20Plan%20of%20HIV_AIDS%20UNDP%20in%20Iran.html

⁴ FHI 360: <https://www.malecircumcision.org/resource/implementation-hiv-prevention-2020-road-map-first-progress-report-2018>

1. Programs for key populations, including sex workers, gay and other men who have sex with men, prisoners, people who inject drugs and trans-gender people;
2. Programs for adolescent girls, young women and their male partners in settings with high HIV incidence;
3. Condom programming (promotion and distribution);
4. Voluntary medical male circumcision; and
5. Pre-exposure prophylaxis (PrEP).

Condoms play a special role in combating the spread of HIV/AIDS because of their ability to protect against the sexual transmission of HIV. Condoms remain central to the five critical pillars for HIV prevention. At the 2016 Political Declaration the world committed to avail 20 billion condoms annually in the low –middle income countries (LMICs) (referred to as the 20 by 20) in support to its commitments to achieve a 90% condom use during the most recent sexual activity with a non-regular partner access for 90% of young people, key populations and other people at higher risk to HIV combination prevention services⁵.

Condoms are effective - Strong evidence shows that condoms effectively reduce the risk of HIV transmission. For specific populations, increased levels of condom use are also associated with decreased rates of reported STIs. Male and female condoms play a central role in halting the rising rates of STIs, including HIV. A reexamination of HIV seroconversion studies suggests that condoms are 90 to 95% effective when used consistently, i.e. consistent condom users are 10 to 20 times less likely to become infected when exposed to the virus than are inconsistent or non-users⁶.

Condoms are cost-effective - condoms are highly effective and the most widely available prevention tool for people at risk of HIV infection and other sexually transmitted infections (STIs). Condoms are inexpensive, cost-effective and easy to store and transport, their use does not require assistance of medical or health-care personnel and they can be utilized by anyone who is sexually active.

1.2. Why PrEP

In September 2015, WHO recommended oral Pre-exposure prophylaxis (PrEP) as “an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.” Several clinical trials have shown that an antiretroviral (ARV) drug called Truvada (Emtricitabine/Tenofovir disoproxil fumarate) reduced the risk of HIV infection in both women and men, an approach known as PrEP. It is a proven effective biomedical HIV prevention intervention that when taken consistently can decrease the risk of acquiring HIV from sex by up to 99%. The expanded indication for the use of PrEP in key populations is very recent.

⁵Introduction to the Condom Needs and Resource Requirement Estimation Tool. <file:///D:/UNAIDS/Condom/Important%20documents/Condom-tool-3.04-intro-26-June-2019-1-1.pdf>

⁶ Pinkerton SD, Abramson PR. Effectiveness of condoms in preventing HIV transmission. Soc Sci Med. 1997 May;44(9):1303-12. doi: 10.1016/s0277-9536(96)00258-4. PMID: 9141163.

1.3. STRATEGY DEVELOPMENT PROCESS

1.3.1. Approach

The strategy development was all-inclusive and participatory with strong government leadership via CDC department of the MOHME and Scientific, technical and financial support of the UNAIDS Country Office in Iran.

The strategy development process used a mixed method approach to develop evidence-based PrEP and condom programming road map for key population in line with the 5th National Strategic Plan (NSP) of HIV prevention of Iran. The development of the PrEP and condom programming is based on a SMART (specific, measurable, achievable, realistic and time-governed) design using a strategic approach. Condom programming strategies and approaches need to be tailored to the context and needs of different communities. High and equitable use of condoms can be achieved efficiently when the public, social marketing and commercial sectors work together to deliver condoms to all target populations. This total market approach seeks to maximize market efficiency, equity and sustainability.

Sustainability is a particular issue in low- and middle-income countries that rely heavily on donor assistance. The principles of the Comprehensive Condom Programming (CCP) was used and central to this strategy is Total Market Approach⁷. The strategy is to strengthen coordination, leadership, demand generation and logistics management, while ensuring growth of the current Total Market. The strategy is aimed at increasing demand for PrEP and male condoms, improving availability, access, and utilization, strengthening the condom logistics management, monitoring and evaluation.

1.3.2. Strategy Development Subjects

Key program managers, policy makers and others most responsible for and knowledgeable of PrEP and condom programming including individuals from UNAIDS Country Office, Government (Ministry of Health, outside of MOHME), AIDS NGOs, Family planning NGOs, Social marketing organizations that distribute condoms, Major commercial condom distributors, University or other special condom programming/HIV prevention researchers included in the study as study subjects.

1.3.3. Study Development Design

The study conducts in following phases:

1. The first phase will involve a **situational analysis**, in two sub activities:
 - a. To do this, a **desk review** of documents, reports and research pertaining to HIV and sexual and reproductive health to gain background information on the various components of the PrEP and condom programming framework (leadership and coordination; demand, access and utilization; supply and commodity security; and support) were done.
 - b. Using **Need Assessment**, data from the field collected. This activity performed in following steps:
 - i. To arrange a group of someone with expertise in demography or related fields, Health economist, and experience in condom programming or HIV prevention to coordinate the Needs Assessment for PrEP and Condom Programming.

⁷ UNAIDS (2018) 'Miles to go: global AIDS update 2018', p.55. [pdf]

- ii. Collecting background information available from the internet and other sources. Documents consisted of all national surveys, specialized studies, program description and evaluation reports, and any other documents that assist the assessment of PrEP and condom programming in the country.
 - iii. To summarize the information available in HIV, PrEP and condom studies and program evaluations.
 - iv. To identify the persons responsible for PrEP and condom programming activities in the country, and make a list, including contact information, of the 10 to 15 key program managers, policy makers and others most responsible for and knowledgeable of condom programming. This List of Agencies and Programs Involved in Condom Programming include individuals from Official AIDS organizations/units, Government (Ministry of Health, outside of MOH), AIDS NGOs, Family planning NGOs, Social marketing organizations that distribute condoms, Major commercial condom distributors, University or other special condom programming/HIV prevention researchers.
 - v. To arrange for and hold meeting with the above individuals
 - vi. Analyzing data.
2. Development of a comprehensive and integrated national strategy for PrEP and condom program road map for key populations.
 3. Development of a multi-year operational plan and budget for PrEP and condom program road map for key populations.
 4. Development of recommendations on ways of expanding access and use of PrEP and condom for key populations using social marketing mechanism.
 5. Using data gathered from previous phases, we will link the operational plan to the existing logistics system including systems for forecasting, procurement, distribution, and warehousing, and also we will recommend on appropriate monitoring plan.

1.3.4. Methods for Data Collection and Analysis

The study utilized a concurrent mixed-methods strategy, using both qualitative and quantitative methods to collect data from primary and secondary sources. Qualitative data remained the main source of information due to circumstances related to country context (eg. existing surveys being outdated and limited access to sub-national data) and COVID-19 situation preventing conduct of new surveys. All interviews were conducted in a remote manner due to circumstances related to COVID-19 and social distancing measures in place. In some cases, structured email questionnaires were made use of to solicit responses from key informants, in line with their preference for this mode of response. It was not possible for the research team to undertake any site visits.

The qualitative data included both primary and secondary sources. Primary data was collected through in-depth interviews of selected key informants, and through structured email questionnaires. Secondary data was collected through desk reviews of existing literature, policy and program documents, databases, various research, and analysis of documents. The interviews were conducted online using Skype platform. To comply with ethics requirements, all interview sessions were confidential and anonymous, and

participants were notified up-front about the recording of the session and their voluntary participation.

For quantitative data, reliance was mainly on secondary sources as mentioned earlier. Quantitative data was extracted from CDC of MOHME's existing reports and documents, national government data and information systems, and surveys.

1.3. 5. Definition of the Key Populations

Key populations are defined groups who, due to specific higher-risk behaviors, are at increased risk and vulnerability to HIV irrespective of the epidemic type or local context. In every setting key population are disproportionately affected by HIV, and have higher morbidity and mortality rates than the general population. In most countries inadequate coverage and poor quality of services for key populations continue to undermine responses to HIV. Members of all key populations continue to experience intense stigma and discrimination, legal barriers and constraints to accessing services, and often low prioritization by the public health systems⁸. In 2017, key populations (KP) and their sexual partners accounted for approximately 40% of new HIV infections globally⁹. The majority of people who are newly infected with HIV, and who are not accessing life-saving HIV services are from the key population groups and they live in vulnerable contexts, where inadequate political will, funding and policies prevent their access to health care. Meanwhile, punitive laws, policies, and practices affecting key populations can block their access to HIV-related services. This is particularly true for the criminalization of drug use, sex work, same-sex sexual activity, cross-dressing, or activities considered to be imitating the opposite sex. Key populations and their sexual partners account for an estimated 62% of new infections globally and 97% of new infections in the Middle East and North Africa.

Definitions used in this project are aligned with the Global Health Sector Strategy on HIV/AIDS 2011–2015 and by the UNAIDS “Guidance note on HIV and sex work”. There are five groups recognized by United Nations (UN) agencies as key populations at increased risk for HIV. As PLHIV benefit most from condom programming, this PrEP and Condom Programming Road Map for Key Populations considered following six key populations as target groups:

1. Female Sex Workers (FSW) (18-49y and their clients and regular partners)
2. Men who have Sex with Men (MSM) (15-64y, regular and non-regular partners)
3. People Who Inject Drug (PWID), (15-64 Y, regular and non-regular partners)
4. prisoners, (15-64Y, regular and non-regular partners)
5. Transgenders (TG) (15-64y, regular and non-regular partners)
6. PLHIV couples (15-64y, discordant & concordant couples)

The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.

Female Sex Workers (FSW) include female adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally.

⁸ Consolidated guidelines on HIV prevention, diagnosis treatment and care for key populations – 2016 update. WHO, 2016.

⁹ UNAIDS, 2018

Men who have Sex with Men (MSM) refers to all men who engage in sexual and/or romantic relations with other men. The words “men” and “sex” are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group.

People Who Inject Drug (PWID) refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as “therapeutic injection” – are not included in this definition. Needle-Syringe Programs (NSP) and Opioid Substitution Treatment (OST) for PWID and prisoners are sufficiently included in the HIV prevention service package of Iran.

Prisoners: There are many different terms used to denote places of detention, which hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. Iran identifies prisoners as a key population and outline a separate package of HIV services for this population. Iran has the most comprehensive package of services for prisoners, and it is largely in-line with the *Consolidated Guidelines* and other foundational reference documents issued by the UN. Notably, the provision of clean needles and syringes is not present in any of the packages of services for prisoners in the MENA region, and the only harm reduction intervention mentioned is within Iran’s package (OST). Only one country in MENA (Iran) includes the distribution of condoms, and only in the conjugal rooms.

Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or, in specific cultures. They may express their genders in a variety of masculine, feminine and/or androgynous ways, yet Iran performs the highest number of Gender Affirming Surgery (GAS) in the world after Thailand¹⁰. The high vulnerability and specific health needs of transgender people necessitates a distinct and independent status in the global HIV response.

¹⁰ Iran’s “diagnosed transsexuals.” <http://news.bbc.co.uk/2/hi/7259057.stm> (2008). Accessed 03 Apr 2018.

CHAPTER 2: SITUATIONAL ANALYSIS

2.1. Rapid Needs Assessment (RNA)¹¹

The population council has worked collaboratively with UNFPA to develop and test a rapid needs assessment and data gathering tool to serve as a basis within a country for improving condom programming to prevent HIV transmission. The rapid needs assessment provides the foundation for assessing countries' perception regarding the importance and feasibility as well as the status of condom programming to guide its further development and improve condom use for HIV prevention. The goal of the RNA is to identify the priority "next steps" to improve condom programming to prevent HIV transmission. The specific objectives of the RNA are to:

1. Identify and engage key key opinion leaders and policy makers in improving condom programming,
2. Describe the current status of condom programming, including the level of policy support and the adequacy and sustainability of condom procurement and supply,
3. Identify the main sexual and other practices that influence HIV transmission,
4. Identify the conditions regarding (knowledge, attitudes, geographical distribution, economic, social and cultural factors) that facilitate and hinder condom use, and
5. Identify the most pressing needs for improving condom programming.

The findings related to the RNA in Iran are as follows:

2.1.1. Used Documents

The situational analysis is based on an assessment of the current situation of the HIV epidemic and response in Iran and the results of expectations from the implementation of the Fourth National HIV Strategic Plan (2015–2019). The Epidemiological Analysis relied on findings from a series of Demographic and Health Survey (DHS) - IrMIDHS-2010; Service Provider Assessment (SPA) Report (2018); Behavioral Surveillance Surveys (BSS) Reports (2010, 2013, 2015, and 2020); Sexual Behavior Surveys (2017); The 2009 national Bio-Behavioural Survey (BBS); Islamic Republic of Iran, AIDS Progress Report (2015); and UNAIDS/WHO guidelines on estimating the size of populations most at risk to HIV (2011), Resolutions of the 14th session of the National High Council for Health and Food Security (2015), National guidelines for managing non-occupational exposure to HIV and pre-exposure prophylaxis (PrEP) (2020), National AIDS control program (5th NSP) (2020). Table 2.1.1.1.

¹¹ Rapid Needs Assessment Tool for Condom Programming, Program Report, Population Council 2003.

Table 2.1.1.1. PrEP and Condom Programming Documents Checklist

Condom Programming Documents Checklist	
Year	Title of report/evaluation
2010	Demographic and Health Survey (DHS)
2010	IrMIDHS
2017	Situational Analysis (SA) Report
2018	Service Provider Assessment (SPA) Report
2020	Behavioral Surveillance Surveys (BSS) Report
2015	Youth
2013	MSM
2010	FSW PWID
2018	MOH (FP/STI) Statistics
2017	Sexual Behavior Surveys
2009	The national Bio-Behavioural Survey
2009	The national Bio-Behavioural Survey
2015	Islamic Republic of Iran, AIDS Progress Report
2011	UNAIDS/WHO guidelines on estimating the size of populations most at risk to HIV
2009	Simaye-Salamat
2015	Islamic Republic of Iran AIDS Progress Report
2014	The global fund and the United Nations development program in the Islamic Republic of IRAN
2016	UNASIDS- Prevention Gap Report
2020	GLOBAL AIDS STRATEGY 2021-2026
2020	National guideline of harm reduction services for substance use disorders in MOHME
2015	Resolutions of the 14 th session of the National High Council for Health and Food Security
2020	National guidelines for managing non-occupational exposure to HIV and pre-exposure prophylaxis (PrEP)
2020	National AIDS control program (5 th NSP)

The major condom promotion/distribution/coordination agencies and programs in Iran was listed in the Table 2.1.1.2. Within the framework of the Fifth National Strategic Plan for AIDS Control, numerous and diverse organizations are participating in the country, and a committee to monitor the implementation of the plan is also foreseen in it. Within the framework of the Fifth National Strategic Plan for AIDS Control, numerous and diverse organizations are participating in the country, and a committee to monitor the implementation of the plan is also foreseen in it. However, for the PrEP and condom program, only the organizations mentioned in the table participate and the major role is played by the Department of CDC and the Department of Mental Illness and Addiction of

the MOHME. The Department of CDC in the form of HIV prevention through Women Centers and VCT centers and the Department of Mental Illness through harm reduction program for prisoners, addicts and their sexual partners. Following changes in population policies since 2014 in Iran, and limited access to condom applicants to prevent pregnancy, the Reproductive Health Department of the MOHME no longer has a role in this program and HIV prevention target groups are deprived of the benefits of dual protection. The Welfare Organization and the Prisons Organization are also required by the Fifth National Strategic Plan for AIDS Control to provide training and condom provision for its target groups to prevent HIV and reduce harm. Limited research centers and non-governmental organizations operate in the field of HIV prevention services in Iran and have a very limited role with a much more limited geographical coverage. The five main companies producing and distributing condoms operate in Iran and with a production capacity far beyond the needs of the country, which due to the limited number of people in the family planning services in the public sector, these companies operate with very low capacities. The major United Nations agencies involved in HIV/AIDS policy making and support is UNAIDS and other UN agencies supporting condom programs are UNFPA, UNDP, and UNHCR which provides support through condom supply via MOHME.

Table 2.1.1.2. Contributed organizations for condom programming

What are the major condom promotion/distribution/coordination agencies and programs?
<p>Official HIV/AIDS organizations/units:</p> <ul style="list-style-type: none"> - UNAIDS (As the major UN agency in HIV/AIDS policy making in Iran) - UNFPA - UNHCR - UNDP through Global Fund
<p>Government (MOH):</p> <ul style="list-style-type: none"> - CDC department - Office of Mental Health and Addiction
<p>Government (outside of MOH):</p> <ul style="list-style-type: none"> - Welfare Organization - Prisons Organization
<p>HIV/AIDS NGOs:</p> <ul style="list-style-type: none"> - Iranian Research Center for HIV/AIDS (IRCHA)
<p>NGO Family planning organizations:</p> <ul style="list-style-type: none"> - Family Health Association
<p>Major commercial condom distributors:</p> <ul style="list-style-type: none"> - Bonyan Poshesh Caspian CO - Anjir Talaei CO - Baran Baspar CO - Keyhanbod CO - Hiva Pad Pars CO

2.2. COUNTRY CONTEXT AND RATIONALE FOR A PrEP AND CONDOM PROGRAMMING

The Islamic Republic of Iran is classified as an Upper-Middle Income country¹² (UMIC), and is the second-largest economy in the Middle East and North Africa (MENA) region, with an estimated national income of 10,300 Trillion IRR in 2016, up from 6,000 Trillion IRR in 2012.¹³ The current population stands at 84 million¹⁴, with a sex ratio of 103 males per 100 females. Over 25 percent of the population is between the ages of 15 to 29¹⁵. Life expectancy at birth increased from 57¹⁶ to 74.2 years¹⁷ between 1980 and 2016 reflecting improvements in the country's economic and social infrastructure over the decades, and most importantly, improvement in the country's health system. Iran's Human Development Index (HDI) score was 0.783 in 2020, ranking 70th out of 189 countries.¹⁸

Many socio-economic indicators could influence HIV prevalence. Government of Iran (GOI)'s comprehensive development strategy to improve social and economic resilience, encompassing both market-based reforms and social welfare improvement, is reflected in the 20-year Vision Document and the 6th FYDP 2017-2021, which focus on: a) development of a resilient economy, b) progress in science and technology, and c) promotion of a culture of excellence. The Government, through Iran's Sixth (6th) Five-year National Development Plan 2017-2021 (the 6th FYDP), takes measures to protect production, employment and social welfare in Iran's various economic sectors; while also taking measures to protect against social harm, and for social protection and social security.

The country is experiencing rapid socio-economic changes. Despite the high literacy rate among youth (more than 98 percent), economic participation is particularly low among women of working age (14.9 percent), even though Iran has very favourable statistics on female tertiary education rate (47 percent of all university students and 57 percent of Ph.D. students are female)¹⁹. Official unemployment rate is at 8.1 percent for men and 16.54 percent for women²⁰.

During last decade, GOI has changed population policies from anti- to pro-natalist and consequently, significant limitations have taken place in access to contraception including condoms in the public sector. These restrictions have raised concerns about access to condoms for HIV/AIDS prevention nationwide.

Iran's health system is cited in global health literature as one of the most robust in the world, with strong national health indicators, defined by a pioneering and well-established Primary Health Care (PHC) system, emphasizing equity, community and inter-sectoral participation.²¹ The strong national network of PHC services is designed to provide quality health care, which can be a good platform for STIs including HIV/AIDS prevention and control programs.

The health sector has over the years undergone significant reforms through the *Health*

¹² <https://www.worldbank.org/en/country/iran/overview>;

<https://datahelpdesk.worldbank.org/knowledgebase/articles/906519> (accessed by January 2021)

¹³ Central Bank of Iran – 1396 Annual Review

¹⁴ Statistical Center of Iran, Oct 2020

¹⁵ Population and Housing Census, 2016, Statistical Center of Iran.

¹⁶ UNFPA Iran Country Program Document 2017-2021

¹⁷ Population and Health Indicators, 2016, Statistical Center of Iran.

¹⁸ <http://hdr.undp.org/en/countries/profiles/IRN>; <http://hdr.undp.org/sites/default/files/hdr2020.pdf> (accessed by January 2021)

¹⁹ Islamic Republic of Iran ICPD Review Report, 2018

²⁰ Labour Force Survey, Summer 2020, Statistical Center of Iran.

²¹ National Action Plan for the Prevention and Control of NCDs and Related Risk Factors in the Islamic Republic of Iran, 2015-2025, Iranian National Committee for NCDs Prevention and Control, 22 July 2015.

Transformation Plan (HTP), focusing on sustainable financing of the health sector, financial risk protection against health expenditures, increasing equitable access to quality healthcare services, improving service provision, and increasing people's satisfaction.²² By 2018, around 95 percent of Iranians (including vulnerable groups) were covered by some form of health insurance. However, there is a need to ensure the design and content of the Universal Health Coverage (UHC) benefit package, focusing on STIs including AIDS/AIDS prevention and control programs. Of course, despite all the financial constraints and regardless of whether the patient is covered by insurance, providing medicine for PLHIV nationwide is free.

Since early-2020, the impact of the COVID-19 pandemic on the global economy and social fabric is unprecedented. Iran has also been severely impacted, compounding existing unilateral sanctions: altogether, possibly leading to a fall of 15 percent of GDP, affecting 50 percent of Iran's workforce, particularly impacting the bottom 40 percent income-percentiles of the population and deepening inequality, and raising additional unemployment possibly by 2 million. Social services (including social protection services) and public health systems are taking a toll and are at risk, given the tighter financial situation of the Government due to unilateral sanctions. Close to 11.5 million households below or just above the multi-dimensional poverty line are significantly impacted by the crisis. Additional complications caused in-between the health, economy and human security nexus will sustain, exacerbating household vulnerabilities in multiple dimensions, with significant implications for the vulnerable populations the UN is targeting, especially in disaster and emergency settings. These challenges require urgent and improved program measures for *combined* social protection and employment generation to pave the way for longer-term sustainable recovery²³.

The cost of healthcare for families increased by 22 percent in urban areas and by 31 percent in rural areas between October 2018 and October 2019, mostly due to hospitals facing shortages of medicines, equipment and consumer goods, placing vulnerable patients at greater risk²⁴. Unilateral sanctions and banking restrictions have had an adverse effect on the production, availability and distribution of medicines, pharmaceutical equipment and supplies.

Over past decades, Iran's urban population has increased from 37 percent in 1965 to 60.2 percent in 1995 and 74 percent in 2016²⁵, due to natural population increase, migration, and increase in the number of cities. Current estimates indicate that over 74 percent of the population lives in urban areas²⁶.

After identifying the first case of HIV in 1987, the response to it in the country began with the formation of the Supreme AIDS Council in 1988. Initially, the country's responses were mainly focused on measures such as providing healthy blood and setting up a positive case registration system. With the onset of the HIV epidemic in PWID, some harm reduction activities were also on the agenda. Then the national strategic programs are designed and implemented as follows.

- **The first National Strategic Plan (NSP) for Control of HIV/AIDS 2002-2006**, was designed with an emphasis on the participation of other stakeholders such as NGOs

²² Dr Iraj Harirchi, Deputy-Minister for Health. Presentation to the 7th World Health Summit Regional Meeting. Kish, Iran. 29-30 April 2019.

²³ Para extracted from Building Back Better - UN Iran Socio-Economic Recovery Program (SERP) against the impact of COVID-19, June 2020

²⁴ UN Iran Country Results Report 2019

²⁵ UN Iran Country Results Report 2019

²⁶ Population and Housing Census 2016, Statistical Center of Iran

and including 11 strategies for HIV/AIDS control and without a monitoring and evaluation program.

- **The Second NSP for Control of HIV/AIDS 2007-2009**, included 10 strategies and 75 specific targets.
- **The third NSP for Control of HIV/AIDS 2010-2014**, was approved by the Council of Ministers. Following the increase in HIV-positive cases through sexual contact, more attention was paid to prevention through sexual transmission, especially in the spouses of infected people and sexual partners of the groups most at risk of contracting HIV.
- **The Fourth NSP for Control of HIV/AIDS 2015-2020**, was developed with the comprehensive cooperation of all relevant organizations and organs. Development of the Supervision on Implementation of Program Committee (SIP) at the national and provincial levels is one of the most important strengths of the 4th NSP.
- **The Fifth NSP for Control of HIV/AIDS 2021–2025**). The most important features of this program are – among others- inclusion of EMTCT strategy, condom programming for KPs, more focus on stigma and discrimination, taking into account all 5 main KPs, a great emphasis on Prevention and development of a special Prevention sub-committee in SIP.

So far, no national PrEP and condom program for key population has been designed and implemented in Iran.

Today, a range of highly effective prevention methods are available for use in combination or on their own. Combination HIV prevention includes both primary prevention (focusing on prevention of new HIV infection) as well as prevention of onward transmission from people living with HIV. Scaling up combinations of scientifically proven, cost-effective interventions targeted to the right populations in the right geographic areas is key to preventing new HIV infections. Especially important is scaling up highly effective, biomedical interventions: treatment as prevention (PrEP), along with other highly effective prevention interventions including correct and consistent condom usage, and harm reduction services. Based on the Global HIV Strategy, HIV prevention responses should be organized around five central pillars which mentioned in the Introduction section. In this PrEP and Condom Programming, we covered two pillars of the Global HIV Strategy as combination HIV prevention (PrEP and Condom).

2.3. HIV Epidemic in Iran

2.3.1. HIV Prevalence

HIV prevalence in Iran is still low in the general population and the HIV epidemic is in a concentrated phase. Prevalence amongst people who inject drugs is slowly decreasing, but gradually shifting towards sexual transmission especially among key populations, and women and men at high risk of HIV. In recent years, there have been signs of increase in the epidemic in women, which might result in an increased number of HIV infected infants. Still, the infrastructure to eliminate mother-to-child transmission is in place; around 80 percent of pregnant women living with HIV receive anti-retroviral drugs to eliminate the risk of

mother-to-child transmission.²⁷ Table 2.3.1.1. summarized HIV prevalence among different population groups.

In 2020 the Middle East and North Africa (MENA) was home to about 578 million people. About 95% of the new HIV infections in 2020 occurred in only five countries: Iran, Sudan, Somalia, Egypt, Morocco and Yemen²⁸. In Iran, HIV prevalence among the general population is very low with the prevalence rate of <0.1%, but being highest among key populations²⁹. In the MENA region, more than 95% of new HIV infections occurred among key populations (predominantly people who inject drugs, gay men and other men who have sex with men and female sex workers) and their sexual partners. HIV prevalence was considerably higher among these key populations compared with the general population, although there was much variation among countries. In Iran, HIV prevalence among sex workers is 16 times higher than among women 15-49 in the general population, and prevalence of 190 times in MSM than of men 15-49 in the general population.

Results of the national Bio-Behavioral Surveillance Studies (BBSS) showed that the prevalence of HIV among FSWs decreased from 2010 to 2020, from close to 5% to 1.5%. The prevalence of HIV in FSWs increases up to threefold by having another concomitant risk factor, such as PWID.

There is not much information about MSM in Iran, but in different groups, the prevalence of HIV has been reported in high proportions in studies, from 3.7% in prisoners and 19% in PWIDIs to 14.8% in the general population of MSM.

People Who Inject Drug (PWID) in Iran have always been among the largest key groups at risk of HIV and the prevalence of HIV among this key group has always been high. Based on the numerous studies, from 2008 to 2014, the prevalence of HIV in this group was over 10%, although in the last national survey in 2019, this figure dropped to 3.1%. In the MENA region, there is moderate HIV prevalence among people who inject drugs in the region but much higher prevalence in Iran and Morocco. In these countries, opioid substitution therapy was established practice. In 2018-2020 in Iran, from an estimated number of 90 000 people who inject drugs, more than 12 000 were receiving opioid substitution therapy in communities and in prisons³⁰. Needle and syringe programs were key to increasing safe injection practices in Iran, with needles and syringes distributed or available for purchase from pharmacies. Together these programs resulted in rates of safe injection of 82% in Iran (2014).

Many countries in the MENA region have developed HIV programs to offer prevention services to prisoners, mostly for those who inject drugs. Among the countries that have reported HIV prevalence among the prisoner population, Iran has the highest prevalence of HIV. The prevalence of HIV among Iranian prisoners has always been higher than the general population. The fact that at least 43% of Iran's prisoners are due to the drug-related victims, may well justify this high prevalence. Studies related to the prevalence of HIV in prisoners show a decrescendo trend. For example, in a large national study, the prevalence of HIV was 8.3% in 2008, down to 3.1% in 2011.

²⁷ HIV Spectrum 2019 Projections, Ministry of Health and Medical Education

²⁸ GloDS Updates 2021

²⁹ <https://www.unaids.org/en/regionscountries/countries/islamicrepublicofiran>

³⁰ GLOBAL AIDS UPDATE 2021

For most of the countries in the MENA region, transgender people have not been acknowledged as a separate key population. Accordingly, there are very limited data available on this key population. Iran has identified male-to- female transgender people as a high-risk population and in 2014 conducted a study establishing a 2% HIV prevalence among this group. Large-scale programs, however, are yet to be established. The latest national AIDS control program (5th NSP), sets goals to cover TG in terms of harm reduction, condom use, and even providing PrEP. In Iran, the total prevalence of transgender is estimated to be 1 per 141,000 populations, and the sex ratio is nearly 1 to 1. This population group has always been recognized as a key group at risk of HIV. In Iran, very limited studies have been conducted in this regard and the prevalence of HIV has been reported from zero to 1.9%.

Table 2.3.1.1. HIV prevalence among different population groups

What is the prevalence of HIV? (Prevalence: Number existing case/year)		
Rank	Group	Prevalence
1	MSM	19% (2004) ³¹ among PWIDs 14.8% (2008) ³² 3.7% (0.6-18.8%) (2009) ³³ among prisoners
2	PWID	15.3% (2008) ³⁴ 15.2% (9.7-233.1%) (2010) ³⁵ 9.4% (2.9-26.2%) (2010) ³⁶ 4.2% (2012) ³⁷ 18.4% (pooled prevalence) (2012) ³⁸ 13.8% (2014) 3.1% (2019) ³⁹
3	FSW	4.5% (2.4-8.3) (2010) ⁴⁰ 5% (2013) ⁴¹ (Tehran) 2.1% (1.4-3.0) (2015) ⁴² 1.59 (2020) ⁴³
4	Transgender	0.0% (2009) ⁴⁴ 1.9% (women) (2014) ⁴⁵
5	Prisoners	3.8% (2.8-3.4%) (2002) ⁴⁶ 1.6% (2009) 2.1% (1.2-3.6%) (2010) ²⁹ 1.3% (1.1-1.5%) (2011) ³⁶ 1.4% (0.6-2.2%) (2013) ⁴⁷ 2.8% (1.8-4.3%) (post 1998) ⁴⁸ 1.2% (2014) in male prisoners
	Women at antenatal clinics	0.5% ⁴⁹

³¹ Zamani S, Ono-Kihara M, Ichikawa S, Kihara M. Potential for sexual transmission of HIV infection from male injecting-drug users who have sex with men in Tehran, Iran. *Sex Transm Dis.* 2010;37(11):7-15.

³² Eftekhari M, Feizzadeh A, Moshtagh Bidokhti N, et al. High risk behavior and HIV/AIDS prevalence among men having sex with men: the first report from Iran. AIDS 2008- XVII International AIDS Conference. Mexico City, Mexico.

³³ Navadeh S, Haghdoost AA, et al. HIV prevalence and related risk behaviours among prisoners in Iran: results of the national biobehavioural survey, 2009

³⁴ Zamani S, et al. Integrated Bio-Behavioral Surveillance for HIV Infection among Injecting Drug Users in Iran, 2008. Final Report.

³⁵ Khajehkazemi R, Haghdoost AA, et al. HIV prevalence and risk behaviours among people who inject drugs in Iran: the 2010 National Surveillance Survey.

³⁶ Alipour A, Haghdoost AA, et al. HIV prevalence and related risk behaviours among female partners of male injecting drugs users in Iran: results of a bio-behavioural survey, 2010.

³⁷ Noroozi AR, et al. Bio-Behavioral Surveillance among PWIDs and their sexual partners in three Provinces: Karaj, Isfahan, Golestan; 2011-2012.

³⁸ Rahimi-Movaghar A, et al. HIV prevalence amongst injecting drug users in Iran: a systematic review of studies conducted during the decade 1998-2007. *Int J Drug Policy.* 2012;23(4):271-8.

³⁹ 5th NSP of Iran for HIV prevention

⁴⁰ BBSS report of Iran-2010

⁴¹ BBSS report of Iran-2013

⁴² BBSS report of Iran-2015

⁴³ BBSS report of Iran-2020

⁴⁴ Jalali Nadoushan A, et al. High-Risk Sexual Behaviors Among Transgender IndivPWIDals in Tehran, Iran. *Acta Med Iran* 2021;59(2):113-117.

⁴⁵ Moayedi-Nia S, et al. HIV Prevalence and Sexual Behaviors Among Transgender Women in Tehran, Iran. *AIDS and Behavior* <https://doi.org/10.1007/s10461-018-02380-w>

⁴⁶ Shahbazi M, Farnia M, Rahmani K, Moradi G. Trend of HIV/AIDS Prevalence and Related Interventions Administered in Prisons of Iran -13 Years' Experience. *Iranian J Publ Health* 2014;43(4):471-479.

⁴⁷ Danesh A, Haghdoost A, et al. HIV prevalence and related risk behaviours among prisoners in Iran: results of the national biobehavioural survey, 2013.

⁴⁸ Haghdoost A, Mirzazadeh A, Shokoohi M, et al. HIV trend among Iranian prisoners in 1990s and 2000s; analysis of aggregated data from HIV sentinel sero-surveys. *Harm Reduction Journal* 2013, 10:32.

⁴⁹ Bozicevic I, Riedner G, Calleja JMG. HIV surveillance in MENA: recent developments and results. *Sexually transmitted infections.* 2013;89(Suppl 3):iii11-iii6.

	General population	<0.1 (<0.1 - 0.2) ⁵⁰
	Youth	<0.1 (<0.1 - 0.2) ²¹

2.3.2. Sexually Transmitted Infections (STIs)

Data on the prevalence of Sexually Transmitted Infections (STIs) in Iran is very sparse with very limited applicability to the general population. For example, a study in Northeast of Iran has reported *Chlamydia trachomatis* in 10.6 percent of men.⁵¹ Another study in the Western parts of the country has reported *Trichomonas vaginalis* to be present in 2.1 percent of women who referred to health clinics.⁵² In a large multi-district study, around 57% percent of the sample had experienced at least one STIs-associated symptom during the previous year. A considerable number of participants had delayed seeking care and treatment or self-medicated.⁵³ Studies show that STIs are concentrated in high risk sub-groups of the population. The Center for Communicable Disease Control (CDC) of MOHME has strategic plans for the control of STIs, and all the medical science universities undertake passive surveillance for different STIs especially syphilis, gonorrhoea, HPV, and chlamydia.⁵⁴ Based on the latest available data from national STI surveillance of CDC, MOHME, in year 2020, only 12,024 STI cases were definitely diagnosed. This number includes 8,146 cases of *Trichomonas Vaginalis* infection, 1,374 cases of Chlamydial infection, 1, 337 cases of Human Papilloma Virus infection, 563 cases of gonococcal infections, 548 cases of Herpes Genitalia infection, 49 cases of syphilis, and seven cases of *Haemophilus Ducreyi* infection, Table 3.3.2.1. Obviously, the actual number of people with different types of STIs is much higher than reported because they were obtained during a passive surveillance program. Meanwhile, HIV/AIDS control programs are designed and implemented for high-risk groups with greater scope and intensity under the fifth National HIV Strategic Plan (2021–2025) that has recently been developed and is under implementation Which includes STIs control interventions.⁵⁵ More than 90% of FSW had either had an STI or symptoms of an STI during the 12 months preceding the population-based survey in 1399, Table 2.3.2.2.

⁵⁰ UNAIDS\Condom\Iran\Islamic Republic of Iran _UNAIDS.html

⁵¹ Ghanaat J, Afshari JT, Ghazvini K. et al. Prevalence of genital Chlamydia in Iranian males with urethritis attending clinics in Mashhad. *East Mediterr Health J.* 2008;14(7):1333–1337.

⁵² Matini M, Rezaie S, Mohebbi M. et al. Prevalence of *Trichomonas vaginalis* Infection in Hamadan City, Western Iran. *Iranian J Parasitol.* 2012;7(2):67–72.

⁵³ Moradi G, Khoshravesh S, Hosseiny M. Situation of linkage between sexual and reproductive health and HIV-related policies in Islamic Republic of Iran—a rapid assessment in 2011–2. *International journal of health policy and management.* 2015;4(3):131.

⁵⁴ Ghorashi Z. Sexually transmitted infections in Iran: A literature review. *JOHE* 2015; 4 (4):260-5.

⁵⁵ https://www.unaids.org/en/resources/presscenter/featurestories/2021/january/20210127_iran-health-care-settings

Table 2.3.2.1. Annual report of sexually transmitted diseases in the country in 2020

Annual report of sexually transmitted diseases in the country in 2020									
Etiologic Diagnosis	Sex	< 15 Y	15-17 Y	18-24 Y	25-34 Y	35-44 Y	45-54 Y	≥55 Y	Total
Trichomonas Vaginalis	Female	8	131	1,006	2,930	2,746	1,088	127	8,036
	Male	0	0	19	40	33	17	1	110
	Total	8	131	1,025	2,970	2,779	1,105	128	8,146
Chlamydial infection	Female	1	29	223	504	410	135	16	1,318
	Male	0	0	16	26	14	0	0	56
	Total	1	29	239	530	424	136	16	1,374
Human Papilloma Virus	Female	21	15	183	511	358	116	18	1,222
	Male	0	0	39	58	14	1	3	115
	Total	21	15	222	569	372	117	21	1,337
gonococcal infections	Female	0	9	71	196	161	60	4	501
	Male	0	0	10	45	7	0	0	62
	Total	0	9	81	241	168	60	4	563
Herpes Genitalia	Female	16	14	100	194	127	30	2	483
	Male	1	1	22	23	18	0	0	65
	Total	17	15	122	217	145	30	2	548
syphilis	Female	1	0	11	16	11	3	0	42
	Male	0	0	1	3	0	0	3	7
	Total	1	0	12	19	11	3	3	49
Haemophilus Ducreyi infection	Female	1	0	1	3	1	0	0	6
	Male	0	0	0	0	0	0	1	1
	Total	1	0	1	3	1	0	1	7
Total	Female								11608
	Male								416
	Total								12024

Table 2.3.2.2. prevalence of STIs among different population groups

What is the prevalence of STIs? (Prevalence: Number existing case/year)												
Group		At least one symptom	Discharge	Genital Ulcer	Wart	Pain	HBV	HCV	Chlamydia Trachomatis	Gonorrhoea	HVS2	Syphilis
FSW	2010	82.1%	53.1% 72.7%	17.6% 18.5%							9.7%- 18%	0-7.2%
	2013											
	2015	64.4%	62.4%	5%	2.4%	42.9%				4.7%		
	2020	90.9%	29.6%	33.1%	15.7%	30.5%						
MSM												
PWID							MPWID: 3.6% 30.9 ⁵⁶ (27.9- 33.9) FPWID: 7.3%	MPWID: 38.6% 41.3 ⁵⁷ (29.8- 53.3) FPWID: 36.6%				
prisoners							7.4% (2006) 16.8% (2008)	34.7 (32.2- 37.2)				0-7.2%
Transgender women		18.1 ⁵⁸ (21.6-14.6)										
PLHIV		77.5					4.7%	24.3%				5.3 ⁵⁹ (5.0-5.6)

⁵⁶ Bagheri Amiri F, Mostafavi E, Mirzazadeh A. HIV, HBV and HCV coinfection prevalence in Iran-a systematic review and meta-analysis. PloS one. 2016;11(3):e0151946.

⁵⁷ Nematollahi S, et al. Prevalence of hepatitis C virus infection among high-risk groups in Iran: a systematic review and meta-analysis. Public Health. 2018;161:90-8.

⁵⁸ Nematollahi A, et al. Sexual Behaviors and Vulnerability to Sexually Transmitted Infections in Transgender Women. 2021.

⁵⁹ Badie BM, et al. Prevalence survey of infection with Treponema pallidum among HIV-positive patients in Tehran. Asian Pacific journal of tropical biomedicine. 2013;3(4):334-6.

General pop.- Male	-	0.4 ⁶⁰ (0.2-0.6)	0.2 ⁴⁸ (0.1-0.3)			0.9 (0.6-1.2)	0.3 (0.2-0.4)	10.9 ⁶¹ (7.6-15.4)			0.02 ⁴⁸ (.01-.02)
General pop.- Female	3.9 ⁴⁸ (3.3-4.5)	1.2 ⁴⁸ (0.6-3.2)	3.7 ⁴⁸ (2.3-6.4)			0.9 (0.6-1.2)	0.3 (0.2-0.4)	12.3 ⁶² (10.6-14.2)			0.1 ⁴⁸ (.07-.16)
Women at antenatal clinics	-	27.2 ⁶³ (19.5-34.3)				1.2%		5.2 ⁵⁰ (4.6-5.8)	0.0%		1.4 ⁶⁴ (1.1-1.7)
Youth	1.9 ⁴⁸ (1.6-2.2)	0.8 ⁴⁸ (0.4-1.9)	1.9 ⁴⁸ (1.2-3.6)					12.4 ⁶⁵ (10.4-14.3)			0.01 ⁴⁸ (.02-.00)

⁶⁰ Nasirian M, Baneshi MR, Kamali K, Haghdoost A. Estimation of prevalence and incidence of sexually transmitted infections in Iran; A model-based approach. *Journal of research in health sciences*. 2015;15(3):168-74.

⁶¹ Ahmadi MH, Mirsalehian A, Bahador A. Prevalence of genital Chlamydia trachomatis in Iran: a systematic review and meta-analysis. *Pathogens and global health*. 2015;109(6):290-9.

⁶² Jahromi AS, et al. Chlamydia trachomatis in women with full-term deliveries and women with abortion. *American Journal of Infectious Diseases*. 2010;6(3):66-9.

⁶³ Manshoori A, et al. A diagnostic and symptomatological study on trichomoniasis in symptomatic pregnant women in Rafsanjan, South Central Iran in 2012-13. *Iranian journal of parasitology*. 2015;10(3):490.

⁶⁴ Motamedifar M, Hassanzadeh P, Taghinia MA, Hassazadeh Y. DETECTION OF SYPHILIS BY SEROLOGIC TESTS IN PREGNANT IRANIAN WOMEN, SHIRAZ, IRAN (SHORT COMMUNICATION). 2013.

⁶⁵ Afrasiabi S, et al. The prevalence of endocervical Chlamydia trachomatis infection among young females in Kashan, Iran. *Jundishapur journal of microbiology*. 2015;8(4).

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2.3.3. Awareness and knowledge of HIV/AIDS and ways to avoid HIV/AIDS

HIV/AIDS basic knowledge was high in over 85% of all population groups reported in included studies - whether general populations and youth, or high risk and bridging, populations (Table 2.2.3.3.1). For example, among key populations at risk, the proportion of PWID who reported ever hearing of HIV/AIDS was 96.9%, among FSW was 89.4% and prisoners was 93.2%. Despite overall universal basic HIV/AIDS knowledge, low comprehensive knowledge was reported in the various population groups. Comprehensive knowledge of youth toward the HIV/AIDS in Iran was 57.6% (56.7%-58.5%)⁶⁶ which is proportionally low. This figure is far below the national response target of 70% for young in 2020. Comprehensive HIV Knowledge was very low for high risk groups; 28.1%, 31.1% and 19.7% for FSWs, PWIDs, and Prisoners, respectively⁶⁷. Based on the results of this study, this was as a result of less programmatic efforts focused on the key population compared general populations. In general, the awareness of key at-risk groups about ways to prevent the transmission of HIV/AIDS is proportionally high, but their perceived susceptibility to HIV/AIDS is not high.

		Total (%)	No education (%)	1 ^o Ed (%)	2 ^o Ed (%)
Comprehensive knowledge of HIV	Youth	57.6 (56.7-58.5)	20.2	24.8	27.1
	FSW 2020	51.5			
	PWID	31.1	14.1	21.8	34.1
	Prisoners	19.7	6.1	12.9	21.5
Ever heard of HIV/AIDS	Youth				
	FSW 2020	89.4			
	PWID	96.9			
	Prisoners	93.2			
Knows how to prevent HIV	Youth	57.6			
	FSW 2020	87.6			
	PWID	90.1			
	Prisoners	84.3			
Knows how people get HIV	FSW	85.9			
	PWID	80.8			
	Prisoners	80.4			
% Perceive they are susceptible to AIDS	Youth				
	FSW	48.5			
	PWID	61.1			
	Prisoners	42.7			

⁶⁶ Momenabadi V, et al. Knowledge and Attitude of Iranian Youth Toward AIDS: A Systematic Review and Meta-Analysis in Iran. *Journal of Medicine and Life* 2020;13(2):119–124.

⁶⁷ Khajehkazemi R, Haghdoost A, Navadeh S, et al. Risk and vulnerability of key populations to HIV infection in Iran; knowledge, attitude and practices of female sex workers, prison inmates and people who inject drugs. *Sexual Health*. 2014, 11, 568–574.

3.3.4. Condom Use patterns

The conditions (knowledge, attitudes, geographic, economic and social) that facilitate and hinder condom use are summarized in the following Table.

Table 2.3.3.1. Level of Awareness and knowledge of HIV/AIDS and ways to avoid HIV/AIDS

What is the level of knowledge and common attitudes toward condoms?		
Availability	FSW	<ul style="list-style-type: none"> - Percentage of women with difficult access to condoms: 26.2 - Percentage of condom procurement from the pharmacy (as the most important source of condom supply): 78.3 - Percentage of unavailability of condoms due to the price of expensive condoms: 41.7 - Percentage of people receiving free condoms in the last three months: 37.9 - Lack of access: 19.8 - Pharmacies (78.3%), Women Centers (33.2%) and sexual partners (18%) are the most important way for FSW to access condoms, respectively.
	PLHIV	<ul style="list-style-type: none"> - The main self-reported reasons of condom non-use by male respondents were reported as: unavailability of condom by 23.7%.
Effectiveness/ Quality	FSW	
	PLHIV	<ul style="list-style-type: none"> Among 7.5% of men and 1.2% of women, the reason for not using a condom was its poor quality.
Affordability		<ul style="list-style-type: none"> - After lack of access, being expensive was the most important reason for not using a condom. - Percentage of unavailability of condoms due to the price of expensive condoms: 41.7
Comfort		<ul style="list-style-type: none"> - Percentage of women with difficult access to condoms: 26.2 -
Willingness to use condoms	FSW	<ul style="list-style-type: none"> - The decision to use a condom was made in 82.8% of cases by women and in 12.7% of cases by a joint decision. - Among those who did not use a condom during their last sex, the main reason was the client's opposition (34.3%).
	PLHIV	<ul style="list-style-type: none"> - Among those who uses a condom during their last sex, it recommended by respondent in 54.5% of cases and was mutual decision in 41.5%.
Use with spouse	FSW	<ul style="list-style-type: none"> - About 22% of women have lived with a permanent partner or concubine, and in 46% of cases they have never used a condom.
	PLHIV	<ul style="list-style-type: none"> - Condom use for men, women and total was 54.1%, 68.1%, and 59.7%, respectively. - consistent condom use was significantly associated with having a HIV positive spouse. In other words, those with a

		HIV positive spouse were more likely to consistently use condoms during sex. This finding suggests that Iranian PLHIV are well informed about the consequences of unsafe sex with a positive partner.
Use in extramarital situations	FSW	- 43.6% of FSWs used condoms in sexual relationships with their paid customers, while 62.9% of them have used condoms in their last sexual intercourse.
	PLHIV	- Permanent partner other than spouse: Condom use for men, women and total was 13.7%, 13.1%, and 13.5%, respectively. - Causal partner: Condom use for men, women and total was 26.6%, 4.3%, and 17.7%, respectively.
Inability to negotiate condom use		- Only 36.3% of FSW have received counseling on condom use.
Inability to use consistently	FSW	- The most important reasons for inability to use consistently condoms among commercial clients are: <ul style="list-style-type: none"> • Customer opposition (34.3%) • Lack of access (19.8%) • Decreased sexual pleasure if using a condom (13.2%) - The most important reasons for inability to use consistently condoms among non-commercial clients are: <ul style="list-style-type: none"> • Customer opposition (38.3%) • Confidence in a stable sexual partner (24.2%) • Decreased sexual pleasure if using a condom (10.2%)
	PLHIV	- consistent condom use has been reported by 25% of PLHIV, while partner's Condom refusal, and unavailability were the most frequent causes of inconsistent condom use by women and men, respectively. - In a study, 15% reported "intention to pregnancy" as their main reason for not using a condom.

3.3.5. Condom Use during high-risk sex

Inconsistent condom use was reported by 78.2% of sexually experienced youth in 13 provinces of the country in 2013 and unprotected last sex was reported by 73.3% of adolescents in northern Tehran. In a study among adolescents in Tehran, unprotected last sex was about two-fold higher among female adolescents compared to male adolescents (74.4% vs. 43.0%). This difference was also evident in a study among 495 sexually experienced youth from 13 provinces which showed greater unprotected last sex among women compared to men (92.9% vs. 74%). In a sample of 3,045 individuals aged 19-29, 35.1% reported condom use at last extramarital sex, but far below the 90% global target. Men reported significantly higher condom use than women (38.5% vs. 25.7%)⁶⁸.

⁶⁸ Hosseini Hooshyar S, et al. Condom Use and its Associated Factors Among Iranian Youth: Results From a Population-Based Study. *Int J Health Policy Manag.* 2018 Nov; 7(11): 1007–1014.

2.3.6. Condom Use among priority Populations

Condom use among FSW and their clients and other sexual partners must be 100% or combined with pre-exposure prophylaxis (PrEP) to prevent HIV transmission. PrEP availability is currently extremely limited, with recent modelling suggesting that typical antiretroviral therapy coverage will not be sufficient to slow HIV incidence among sex workers, and that antiretroviral therapy coverage at approximately 80% must be accompanied by increased condom use⁶⁹. These data reinforce the importance of combination HIV prevention strategies, including the integration of condoms throughout the continuum of HIV services and increased linkages between HIV and sexual and reproductive health services and the use of combination prevention strategies.

Condoms are most effective when they are used consistently rather than occasionally. The current indicator will overestimate the level of consistent condom use. However, the alternative method of asking whether condoms are always, sometimes or never used in sexual encounters with clients in a specified period is subject to recall bias. Further, the trend in condom use in the most recent sexual act will generally reflect the trend in recent consistent condom use.

Condom use reported by sex workers in Asia Pacific is 90% or greater in five countries, including the two largest, China and India. Countries in the Middle East and North Africa including Iran generally have inadequate condom use to prevent HIV transmission to and from sex workers. Condom use among sex workers in Iran is 62.9% almost double that of women 19-29 in their last extra marriage life (35.1%).

Gay men and other men who have sex with men (MSM), and who have multiple sexual partners also require consistent condom use. However, condom use in many countries is not occurring at sufficient levels to reduce HIV transmission rates. Overall, many countries report levels of condom use which are insufficient to curtail HIV transmission among men who have sex with men. Only three of 104 countries with available data reported greater than 90% condom use at last sexual intercourse. In Iran, despite having a much higher HIV prevalence, condom use among Men having Sex with Men (20%) is considerably lower compared to men in the youth population (38.5%). Condom use among PLHIV couples is low at 37.2%.

Condom use with the most recent sex partner among People Who Inject Drugs (PWID) is almost universally low. No countries were above 90% and in areas with high prevalence of injection drug use and HIV, such as Manipur, India, non-injecting female partners exhibit very high HIV prevalence, in large part due to low condom use. In Iran, condom use with the most recent sex partner among male PWID was reported 32%, Table 2.3.6.1.

Data on condom use among transgender people are lacking, but there is evidence that condom use in this population is low.

⁶⁹ Prevention Gap Report, UNAIDS 2018.

Table 2.3.6.1. Condom Use among different priority Populations

Condom Use among priority Populations							
Group			Prevalence				
			With most recent client	Always	Usually	Occasionally	Never
PLHIV	Commercial	Male	26.6	24.6	35.9	39.5	30.4
		Female	4.3	25.5	25.5	49	36.2
		Overall	17.7	37.2		32.2	30.5
	Non-commercial	Male	54.1				
		Female	68.1				
		Overall	59.7				
MSM			20				37.8
FSW	Commercial	2010	57	30.6	18.5	20.1	30.8
		2015	59.1	32.9	27.1	21.7	18.4
		2020	62.9	43.6	13.6	27.9	14.9
	Non-commercial	2010	36.2	18.6	9.4	24.1	47.9
		2015	43.3	25.4	17.7	18.7	38.2
		2020	38.4	23.5	9.4	21.1	46.0
PWID		Male	32	18			
General pop.			13.8				

2.3.7. Condom use efficacy

Condom use self- efficacy refers to an individual’s knowledge of how to correctly and consistently use a condom. Correct use of both female and male condoms is still low yet there has been sustained messaging geared towards correct and consistent condom use. Based on the 5th HIV NSP in 2021, almost 21% of female at highest risk for HIV know how to correctly use a condom while this ratio was only 1% for men.

CHAPTER 3: Comprehensive Condom Programming (CCP)

Comprehensive condom programming is a means of ensuring that sexually active persons at risk of STI including HIV are motivated to use condoms, have access to quality condoms, and have suitable knowledge and skills to use them correctly and consistently. The components of the CCP framework includes:

- **Leadership and Coordination**
 - Coordination and Partnerships
 - Advocacy
 - Policies and Regulations
 - Resource Mobilization
- **Demand, Access and Utilization**
 - Market Research
 - Total Market Approach
 - Targeted Distribution
 - IEC and Behavior Change Communication Strategies
 - Social Mobilization
- **Supply and Commodity Security**
 - Forecasting
 - Procurement
 - Quality Assurance
 - Warehousing and Storage
 - Distribution to supply chains
 - Logistic Management Information system
- **Support**
 - Advocacy
 - Social, Behavioral and Operation Research
 - Capacity and Institutional Strengthening
 - Monitoring and Evaluation
 - Documentation and Dissemination.

Therefore, CCP requires components of effective governance to sustain an enabling environment and vibrant condom market; responsive commodity supply chain; sustainable demand generation; and program data management. Supply and demand do not necessarily translate into access and use. Achieving high levels of condom access requires understanding where different priority populations prefer to access condoms. Key populations face different access barriers that need to be removed. Restricting the quantities of condoms distributed to key populations per service encounter rather than multi-month dispensing of supplies creates a major common barrier. Investments in condom programming should aim to increase condom use equitably and sustainably among priority groups to reduce the incidence of HIV and STIs.

3.1. Leadership and coordination

This component of the CCP aims at improving coordination of partnerships to address gaps, advocacy, policies, and regulations as well as resource mobilization. Achievements under this component include the existence of favorable national policies under the title of “The Fifth NSP for Control of HIV/AIDS 2021–2025”. Although condom-specific programs have not yet been designed and implemented nationally, condom-related activities have been implemented in the context of the same NSP in the country. There has been widespread support for policy change and resource mobilization, which has led to continued support for condom planning, particularly from USAID and, in recent years, the Global Fund, which supports condom programming, capacity building, condom purchase activities, drugs for the prevention and treatment of HIV/AIDS has already increased. More details in the component of Leadership and Coordination are explained in detail in the Condom Total Market section. It should be noted that due to changes in Iran's population policies, the supply and promotion of condoms for contraception in Iran is limited and the governmental sector support for condoms is only to prevent HIV/AIDS.

3.2. Demand Creation, Access and Utilization

The demand component includes Market Research, Total Market Approach, Targeted Distribution, IEC and Behavior Change Communication Strategies, and Social Mobilization. Demand for condoms in key populations has decreased, except in limited cases, due to barriers that need to be overcome to accelerate demand and increase their use. In many countries, including Iran, creating sustainable demand that leads to behavioral change tailored to the different needs of key populations in need of condoms is a vital need. Failure to support condom programming undermines the interventions needed to change the scale and intensity of behavior to overcome barriers to condom use. Substantial investment in demand-generating activities, from the media to highly targeted interpersonal communication, is needed to ensure that key populations have the knowledge, skills, and agency necessary to use condoms properly and consistently.

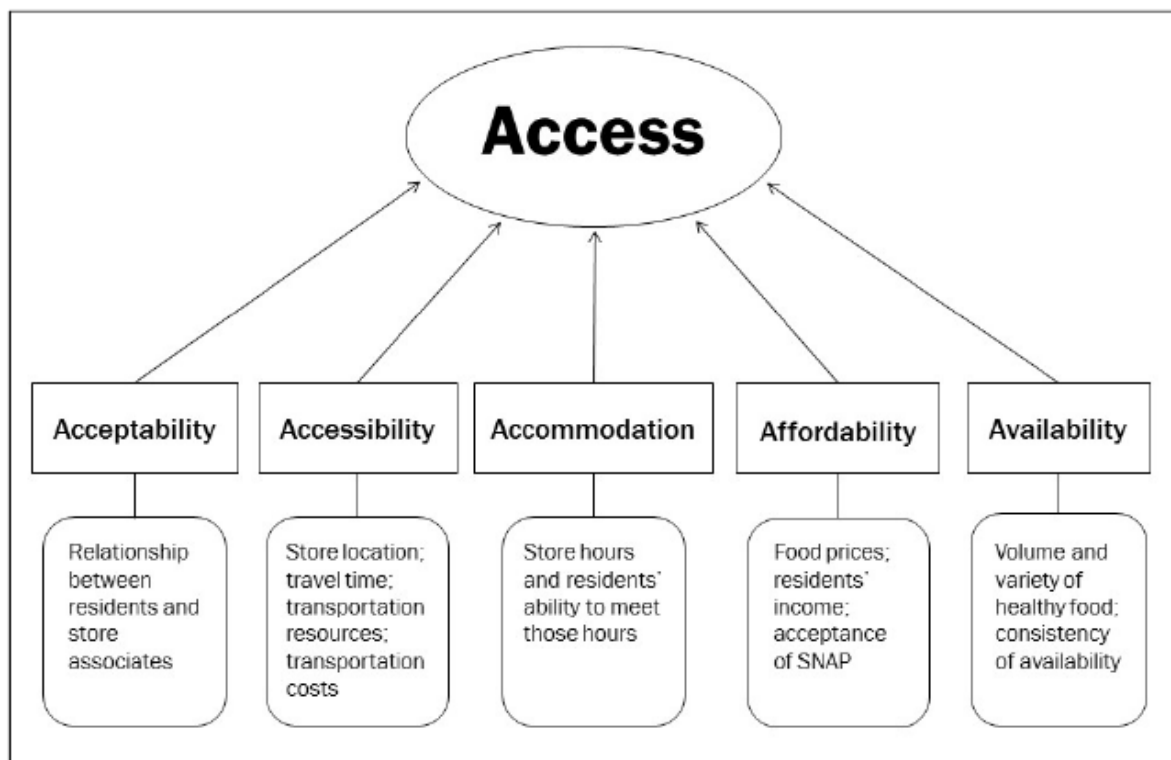
CONDOM USE BARRIERS

Many barriers to condom use relate to the concept of Access. Usher has illustrated five dimensions for the concept of Access including Acceptability, Accessibility, Accommodation, Affordability, and Availability (Figure 3.2.1)⁷⁰. Acceptability is defined as the relationship between customers and store associates, including owners. Regarding condom market, it considers clients' attitudes toward the quality and cultural appropriateness of the condoms being delivered. Accessibility queries residents' perceptions of the relationship between the location of the condom sources and the location of clients, taking account of clients' transportation resources, travel time, distance, and transportation costs. Accommodation refers to clients' perception of outlets' hours of operation, condom displays, the physical

⁷⁰ Usher, K. M. (2015). Valuing all knowledges through an expanded definition of access. *Journal of Agriculture, Food Systems, and Community Development*, 5(4), 109–114. <http://dx.doi.org/10.5304/jafscd.2015.054.018>

condition of the venue, and perception of area crime. Affordability refers to clients' perception of their ability to purchase the condoms, including consideration of their income and their knowledge of condom prices outside their neighborhoods for comparison shopping. This dimension also includes the condom sources' ability to make healthy condoms more attractive to clients through subsidies and discounts. Finally, the fifth dimension is Availability, which investigates the relationship between the volume and variety of condoms and the needs of clients, as well as the availability of condoms throughout the year.

Figure 3.2.1. The Five Dimensions of Access



Attitudes and beliefs (Acceptability): The most notable barrier is that condoms have been labelled, stigmatized and associated with sex work and unfaithful relationships. There is also lack of perceived risk where individuals say they do not need condoms (For FSW is about 24.2%) because their relationship is built on trust. Our data reveals that condom usage among all key populations declines when engaging in sex with a regular partner. About 22% of FSW have lived with a permanent partner or concubine, and in 46% of cases they have never used a condom. The most important reasons for inability to use consistently condoms among commercial clients of the FSW are Customer Opposition (34.3%), decreased sexual pleasure if using a condom (13.2%) and among non-commercial clients are Customer

Opposition (38.3%), confidence in a stable sexual partner (24.2%), and decreased sexual pleasure if using a condom (10.2%).

Inequity amongst socio-economic status (Affordability): This study conclusion on willingness to pay suggest that men are prepared to pay more for condoms, certain target groups, particularly poor, continue to face access and price challenges. Despite all public outlets in the country supplying free condoms, 41.7% % of condom users among key populations felt that they were not affordable. Condom use among poor key populations remains low. However, the impact of socioeconomic status on condom use among key populations is crucial in Iran as follows:

- After lack of access, being expensive was the most important reason for not using a condom by FSWs.
- 41.7% of FSWs did not have access to condoms because of their high price.
- Access to free condoms for PWID at the end of the Fourth NSP was 36%.
- The goal to get free condoms for high-risk women via Welfare Organization at the end of the Fourth NSP was 20%, which only 11% achieved.
- Only 3% of the MSM had access to free condoms at the end of the Fourth NSP.

Women Centers do not cover all FSWs, and most clients are in middle-class. People in the lower social classes do not come to these public centers because they do not care about their own health. People with high social class also do not go to government centers and receive services from the private sector. The problem with these high-class groups is that they do not receive training. We conclude that provision of free-of-charge condoms is still needed for key populations in order to persuade them to use condom.

Limited Availability: While condoms are available at public condom provision outlets; they are not consistently available at community level where they are needed most. We found a 26.2% of women with difficult access to condoms at community outlets, 19.8% had lack of access and overall accessibility on 24hrs basis was more limited where only 41% of FSW reported ability to obtain condoms during all weekdays. Inconvenience during purchasing condoms caused by lack of privacy, embarrassment and stigma are some of the hindrances to availability. Similarly, lubricants are not available on the public condom provision outlets. Availability however is still limited in Iran.

Limited Accessibility: There is some limited accessibility of the key populations to condoms, as some following examples:

- There are only 40 active Women Center in the country, and if on average each of them covers about 300 FSW, then less than 10% of FSW in the country are cared for by condoms.
- 26% of the FSWs had difficult access to condoms.
- Free condom delivery centers in the public sector are open during office hours. As a result, problems for key populations arise when condoms need to be used. As a result, 19.8% of FSWs had lack of access. And 78.3% of them provided condoms from the pharmacy (as the most important source of condom supply). In order to increase access, more exposure and visibility for condoms in pharmacies is required.

Limited Knowledge/Ability to use or negotiate condoms: Generally, men and women of all ages have adequate knowledge of condoms as a means of HIV/AIDS prevention. However, among key populations the figure is some different. Finding of this project showed that among key populations at risk, the proportion of PWID who reported ever hearing of HIV/AIDS was 96.9%, among FSW was 89.4% and prisoners was 93.2%. Despite overall universal basic HIV/AIDS knowledge, low comprehensive knowledge was reported in the various population groups. Comprehensive HIV Knowledge was very low for high risk groups; 28.1%, 31.1% and 19.7% for FSWs, PWIDs, and Prisoners, respectively. Based on the results of this study, this was as a result of less programmatic efforts focused on the key population compared general populations. In general, the awareness of key at-risk groups about ways to prevent the transmission of HIV/AIDS is proportionally high, but their perceived susceptibility to HIV/AIDS is not high. Meanwhile, many key populations continue to face challenges with negotiating condom use due to traditional and cultural factors. This limitation also exists in providers. We found that only 36.3% of FSW have received counseling on condom use.

Condom Distribution Programs (CDP)

There are several ways to promote condom use among people key populations at high risk for sexual transmission of HIV. Individual and group-level interventions help do this by directly addressing individual's knowledge, attitudes, skills, and behaviors related to condom use. Although, individual-level, and group-level interventions demonstrate moderate to high success in promoting condom use, they show the greatest effect in reducing the risk of HIV infection when combined with structural-level interventions. Structural-level interventions, such as distributing free condoms in diverse venues can address the social, economic, and political environments that shape individual, community, and societal health outcomes. To design and implement an effective Structural-Level Condom Distribution Programs (CDP), organizations are encouraged to adhere to the following elements:

- Provide condoms free of charge.
- Conduct wide-scale distribution.
- Implement social marketing campaigns to promote condom use. Consider using messaging that increases awareness of condom benefits and normalizes condom use within communities for key populations.
- Conduct both promotion and distribution activities at the individual and organizational levels.
- Supplement the CDP with more intense risk-reduction interventions or health services for individuals at highest risk.
- Establish organizational support for condom distribution and promotion activities in traditional and non-traditional venues.

Strategic Planning of CDP

Identify the internal and external factors that will help build an effective CDP:

1. **Select your audience:**
 - Individuals at high risk (key populations);

- Venues frequented by high-risk individuals;
 - Communities at greatest risk for HIV infection, especially those marginalized by social, economic, or other structural conditions.
2. **Resources and partners:** Develop a process for identifying and engaging appropriate community partners and agencies that plan, implement, manage, or provide resources to support your program.
 3. **Define your obstacles:** Identify difficulties, such as reaching members of vulnerable or hard-to-reach populations and strategies to overcome those challenges.
 4. **Assessment:** Conduct an evaluation to identify any structural barriers and ensure that condoms are:
 - **Available** in the locations where members of the target population are found (e.g., pharmacies, condom dispensing machines, outreach workers).
 - **Accessible** in venues frequented by the target population (e.g. massive distribution of free condoms).
 - **Acceptable** to community members and in alignment with social norms (e.g. social marketing of condoms).
 5. **Cost and Scale:** Calculate the costs and determine the scale of CDP.
 6. **Policy:** Identify the laws, policies, or practices that may support or hinder a CDP.
 7. **Define objective, goals, and measurements:** Define your programmatic objectives, key indicators for measuring the program's performance, and define how data will be collected. Key indicators to consider are:
 - Number of condoms distributed
 - Number of agencies, venues, or settings where free condoms are distributed
 - Estimated number of audience impressions from campaign messages.

3.3. Supply Chain and Commodity Security

SUPPLY AND COMMODITY SECURITY

The supply and commodity security component includes Forecasting, Procurement, Quality Assurance, Warehousing and Storage, Distribution to supply chains, and Logistic Management Information system. Condom programs must ensure that the condom supplies and distribution systems are adequate to meet current and future user demand. Efforts need to include adequate condom procurement and supplies; community-based distribution to key populations; targeted distribution of free outlets for those with greatest need such as key populations, and deliberate efforts to engage the commercial sector.

Forecasting and quantification (Supply planning): In Iran there is no Condom Program and MOH coordinates supply planning for condoms only for key populations in consultation with partners in line of the 5th NSP of the HIV/AIDS. In this project we calculated condom needs as followings:

- In order to calculate the number of condoms required to be divided into six key populations at risk of sexually transmitted diseases including HIV/AIDS, we need epidemiological data related to these populations, which are presented in the table

below. Data for all groups except MSM and Transgender groups, for which local data are very limited, have been extracted from population studies, especially systematic review studies and meta-analysis related to Iran. In the case of the MSM and Transgender groups, demographic data from other similar countries have been used. However, the prevalence of these groups is much lower than other study groups and does not seem to have a significant effect on the final results of the study. The data in the table below is shown as the prevalence / percentage of each variable with a 95% confidence interval of each.

Table 3.3.1. The required statistics to estimation the condom use (data are presented in prevalence/percent values

Sub-groups		Base value	Upper limit	Lower limit
PLHIV		<0.1	<0.1	0.2
MSM Prevalence*		0.5 ⁷¹	0.7	0.3
Frequency of sex a year		84 ⁷²	60	108
Frequency of sex among FSW a year		114 ⁷³	96	132
MSM drug users		20.8 ⁷⁴	23	18.6
Prevalence of FSWs		1.43 ⁷⁵	0.96	1.84
FSWs drug users		24.9 ⁷⁶	16.1	36.4
FSWs IDU		20.45 ⁷⁷	14.32	28.33
Transgender prevalence	MTF	0.077	0.070	0.084
	FTM	0.029	0.025	0.034
	Total	0.053 ⁷⁸	0.048	0.059
Transgender drug users		8.7 ⁷⁹	7.4	10
PWID prevalence		0.43 ⁸⁰	0.38	0.48
Prisoners prevalence		0.32 ⁸¹	0.29	0.35
Prisoner drug users		74 ⁸²	73.2	75.5
Prisoner with PWID		16.6	15.5	17.8

⁷¹ Mauck DE, et al. Population-based methods for estimating the number of men who have sex with men: a systematic review. *Sexual health*. 2019;16(6):527-38.

⁷² Call V, et al. The incidence and frequency of marital sex in a national sample. *Journal of Marriage and the Family*. 1995:639-52.

⁷³ Shushtari ZI, et al. HIV risk perception and sexual behaviors among female sex workers in Tehran, Iran. *Medical journal of the Islamic Republic of Iran*. 2019;33:101.

⁷⁴ Zamani S, et al. Potential for sexual transmission of HIV infection from male injecting-drug users who have sex with men in Tehran, Iran. *Sexually transmitted diseases*. 2010;37(11):715-8.

⁷⁵ Sharifi H, et al. Population size estimation of female sex workers in Iran: synthesis of methods and results. *PLoS one*. 2017;12(8):e0182755.

⁷⁶ Shokoohi M, et al. Drug use patterns and associated factors among female sex workers in Iran. *Addictive behaviors*. 2019;90:40-7.

⁷⁷ Khajehkazemi R, et al. Risk and vulnerability of key populations to HIV infection in Iran; knowledge, attitude and practises of female sex workers, prison inmates and people who inject drugs. *Sexual health*. 2014;11(6):568-74.

⁷⁸ APA E. *Diagnostic and statistical manual of mental disorders, Text Revision (DSM-IV-TR)*. Washington, DC. 2000.

⁷⁹ Moayedi-Nia S, et al. HIV Prevalence and Sexual Behaviors Among Transgender Women in Tehran, Iran. *AIDS Behav*. 2019;23(6):1590-3.

⁸⁰ Mumtaz GR, et al. HIV among people who inject drugs in the Middle East and North Africa: systematic review and data synthesis. *PLoS medicine*. 2014;11(6):e1001663.

⁸¹ Walmsley R. *World Prison Population List* (London: Institute for Criminal Policy Research). 2018.

⁸² Moradi G, et al. Patterns of drug use and related factors among prisoners in Iran: results from the national survey in 2015. *The journal of primary prevention*. 2020;41(1):29-38.

MSM prisoner		7.8 ⁸³	7.3	8.3
Iranian population Male (15-49 years)		46,042,950 ⁸⁴	-	-
Condom use	PLHIV	25.0	-	-
	MSM	27.0	-	-
	Sex workers	33.6	24.7	43.9
	Transgender people	17.7	-	-
	PWID	83.3	78.5	88.1
	Prisoners	24.7	17.9	32.9

* It considered similar to countries like China, Ghana, Georgia, sub-Saharan African countries

Table 3.3.2. shows the population and number of condoms required annually for each group of PWID, PLHIV, FSW, male prisoners, MSM and transgender with an average 95% confidence interval based on prevalence. Each group is estimated and presented. In this estimate, the average number of sexual intercourses per person is 7 times a month (84 times a year) and for FSW 9.5 times a month (114 times a year)⁸⁵. Also, given that these high-risk groups overlap in terms of population and the corresponding values are shown in Table 4.3.1. population estimates and the number of condoms required annually for each group, as well as by omission, overlap values are shown in the bottom row to avoid double or multiple calculations. In other words, these results show that the group of HIV/AIDS patients has an average population of 53,000 and needs more than 4.4 million condoms each year. Of course, we must not forget the precondition that people use condoms in all their sexual relations. These statistics were obtained for the group of sex workers 600,415 people and about 50,434,000 condoms, respectively. If we do not consider the overlap values and coefficients of these groups, the total population of these groups is equal to 844341 people and the number of condoms required annually for these people is estimated at 63989225 condoms. However, if we consider group matching only once for one group and exclude for the other groups, the total population of the 6 groups at risk of sexually transmitted diseases and AIDS is 746,222 each year. They need about 56553164 million condoms. The upper and lower limits of the at-risk modified key population are 562,602 and 946,378, respectively, and the range for condoms required for this population is estimated at 47-79 million annually.

Table 3.3.2. The number of condom needed for Iranian key population subgroups of 15-49 old years

Subgroups	Estimated population			Estimated number of required condom yearly		
	Base value	Lower limit	Upper limit	Base value	Lower limit	Upper limit
PLHIV	53,000	39,000	92,086	4,452,000	3,276,000	7,735,224
MSM	117,410	70,446	164,373	9,862,440	5,917,464	13,807,332
FSW	322,623	216,586	419,635	36,779,022	24,690,804	47,838,390
Transgender	24,403	22,101	27,165	2,049,852	1,856,484	2,281,860

⁸³ Pourahmad M, et al. Seroprevalence of and risk factors associated with hepatitis B, hepatitis C, and human immunodeficiency virus among prisoners in Iran. *Infectious Diseases in Clinical Practice*. 2007;15(6):368-72.

⁸⁴ World Population Review (2021) Iranian population 2021

⁸⁵ Call V, Sprecher S, Schwartz P. The incidence and frequency of marital sex in a national sample. *Journal of Marriage and the Family*. 1995:639-52.

PWID	197,985	174,963	221,006	16,631	14,696,892	18,564,504
Prisoners	128,920	115,107	142,733	10,829,280	9,668,988	11,989,572
Total (in raw)	844,341	638,203	1,066,998	63,989,225	53,609,052	89,627,832
Total (Corrected)	746,222	562,602	946,378	56,553,164	47,258,568	79,495,752

Due to the considerable uncertainty in the average number of sexual intercours over a given period of time, we performed a one-way sensitivity analysis taking into account the number of sexual intercours 60-108 times per year (5-9 times per month) and the results We show in Table 3.3.3.

The results show that the total number of condoms required annually for the 6 key populations is between 50.4-77.5 million raw and between 44.4 and 68.8 million corrected condoms.

Table 3.3.3. One-way sensitivity analysis on the number of condom needed for Iranian key populations of 15-49 old years based the average number of sex yearly

Subgroups	Estimated number of required condom yearly		
	Base value (n=84)	Lower limit (n=60)	Upper limit (n=108)
PLHIV	4,452,000	3,180,000	5,724,000
MSM	9,862,440	7,044,600	12,680,280
FSW	36,779,022	30,971,808	42,586,236
Transgender	2,049,852	1,464,180	2,635,524
PWID	16,631	11,879	21,382
Prisoners	10,829,280	7,735,200	13,923,360
Total (in raw)	63,989,225	50,407,667	77,570,782
Total (Corrected)	56,553,164	44,436,437	68,801,719

Considering that people belonging to key populations use condoms only in a part of their sexual relations, the information of which is given in Table 4.3.1. Accordingly, the demand for condoms is much lower than the demand for them, the results of which are shown in Table 3.3.4. These findings show that the average annual demand for condoms is estimated at more than 31.6 million with a confidence interval of 22.6-36 million.

Table 3.3.4. The number of condom demanded by Iranian key populations subgroups of 15-49 old years

Subgroups	Estimated population			Estimated number of required condom yearly		
	Base value	Lower limit	Upper limit	Base value	Lower limit	Upper limit
PLHIV	53,000	39,000	92,086	1,113,000	819,000	1,933,806
MSM	117,410	70,446	164,373	2,662,859	1,597,715	3,727,980

FSW	322,623	216,586	419,635	12,357,751	8,296,110	16,073,699
Transgender	24,403	22,101	27,165	362,824	328,598	403,889
PWID	197,985	174,963	221,006	16,630,740	12,242,511	15,464,232
Prisoners	128,920	115,107	142,733	2,674,832	2,388,240	2,961,424
Total (in raw)	844,341	638,203	1,066,998	35,802,006	25,672,174	40,565,030
Total (Corrected)	746,222	562,602	946,378	31,641,534	22,631,069	35,979,310

The demand for condoms is significantly affected by the average number of sexual intercourses over a period of time. Considering the average number of sexual intercourses 60-108 times per year (5-9 times per month), the demand for condoms among the study groups is presented in Table 3.3.5. These findings show that the demand for condoms in these groups is between 24-37 million per year for the key populations in the age group of 15-49 years.

Table 3.3.5. One-way sensitivity analysis on the number of condom demanded for Iranian key populations of 15-49 old years based the average number of sexual intercourse yearly

Subgroups	Estimated number of required condom yearly		
	Base value (n=84)	Lower limit (n=60)	Upper limit (n=108)
PLHIV	1,113,000	795,000	1,431,000
MSM	2,662,859	1,902,042	3,423,676
FSW	12,357,751	10,406,527	11,707,343
Transgender	362,824	259,160	570,152
PWID	16,630,740	11,879,100	21,382,380
Prisoners	2,674,832	1,910,594	3,439,070
Total (in raw)	35,802,006	27,152,423	41,953,621
Total (Corrected)	31,641,534	23,997,100	37,078,283

Condom Procurement: In Iran, there is enough stock of condoms in the pipeline to cover public sector condom needs with potential for increased quantities in case of need for key populations. Most free condoms are provided by the MOHME and to some extent by UN agencies. For example, in the last six months, more than 19 million condoms have been distributed nationwide by the MOHME, of which about 4 million were provided by UNAIDS, Global Fund, UNDP, UNFPA and 500,000 by the UNHCR.

Regarding stock-outs, supply problem, and procurement problem, our findings show that in most free condom centers, there are quantitative and qualitative problems. For example, there is not enough stock, there is not a variety of products that applicants have the right to choose. In the case of women's centers where the service is outsourced, these restrictions do not exist.

Annual budget required to supply condoms and PrEP drugs

The annual budget for the total number of condoms required, as well as the annual cost of the number of condoms requested by six key populations at high risk of contracting and

transmitting HIV/AIDS, is presented in Table 3.3.6. These estimates are based on the average annual number of sexual intercourse equal to 84 (95% confidence interval: 108-60) for all studied groups except female sex workers who have an average of 114 cases (95% confidence interval: 96 -132). Also, the cost of each package containing 12 simple and classic condoms is equal to 150,000 IRR based on free market data.

The highest and lowest annual budgets needed to supply the condoms required by the high-risk groups studied were related to FSW (about 460 billion IRR) and Transgender people (about 26 billion IRR), respectively. The total adjusted cost of these key populations is estimated at more than 890 billion IRR. Also, the highest and lowest annual costs requested were the same groups of FSW (more than 154 billion IRR) and Transgender people (more than 4500 million IRR) that the total annual cost requested by these six groups was equal to 498 billion IRR.

Table 3.3.6. The estimated annual budget of condom needed and demanded among the Iranian high-risk subgroups (Billion IRR).

Subgroups	Estimated budget of condom needed (95% CI)	Estimated cost of condom demanded (95% CI)
PLHIV	55.65 (39.75-71.55)	13.91 (9.94-17.89)
MSM	123.28 (88.06-158.50)	33.29 (23.78-42.80)
Sex workers	459.74 (387.15-532.33)	154.47 (130.08-178.86)
Transgender	25.62 (18.30-32.94)	4.54 (3.24-5.83)
PWID	207.88 (148.49-267.28)	173.17 (123.69-222.64)
Prisoners	135.37 (96.69-174.04)	33.44 (23.88-42.99)
Total (in raw)	1007.54 (778.44-1236.65)	563.72 (435.54-691.90)
Total (Corrected)	890.47 (687.98-1092.95)	498.22 (384.93-611.51)

Table 3.3.7 presents the number of PrEP drug packages required to cover the total population of the four groups considered in the national medium-term strategy of condom planning and PrEP, as well as the number required to achieve the 2026 goals in this national program. In total, the number of adjustments required to cover the total population is estimated at 1.2 million packages and to achieve the program objectives a little over 245 thousand packages. The main need for this has been the partners of two groups of PLHIV partners and FSW.

Table 3.3.7. PrEP needed and required for Iranian targeted subgroups of 15-49 old years based on NSP of HIV/AIDS control (Annually)

Subgroups	Population (95% CI)	Percent of consistently condom use	PrEP package needed (95% CI)	Coverage target	PrEP required (95% CI)
PLHIV partners	53,000 (39,000-92,086)	69.50%	193,980 (142,740-337,035)	90%	174,582 (128,466-303,332)
MSM	117,410 (70,446-164,373)	62.20%	532,572 (319,543-745,596)	6%	31,954 (19,173-44,736)
FSW	322,623 (216,586-419,635)	85.10%	576,850 (387,256-750,307)	15%	86,528 (58,088-112,546)
Transgender	24,403 (22,101-27,165)	62.20%	110,692 (100,250-123,220)	6%	6,642 (6015-7393)
Total (in raw)	523,436 (348,133-703,259)	77.97%	1,383,755 (920,324-1,859,135)	20%	27,6751 (184,065-371,827)
Total (Corrected)	464,264 (306,893-621,535)	77.97%	1,227,328 (811,302-1643,090)	20%	245,466 (162,260-328,618)

+ Each high risk person must receive 12 Truvada (Emtricitabine/Tenofovir disoproxil fumarate) package as oral Pre-exposure prophylaxis (PrEP) annually.

According to the findings of Table 3.3.7, the annual budget required to provide oral pre-exposure prophylaxis for the entire population of each subgroup at risk, as well as the budget required to achieve the 2026 goals in Table 3.3.8 estimated and presented. In these calculations, the price of each 30/month Truvada package is equal to \$ 4.2 and each USD is equal to 232,000 IRR according to the Nima system.

The average annual budget needed to cover the entire at-risk population ranged from \$ 5.58 million (1,290 billion IRR) in the transgender group to \$ 26.84 million (6,750 billion IRR) in sexually active women. In general, a figure of 61.85 million dollars (14,350 billion IRR) per year is needed to cover all four groups studied.

In order to achieve the 2026 policy goals, this required budget range from \$ 330,000 (78 billion IRR) for transgender people to \$ 8.8 million (2,040 billion IRR) in PLHIV partners each year. The total and adjusted annual budget required is estimated at about \$ 12.37 million (2,870 billion IRR).

Table 3.3.8. PrEP budget needed and required for Iranian targeted subgroups of 15-49 old years based on NSP of HIV/AIDS control (Annually)

Subgroups	PrEP budget needed for total population	PrEP budget required for reach the targets
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	(95% CI)		(95% CI)	
	In Million USD	In Trillion IRR	In Million USD	In Trillion IRR
PLHIV partners	9.78 (7.19-16.99)	2.27 (1.67-3.94)	8.80 (6.47-15.29)	2.04 (1.50-3.55)
MSM	26.84 (16.10-37.58)	6.23 (3.74-8.72)	1.61 (0.97-2.25)	0.37 (0.22-0.52)
FSW	29.07 (19.52-37.82)	6.75 (4.53-8.77)	4.36 (2.93-5.67)	1.01 (0.68-1.32)
Transgender	5.58 (5.05-6.21)	1.29 (1.17-1.44)	0.33 (0.30-0.37)	0.78 (0.70-0.86)
Total (in raw)	69.74 (46.38-93.70)	16.18 (10.76-21.74)	13.95 (9.28-18.74)	3.24 (2.15-4.35)
Total (Corrected)	61.85 (40.89-82.81)	14.35 (9.49-19.21)	12.37 (8.18-16.56)	2.87 (1.90-3.84)

CHAPTER 4: MALE CONDOM TOTAL MARKET IN IRAN

4.1. Introduction

Condoms are a critical component of a comprehensive and sustainable approach to the prevention of HIV and other STIs. Building equitable condom programs requires a clear understanding of how and why existing markets are failing. Mann Global Health provided a guidance on how to improve the use of market development approaches in condom programming. We use this guidance in condom programming in Iran.

Over the last 20 years, there have been significant changes among consumers and in the evolution of condom programs, yet little attention has been paid to long-term planning, vision or strategy for condom programming. There is a need to ensure that adequate condom supply meets increasing demand. The vision of success for a healthy condom market begins with programming where condom use increases to meet the total need for condoms, based on the epidemiological context across different countries. By using criteria of gender, age, geography, wealth quintiles and risk behaviors, the condom market can be further analyzed by its ability to provide equity. It is also important to determine the best allocation of resources for condom programs so that they become sustainable. As donor support for condom programming declines, there is a need not only for advocacy to increase funding (from donors or from governments), but also for the realignment of existing resources to move towards more equity and sustainability.

4.2. General Concepts

Glossary of Terms

Condom Markets – Condom Markets are comprised of the network of procurers, buyers, sellers and other actors that come together to support condom access and use. The market includes commercial, subsidized and free condoms. Actors in this system are: Direct market players – producers, buyers and consumers who drive economic activity and use in the condom market; and Indirect market players --suppliers of supporting services, such as finance, condom coordinating committees, regulatory agencies, policy and quality control.

Condom Need – There are many definitions of condom need for any given country or context. For the purposes of this analysis, WHO used the UNAIDS definition of need where condom supply meets UNAIDS targeted need of 90% of high risk sex acts covered by condom use by 2020.

Condom Program Pathway – The Condom Program Pathway is a framework for assessing and understanding condom programs and includes all the necessary elements for a successful condom program at the country level. Key market functions in the Pathway were initially identified based on findings from an extensive literature review as well as inputs from global condom stakeholders. Fieldwork in five countries then further refined the functions required for successful condom programming, determined the importance of different market failures seen within these functions, and proposed recommendations for future investments in condom programming.

The Condom Program Pathway includes: condom program stewardship, condom market development, and condom market management.

Condom Program Stewardship – The work that must occur at the national level to create a favorable environment for a condom market. Stewardship requires leadership and coordination from national governments, and financing from national and external sources to fund condom market functions. Good stewardship also requires that policies and regulations (e.g., taxes and regulatory requirements) create an enabling environment for all market players and strengthen condom markets in the long run.

Condom Program Development – An aggregation of all the market actors across the core functions of demand and supply in a country. At this level, the supply chain must function

well, and there must be sufficient condom demand across all population groups, particularly key and vulnerable groups. In addition, in order to understand the condom market and routinely measure its performance, good market analytics must be available for all market players, including government agencies, donors and implementing agencies or businesses.

Condom Market Management – The work that market actors (whether public sector, for-profit or not-for-profit players) undertake to achieve equity and sustainability in a condom market. Different actors' program designs or business models evolve to ensure that the needs of key and vulnerable populations are met, and that their own programs move towards sustainability.

Last Mile Distribution – The challenge of reaching the most remote and underserved areas with high quality and timely products and services.

Market Development Approach (MDA) – An analytical approach that begins with an understanding of current market performance in terms of users as well as market functions and actors. This analysis helps determine which market functions are not performing or are under-performing, and consequently result in market failures in terms of growth, equity and/or sustainability.

Market System Approach (MSA) – The network of procurers, buyers, sellers and other actors that come together to support condom access and use. The market system includes commercial, subsidized and free condoms.

Market Failures – Challenges to different functions in condom programs, which are preventing condom markets from achieving growth, equity and sustainability.

Total Market Approach (TMA) – A lens or process that can be applied to develop strategies that increase access to priority health products in a sustainable manner. This approach helps grow the market for health products by better targeting free or subsidized products, reducing inefficiencies and overlaps, and creating room for the private sector to increase its provision of health commodities (*USAID Global health e-learning Center*).

Social and Behavior Change Communications (SBCC) – A research-based, consultative process that uses communication to promote and facilitate behavior change and support the requisite social change for the purpose of improving health outcomes (Manoff Group, 2013).

Social Enterprise – An emerging model of service delivery that uses for-profit ventures to achieve social objectives. In contrast to Social Marketing, which may focus on equity of services and products across all population segments, Social Enterprises require cost recovery of services and products.

Social Marketing – Social marketing is the use of commercial marketing concepts to plan and implement programs designed to bring about social change (Social Marketing Institute, 2011).

Root Cause Analysis – A technique designed to ask *why* something has occurred within a market system. It involves 3 steps: Define the problem; determine what happened; determine why it happened – “you keep asking why, until you can't ask any more.”

Condom Social Marketing - Condom Social Marketing is a means in which condom brands are developed and marketing with the promotional campaigns to be sold to specific target groups. Condom social marketing aims to ensure that condoms reach the groups who most need them, in an affordable and accessible way, so the product is typically subsidized and made available through both traditional and non-traditional outlets

4.3. Methodology – Identifying the Challenges in Condom Total Markets

The Condom Program Pathway

This Pathway includes all the necessary elements for a successful condom program at the country level. Key market functions in the Pathway were initially identified based on findings from an extensive literature review as well as inputs from global condom stakeholders. The Condom Program Pathway includes: condom program stewardship, condom market development, and condom market management.

Condom program stewardship is the work that must occur at the national level to create a favorable environment for a condom market. Stewardship requires leadership and coordination from national governments, and financing from national and external sources to fund condom market functions. Good stewardship also requires that policies and regulations create an enabling environment for all market players and strengthen condom markets in the long run.

Condom market development is the next level down from the larger stewardship/enabling environment. It is an aggregation of all the market actors across the core functions of demand and supply in a country. At this level, the supply chain must function well, and there must be sufficient condom demand across all population groups, particularly key and vulnerable groups. In addition, in order to understand the condom market and routinely measure its performance, good market analytics must be available for all market players, including government agencies, donors and implementing agencies or businesses.

Condom market management is the work that market actors (whether public sector, for-profit or not-for-profit players) undertake to achieve equity and sustainability in a condom market. Different actors’ program designs or business models evolve to ensure that the needs of key and vulnerable populations are met, and that their own programs move towards sustainability.

Figure 4.3.1.: The Condom Program Pathway



Table 4.3.2. Rationale for inclusion of different building blocks/functions in the Condom Program Pathway

Functions within the Condom Program Pathway		Rationale for Inclusion
Condom Program Stewardship	Leadership & Coordination Capacity	Important that government is responsible and accountable for the overall strategy/direction of the program, including coordination of different market players, market facilitators, donors, and private actors.
	Financing	Coordinated and adequate financing for all critical aspects of condom programming. Ensure that appropriate use of subsidy addresses gaps in the condom program.
	Policy & Regulation (includes taxes, tariffs, testing, etc.)	Enabling environment factors that are supportive of all market players and target populations, while ensuring compliance with national standards.
Condom Market Development	Market Analytics	Total market data needed to analyze condoms needs and condom market performance across all players and functions, in order to adjust and plan for interventions.
	Supply	Comprehensive approach looking at the entire value chain in the public sector and across private channels, including quantification, forecasting, procurement efficiencies, supply chain management and pricing structures.
	Demand	Ensuring increased and sustained demand with a focus on increasing use within priority target populations.
Condom Market Management	Equity	Equitable condom programs address specific barriers to use across target populations based on age, gender, geography, wealth quintile and risk behaviors. Equity requires a balancing of subsidy to meet the needs of these populations.
	Sustainability	Sustainable condom programs are those that have long-term, reliable and predictable sources of funding to meet all their population needs. This funding can come from the government only, for example, or from a diverse portfolio that includes commercial actors with profit incentives. Most sustainable condom programs are diverse.

4.4. Findings from Iran

How are these condom markets failing?

Method of evaluating Iran's country condom programs included review of all relevant documents as well as primary data collection through email and virtual key informant interviews. The key informant interviews reflected a cross-section of stakeholders involved in condom programming at the country level, including representatives from government agencies, international bodies, international and local organizations, and private sector players.

Results

- ***There is no link between country-wide strategy documents, work plans and resource allocation*** – Iran had relatively strong national strategy and planning documents. However, there is a general lack of understanding of the condom total market performance. There is also a limited understanding of the roles of different market actors and how they supported functions within the total market. There is a clear need for national condom programming to include a strategy for achieving the healthy condom market vision of equitable and sustainable growth.
- ***The condom market does not constantly monitor market performance in terms of equity and sustainability*** - One of the reasons that there is no vision of a healthy market, is that there is inadequate use of market information to assess performance. In Iran, some critical parts of a total market, such as commercial players are entirely missing from national strategy documents, as information on these actors is not readily available or tracked. As a result, the potential role of private market players is often under-estimated. Similarly, equity issues are difficult to identify as there is insufficient data collection and reporting of access, affordability and condom use across age, gender, geography, wealth quintiles and risk behaviors. All of these challenges result in a myopic view into market performance. In the private sector in Iran, market players across the value chain (importers, distributors, wholesalers and retailers) play a key role in ensuring product access, but information on their contribution to the total market is not tracked.
- ***Commercial actors play less of a role in diversifying the national response and ensuring the long-term sustainability of the entire condom market*** –commercial actors played a very small role across the condom markets of Iran and there are several commercial condom brands in Iran, but distribution is limited to pharmacies. In Iran, there are other market entry barriers that include policy and regulatory challenges such as prohibition of advertising and encouraging the use of contraceptive methods including condom in the public sector and even in the private sector at the country level. This has led to the frequent bankruptcy of condom manufactures and distributors in the private sector. Finally, commercial actors are unable to generate the volumes needed to justify marketing and distribution investments, as they compete on uneven playing fields against heavily subsidized and free condom brands in Iranian situation.
- ***Limiting government support for condoms to HIV prevention and government subsidies to weak condoms is a barrier to condom business and costs a lot of opportunity*** – Most markets are either overly reliant on free government condoms or on heavily subsidized social marketing condoms. Data show that people in middle to upper wealth quintiles are using free or subsidized condoms to prevent HIV, when they are able to pay full cost and to prevent pregnancy, they get condoms from pharmacies for a fee. Redirecting condom funding to focus resources on priority populations such as most at-risk populations, would provide far greater value for

money, as well as HIV impact. Lack of product variety and customers' right to choose are another limitation of the uniqueness of the supply of condoms in the public sector.

- ***Lack of proper investment to create demand to ensure proper and continuous growth of the condom market and increase condom use in higher risk populations*** – Condoms, like PrEP, require regular recruitment of new users, and constant presence in convenient locations (because most at risk people perceive few condoms at any one time, and often need convenience at a time and location close to sex negotiation or opportunity). Condom use is still associated with a range of socio-cultural factors around taboo subjects like sex and stigma, so that social and behavior change interventions continue to be necessary. In order to limit the education and development of family planning program, demand creation/behavior change activities have declined, however, despite the need for campaigns addressing deeper barriers to condom use among HIV prevention target populations. Strategies is now required to support demand creation campaigns with the aim of overcoming barriers to condom and PrEP use by priority groups.
- ***Not all aspects of condom programming are supported by the public sector*** – Often UN agencies and CDC department of the MOHME focus on commodity procurement as the main funding priority. This practice starves other aspects of condom programming, such as supply chain management and targeted demand creation. Condoms – like PrEP – require regular recruitment of new users, and constant presence in convenient locations.

The table 4.4.1. summarizes specific market failures in Iran.

Table 4.4.1: Market Failures

Condom Program Pathway	Function	
Condom Program Stewardship	Leadership & Coordination Capacity	Limited national stewardship of the national condom market as key government agencies focused on direct implementation through the public sector especially for key populations and there is no common vision for a healthy condom market.

	Financing	While the Iranian government allocates domestic resources for goods, it also enjoys the support of different UN agencies. The MOHME is the main source for supplying financial resources for HIV/AIDS prevention program including condom market.
	Policy and Regulation	We concluded a significant support from policy level especially for high risk groups. Supportive regulatory and policy environment for all sectors is visible. Supervising Implementation of the Program (SIP) in the national and provincial level which is foreseen in the 6 th NSP is a good sample.
Condom Market Development	Market Analytics	Limited use of marketing and consumer research data to inform consumer segmentation and brand positioning.
	Supply	Supply chain challenges in the public sector limited due to the change in the population policies in Iran since 2014. There is sustained access to condoms when and where populations need them, who prefer to access condoms discreetly outside of clinical facilities. Key populations such as FSW, MSM, and PWID have free access to malecondom via Women Centers, VCT centers and prisons.
	Demand	Lack of adequate coordinated efforts to address access and affordability barriers among key and vulnerable populations. Social marketing organizations do not coordinate.
Condom Market Management	Sustainability	For key populations, there is no problem in maintaining condom access and sustainability of the service, even if UN agencies cut off their support.
	Equity	<ul style="list-style-type: none"> - Insufficient targeting of key and vulnerable populations with demand creation and distribution tailored to their needs. For example, there is no service for MSM and transgender. - Inadequate investment in promoting the importance of a healthy condom market in achieving equitable and sustainable condom Programming. - Lack of market development approaches means Some key populations often without condoms.

The main companies producing and distributing condoms in Iran

- **BARAN BASPAR:** In 2009, it started its activity as a manufacturer of condoms with the X-Dream brand in Iran, since the production of a product with diverse quality and tailored to Iranian needs has been and is the biggest and most important concern of the company's managers from the very beginning. X DREAM condoms in 13 varieties and in packs of 3 and 12 made in Iran with German technology. The company is currently the

largest manufacturer in the Middle East with a production capacity of 150 million pieces. Be The company's brands include Shodo-X-Dream-Codex-Hood-Emotion-Delta-parman.

- **BONYAN POSHESH CASPIAN:** It was established in 2010 with the aim of producing various products derived from latex and started its production in the male condom industry at the beginning of 1392 using the most modern machines and the most up-to-date technology in the world. At present, in the first phase, it has the capacity to produce 120,000,000 pieces of male condoms per year, which can be upgraded to 600,000,000 pieces.
- **KEYHANBOD:** It is the first condom manufacturer in the country, Middle East and West Asia.

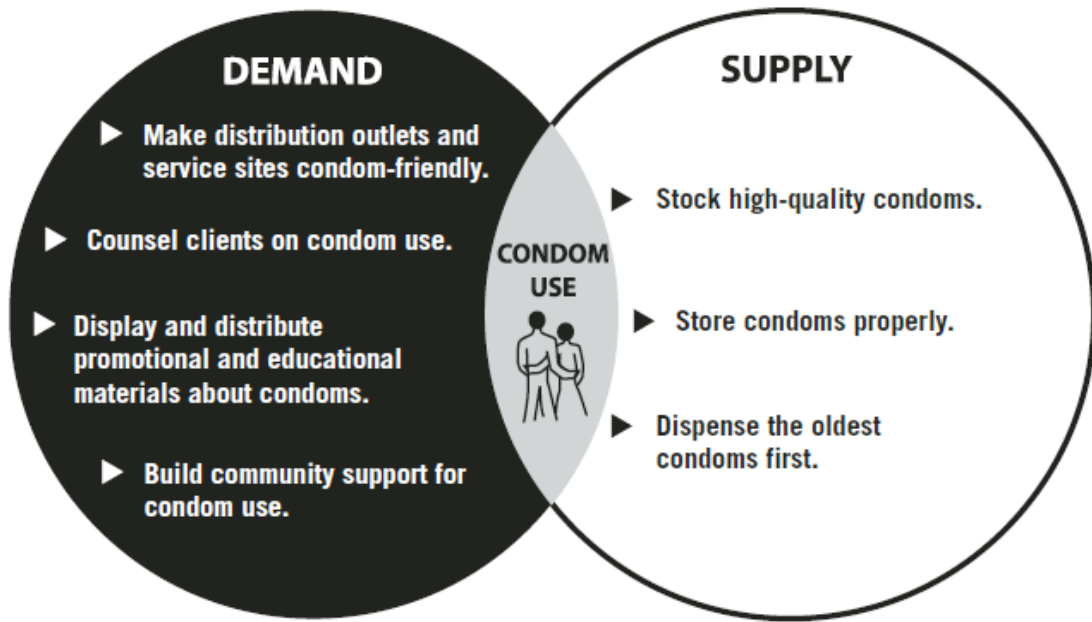
4.5. CONMDOM SOCIAL MARKETING

4.5.1. Elements of condom provision: Demand and Supply

Effective condom programs (Figure 4.5.1.1) must overcome all of potential barriers to condom use by:

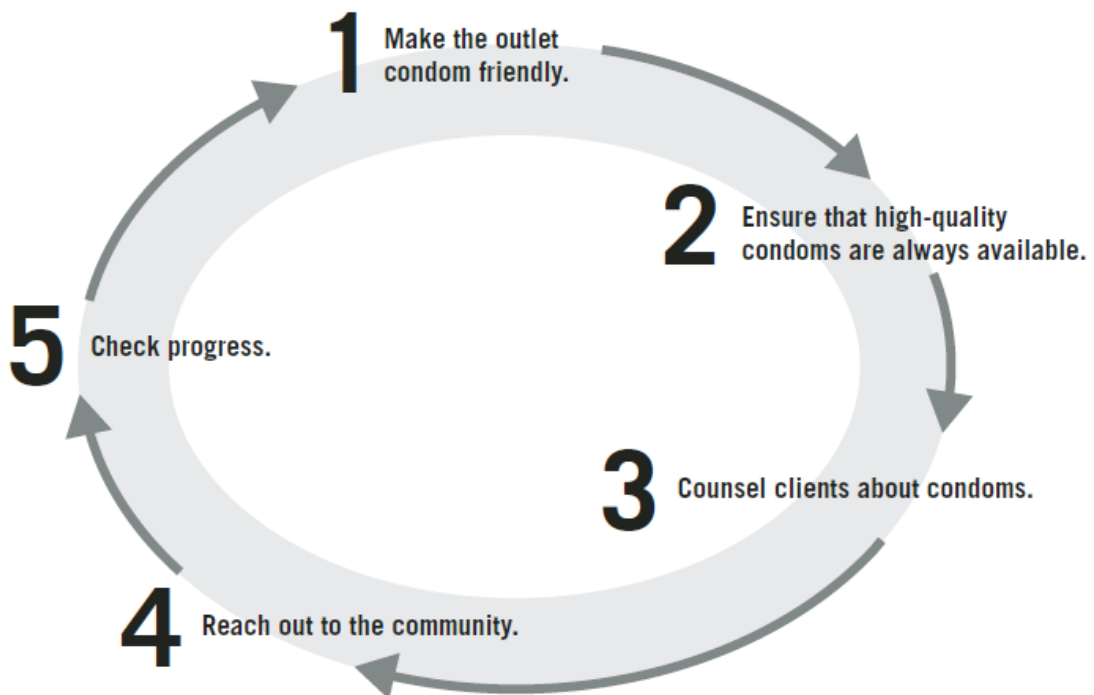
- Creating a reliable supply of good-quality condoms by improving stock management and storage conditions;
- Making condoms readily available even for spontaneous users;
- Promoting demand for condoms by raising awareness of HIV/STI risks and teaching people how to use condoms correctly and consistently;
- Working to eradicate the social stigma associated with condoms; and
- Promoting a supportive environment by advocating for HIV prevention and condom use in the broader community.

Figure 4.5.1.1. Elements of condom provision



In this project, we collected some practical advice on how to promote condoms using a five-step process, Figure 4.5.1.2.

Figure 4.5.1.2. Five steps for condom provision for HIV prevention



4.5.2. Findings related to the condom provision in the public sector for key populations:

Findings obtained from the review of documents and interviews with experts and stakeholders are presented in the form of the five steps for condom provision for HIV prevention model for key population in Iran.

Step 1: Make the outlet condom friendly

- **Clients` privacy and confidentiality-** Privacy and confidentiality are essential for clients. Findings showed that privacy and confidentiality are considered for clients seeking HIV/STI prevention and condom services in VCT centers and Women Centers in overall term, they often feel uncomfortable, especially if they are young or belong to a marginalized group such as sex workers. Often, they may want to minimize face-to-face interaction.
- **Make it easy for clients to get condoms and counselling-** Condom clients often feel welcome and comfortable, regardless of their marital status in outlets belong to the key populations in Iran.
- **Display promotional and educational materials about condoms-** Educational materials can help create a condom-friendly setting:
 - Posters and signs in the workplace
 - Brochures are especially useful at shops, kiosks, and other locations where individual counselling is not available. In Iranian setting they could be available in the workplace.
 - Videos and audiocassettes are especially helpful where literacy levels are low, but audiences of all kinds find them appealing. The World Health Organization (WHO) developed a 'Decision-Making Tool (DMT) for Clients and Providers' which aims to improve the quality of services by improving the counselling process through better client-provider interactions, the provision of accurate information and by increasing informed choice. The DMT essentially is a generic, two-sided flipchart that providers use in their counselling discussions with condom clients. The DMT has been tested in several countries including Iran and been shown to improve the quality of counselling for condom clients. The Iranian version of the WHO-DMT improved many client-provider interaction indicators, including verbal and nonverbal communication. The tool also impacted positively on the client's choice of condom, providers' technical competence, and quality of information provided to clients. Use of the tool improved the clients' satisfaction with services including condom provision and overall, the adapted WHO's DMT in Iran has the potential to improve the quality of services including condom provision service. The findings of this project showed that the providers were dissatisfied with the lack of teaching aids such as brochures at service providing centers for key groups.

Step 2: Ensure that high quality condoms are always available- Keeping enough good-quality condoms in stock to satisfy clients' demands poses a constant challenge.

- **Track supply levels-** All centers providing condom for key populations in Iran, always had enough condoms to offer clients. Of course, most centers do not have all the different types of condoms at different times, and there are also a few centers where the variety of condoms available was comparable to the condoms on the

market. Another limitation of condom delivery centers for key populations in Iran is the lack of variety in the size of condoms, and in most cases they offer only the size they have to applicants.

- **Decide when and how many condoms to order-** A maximum-minimum inventory control system can help providers decide when and how many condoms to order.
- **Store condoms properly-** Condoms are perishable and need proper storage. Male condoms remain effective for three years to five years. Exposure to direct sunlight or fluorescent light, heat, humidity, moisture, and ozone can considerably shorten the shelf life of male latex condoms. Our findings showed that the providers of VCT centers and Women Centers in Iran have good experience and learnings to make sure that all condoms dispensed are in good condition, they regularly and randomly inspect condom supplies, maintain proper storage conditions, and dispense condoms before they expire. Overall, they consider **Inspection, Storage conditions, and Security principles.**
- **Dispense the oldest condoms first,**

Step 3: Counsel clients about condoms- Counselling helps clients make and implement decisions based on their individual needs, preferences, and circumstances with following key actions:

- **Providers need to explore their own attitudes and values**
- **Assess the client's risk of infection and create a plan to reduce it**
- **Address myths, perceptions, dislikes, and fears**
- **Evaluate the client's need for dual protection**
- **Teach condom use and negotiation skills**
- **Help clients deal with problems using condoms**
- **Refer clients for other services**

Our findings showed that all of the providers of VCT centers and Women Centers have good practical counselling skills and they have all participated in several national and local skills workshops. Staff stated that they felt the need for training and other skills, such as specialized sexual health workshops, as well as specialized counseling with various clients such as transgender people, homosexuals, and others.

Step 4: Reach out to the community- People are more likely to use condoms if they believe their family, friends, and community support, rather than stigmatize, condom use. We can reach the community using the following items:

- **Discuss HIV/STIs and condom use with community groups.**
- **Display and distribute print and promotional materials.**
- **Use local forms of entertainment to promote condoms.**
- **Persuade influential individuals and organizations to endorse condoms.**

Our findings showed that due to the current situation of the country, providers could not use promotional materials and some entertainment materials. However, staffs working in condom service centers have had invaluable experience in communicating with key players in the sex worker market and are also demanding that more outreach investment be made to connect more and attract more customers to their centers.

Step 5: Check progress- using the following activities:

- **Monitor the quantity of condoms distributed and clients served.**
- **Monitor the quality of counselling provided.**
- **Seek client feedback on services.**
- **Work with supervisors and staff to improve services.**

4.5.3. Key Elements of Condom Marketing: 6Ps

Social marketing is the adaptation of commercial marketing techniques to social goals. Using traditional commercial marketing techniques, social marketing makes needed products available and affordable to low-income people, while encouraging the adoption of healthier behavior. According to Kotler (1997) the term Marketing has been defined in various ways. One of the definitions is " Marketing is a social and managerial process by which individuals and groups obtain what they need and want through creating, offering and exchanging products of value with others."⁸⁶. According to Stanton et al (1994), marketing has also been defined as the total system of activities designed to plan, price, promote and distribute want-satisfying products to target markets, so as to achieve organization's objectives. Hence marketing is also defined in terms of the 4 P's, which includes Product, Price, Place (distribution), and Promotion⁸⁷. In each of these, it is very important that the marketers consider what is important to the customer to increase his or her satisfaction level. In response to the HIV/AIDS epidemic, social marketing programs have made condoms accessible, affordable and acceptable to low-income populations and high-risk groups in many of the world's developing countries. The implementation of condom social marketing programs can be explained by using the basic principles of the four "Ps" of marketing (Key Elements): product, price, place and promotion. For the purpose of this study, we added two important Ps including Person and Period (time), to know specifically which KPs needs what condom, when and where. In this section we have discussed these six basic principles and concluded with a look at research and evaluation - a valuable component of any social marketing program.

1. Product

Social marketing organizations obtain condoms - the product - using funding from different sources. Through brand development research, different condom brands are developed and attractively packaged in response to local needs and issues. While a desirable package and brand may encourage a person to make an initial purchase, it is a high quality reliable product that will encourage continued use. Once developed and packaged, the condom brand is heavily promoted and sold to the consumer.

2. Price

A price is attached to a socially marketed product such as condoms for two principle reasons:

- A purchased condom allows a consumer to make a personal investment and, therefore, encourages the consumer to use the product.
- The price charged generates a profit margin that helps motivate retail traders to distribute the product as widely as possible, thus improving its accessibility.

Selling the products and services might seem in contradiction with the objectives of social marketing programs aimed at improving the health of low-income populations. Market

⁸⁶ Kotler, P. (1997), Marketing Management, Analysis Planning, implementation, and Control. Prentice Hall of India.

⁸⁷ Stanton W.J, Etzel J.M, Walker B.J. (1994); *Fundamentals of Marketing*. 2nd Edition, DP Publications London

research has shown, however, that when products are given free, the user often does not attach value to them and does not use them. In social marketing programs, the price of the product is kept low enough to be affordable to low-income consumers but high enough to attach a value to the product.

3. Place

Condoms need to be widely available when and where they are needed. Distribution is, therefore, targeted to high-risk situations and to environments where people feel comfortable purchasing them. Thus, as well as using traditional wholesale and retail networks, condom social marketing organizations also focus on developing non-traditional outlets and informal distribution systems. Such outlets include bars, brothels, bus terminals, gas stations and beauty salons. Easy availability and convenience encourages the use of condoms.

Broadening access also means training sales staff to provide retailers with information about condoms and the diseases against which they protect. Social marketing programs have found that, given appropriate training and information, retailers (from pharmacists to street vendors) can help accomplish the essential social marketing goal of changing behaviour.

4. Promotion

Promotion - information, education and communication - creates consumer demand for a product by providing information about the product, its price, its availability, its benefits and its correct usage. The goal is to motivate consumers to seek out a product, buy it and use it correctly and consistently. The purchase and subsequent use of many socially marketed products requires a change of attitude and behaviour. "Such changes tend to grow out of new information, new attitudes, new opportunities and new product awareness and product use. To achieve this, social marketing must communicate wide and well.

Promotion involves a wide range of traditional and non-traditional media and techniques, ranging from radio, television, print, point-of-purchase advertising, public transport, drama, street theatre, puppets, special events, mobile video vehicles, soap operas and rural road shows. The choice of "media mix" is determined by local conditions and by the budget of the program.

5. Person

Condom needs of the different population groups vary by many variables such as client characteristics, income, age, sex, parity, rural versus urban, cultural expectations regarding sexuality and childbearing, city or province, etc. These variations must be understood in order to understand how progress can be made toward greater condom security through an effective condom social marketing program per each target group. The goal of public sector condom outlets for key populations is to provide condom security for them. Condom security exists when the "demand" of applicants from both the public and private sectors is met. Individual characteristics are important factors influencing utilization of condom as a HIV/STI preventive measure. More in-depth information about the reasons for not using condoms (e.g., lack of satisfaction, spousal objections, lack of physical access to a facility or

other re-supply source, lack of product, financial constraints, did not get preferred method among different groups (e.g., by age, socioeconomic or education status) is required.

6. Period (Time)

The importance of the element of time in condom social marketing can be determined from several aspects. First, based on the Condom Commodity Security (CCS), which is defined as the ability to continuously provide high quality condoms to vulnerable groups and target populations at the right **time** and place when they are needed and at an affordable cost. Therefore, key populations have right to access CCS. Second, ensuring a continuous supply of condoms is also essential for key populations. Gaps in condom availability for key populations induces a substantial potential for HIV transmission.

Research and Evaluation

A valuable element of successful condom social marketing programs is a strong research and evaluation component. Research plays a significant role in the development of the brand, its positioning and promotion. It informs the development of HIV/AIDS prevention messages and identifies misconceptions and societal or cultural prejudices to both condoms use and behaviour change. Research is also conducted into the effectiveness of distribution networks and consumer profiles.

Findings related to the situation of the elements of Condom Social Marketing for key populations in Iran

In this project, we conducted in-depth interviews with related stakeholders, representatives from NGOs, Main condom distributors and producers, and providers of the Women Centers, and VCT centers. We conducted a market survey on condom brands and types available on the market. We also conducted a Condom Total Market survey, which results are presented in the previous section. In order to obtain a comprehensive picture of the elements of Condom Social Marketing, the results of our situational analysis were categorized in 4 Ps model.

Product

The findings related to the “Product” are as followings:

- Condom supply management and supervision is done by the Department of CDC of the MOHME. In this way, it directly funds the purchase of condoms for the Universities of Medical Sciences across the country or distributes the purchased condoms directly to the Universities. Condoms purchased by some UN agencies are also distributed among Medical Universities.
- Free-of-charge condom distributed among key target population including PLHIV, FSW, PWID, MSM, Prisoners and TG. In addition, DICs distribute condom within frame of harm reduction programs.
- The distributed condom is often the classic condom with no additional specification. This is not common, and in some Women Centers the variety of condom products can compete with the private market and pharmacies.

- Due to the prevailing conditions in Iran, condoms are produced and distributed in the public sector only for the prevention of HIV/AIDS, and for contraception, applicants from the private sector can provide them.
- The private sector has been active on awareness raising and introducing variety of condoms to both providers and users only via cyber space.
- It seems that most condoms produced and distributed in Iran are of good quality. In a new 2020 study of PLHIV, among 7.5% of men and 1.2% of women, the reason for not using a condom was its poor quality.
- If we do not take as an exception a few Women's Centers that, according to the opinions of the recipients, the variety of condoms they receive does not differ much from the market, in most condom outlet centers for key populations, there is no variety in shape, brand, size and quality of condoms and they only deliver one type of condom to the customers which they have. As a result, customers often have no choice.
- Condoms in the public sector are limited to simple and classic types. In limited cases, other types, including flavored, delayed, etc. are provided to the centers, especially Women Centers, which are given as a reward to customers who have more and better cooperation.
- Compared to condoms provided to applicants by the MOHME with condoms provided by UNs, customers prefer the former because it has single packages and is easier for FSWs to store.
- The condoms that are provided to the public condom outlets do not have a variety in size and are of a certain size, but so far they have not complained about this from customers, except as an excuse for a sexual partner not to use a condom.
-

As a conclusion, private sector provides a variety of condoms only in the private markets and the public sector provides condom for only key populations to prevent HIV/AIDs via different outlets.

Different types of condoms in Iran Condom Market

- **Sagami (Japan made):** Japan Sagami condom is the only foreign condom in the Iranian market. It is made of polyurethane, despite its very low thickness, it is three times stronger than ordinary condoms and is considered the best thin condom in the world. But due to being foreign, its price is high.
- **45-minute delay condom:** This model is the first offer of the condom to have a long and enjoyable relationship. The delay material in this model is more than all other models.
- **Space condoms, coarse prickly:** This condom, as its name suggests, is completely different from other condoms. The presence of large and prominent latex spines on the tip and body of the condom causes maximum stimulation for the female sex. Men who have trouble orgasming their partner use a space condom to describe the extraordinary experience of a relationship.

- **Very thin Codex Condom 30 microns thick (03):** The 30-micron Codex ultra-thin condom is a very thin condom with Japanese technology that is only 0.03 mm thick. This model is one of the strongest and thinnest condoms in the world and is suitable for couples who do not want to use condoms. This product transmits the feeling of warmth well and has a pleasant scent to create a sense of fantasy. Among the codex brand condoms, 5 models are the most famous. These five models are the best condoms and have had the most satisfaction among customers.
- **Double Delay Condom:** The delay ring in the Double Daily condom puts pressure on the circumcision area and delays ejaculation. Benzocaine powder is also used in the inner layer of the condom, which causes local anesthesia and delays ejaculation. This type of condom has no other example and is unique to Codex.
- **Big Dots Condom:** It is the best-selling model. This model has 690 large spines on its body, which are up to three times larger than the rest of the regular barbed wire condom.
- **Zero Condom:** Codex has designed an ultra-thin latex condom called Zero. If everyone does not want to use a condom, be sure to try this model. The feeling of a relationship without a condom is a distinctive feature of the Zero Notch model. Zero Notch condoms are a great option for starting a painful marriage. Zero condoms also have antifungal properties and prevent fungal infections.
- **Nobel Condom:** The Nobel Codex model is a masterpiece of orgasm synchronization. It is both irritating and delaying. This model has small spines on its body that completes all the features of a superior model. The Nobel condom may not be the best condom on the market, but it has been welcomed by many customers over the years.
- **Aloe Vera Classic Condom:** The best condom does not always have to be delayed or barbed. The classic model has always been one of the best-selling condom models in the world. Without any delay material and protrusions. But this codex model also has a pleasant scent that increases sexual pleasure in the relationship.

Price

Price refers to what the consumer must do in order to obtain the social marketing product. In order to have a clear picture about monetary values of various brands/types of condoms on the market, a Condom Market Survey was conducted in this project. The major companies producing and distributing condoms, their products, brands and price in Iran are summarized in the table below, Table 4.5.3.1. The results indicate that the price of a dozen (12 Pcs) of condom varies between 15,000-450,000 IRR (1 USD= 263,315 IRR).

Table 4.5.3.1. The major companies producing and distributing condoms in Iran

Company name	Brands	Market share	Average price (12 Pcs) IRR
BONYAN POSHESH CASPIAN	Fiesta	30	350,000-150.000
	Secret		
	Alpha		
	Ours		
	Climax		
	Hero		
	4U		
	Hilton		
ANJIR TALAEE	Kodex	40	450,000-15,000
	Benito		
	Xenon		
	Dart		
	Flash X		
	NACH K		
	Kapeet		
BARAN BASPAR	Shadow	5	200000
	Farex		
	Xdream		
KEYHANBOD	Hi Hi	10	150,000-200,000
	Lotus		
	Happy		
	Rubex		
	Kanopy		
	Angel		
	Skin Jilia		
	Hot		
HIVA PAD PARS	Bonex	15	250.000-150.000
	T.N.T.		
	UNISIX		
	Bereta		
	Best Life		

However, the results of the last BSS study (in 2020) and other documents related to the price of condoms and other indicators related to limitation of access, showed the following results:

- After lack of access, being expensive was the most important reason for not using a condom by FSWs.
- 41.7 percent of FSWs did not have access to condoms because of their high price.
- Access to free condoms for PWID at the end of the Fourth NSP was 36%.
- The goal to get free condoms for high-risk women via Welfare Organization at the end of the Fourth NSP was 20%, which only 11% achieved.
- Only 3% of the MSM had access to free condoms at the end of the Fourth NSP.

We conclude that provision of free-of-charge condoms is still needed for key populations in order to persuade them to use condom. Also, it is necessary to expand the number and variety of condom delivery outlets to increase the access of key populations to condoms.

Place

We concluded that condom provision for most of the key target populations for HIV/AIDS are covered by the following outlets in public sector:

- **Women Centers:** There are forty active Women Centers nationwide, where the services provided cover comprehensive packages including HIV/AIDS prevention. These centers are distributed amongst all provinces and cover at-risk populations in three groups including Pure FSWs, FSWs who are addict (injectable or non-injectable), and women whose sexual partners are belong to key people at risk of HIV/AIDS. Most women's centers have mobile teams to increase access to target groups via outreach, but the number of mobile teams is not desirable and responsive, and all women's centers demand their development. UNAIDS has a leading role to support covering a broad spectrum of HIV prevention services in these centers, consisting of capacity building for staff, providing equipment, helping provide condoms via other UN agencies, educational packages for training staff and mobile team. These centers are created by the CDC department of the MOHME and supported by UNAIDS in partnership with UNICEF, UNFPA and WHO.
- **VCT centers** were introduced in Iran in 1995, and have served as an important tool in the prevention of HIV infection ever since. These centers provide a dialog between the counsellor and client to offer information about HIV/AIDS testing, benefits, and risks associated with the disease. We found that VCTs act as an effective strategy to facilitate behavioural change for HIV prevention⁸⁸. It offers an entry point for early care and support for those infected with HIV, and for PMTCT. VCTs also plays a role in reducing stigma and discrimination. Condoms are distributed at VCTs and are available to anybody asks for them. These centers are created by the CDC department of the MOHME and supported by UNAIDS in partnership with UNICEF, UNFPA and WHO. The VCT centers are the only PrEP outlet for target groups in the country. **DIC centers** via out-reach and peer education programs distribute condom within frame of harm reduction programs. DIC centers are created by the Welfare Organization (WO) and supported by CDC department of the MOHME. The WO participated in condom distribution within harm reduction context and condoms are distributed among PWID as an item within the harm reduction kits. Within harm reduction program a Harm Reduction Kit is distributed among PWID but not in all of the country. Nowadays, DIC centers' condom mostly provided by different Medical Sciences Universities and participation of some NGOs and some NU agencies.
- **Prisons** are another convenient place to provide counselling and condoms to one of the most important key populations offered in the rooms with their sexual partners. Triangular clinics and medical centers of prisons are condom outlets in the prisons. Under the 5th NSP, prisons, in collaboration with the MOHHME, are required to provide

⁸⁸ FGDs with VCT Cwntres providers and Interviews with SRH consultants as part of Key Informant Interviews, Jan-Mar 2021

training, counselling, and free condoms for 100% of prisoners` visits to their spouses, but in practice this does not happen properly.

- NGO: There are a limited number of NGOs involved in providing condoms to key populations, the most important of which is the Family Planning Association, which has recently been renamed the Reproductive Health Association and provides free education counselling and condoms to FSWs in limited locations only in Tehran.

Private sector provides condom through a vast network of outlets. The outlets mainly consist of private pharmacies but in some places supermarkets are also included.

Availability of condom is one of sub-components of “Place”. Our findings summarized as follows:

- Among FSWs, 26.2% reported difficult access to condoms, in 78.3% the pharmacy was as the most important source of condom supply, and in 33.2% the Women Centers was the most important way to access condoms.
- Women's centers, VCT centers and other condom outlets in the public sector usually do not have a problem in providing condoms for their applicants, but this access to condoms is a classic type and is not varied and applicants cannot choose.
- Of course, this constant availability of condoms does not mean that customers will be provided with as many condoms as they request, but providers are forced to manage demand and deliver fewer condoms to customers when there is a shortage.
- Women Centers do not cover all FSWs, and most clients are in middle-class. People in the lower social classes do not come to these public centers because they do not care about their own health. People with high social class also do not go to government centers and receive services from the private sector. The problem with these high-class groups is that they do not receive training.

Promotion

Promotion, creates consumer demand by providing information about the product.

Some promotional techniques such as mass media advertising, the use of logos, and educational materials are used only by the private sector and mostly via cyber space in Iran.

Our findings in this project regarding “Promotion” can be summarized as follows:

- Condom promotion in public sector restricted to condom delivery outlet centers for key populations.
- The staff of the condom delivery outlets for key populations stated that they had not seen specialized training on the types of condoms available in the market and how to use and use each of them, and could not train and guide customers. They stated that FSWs need to know different types of condoms.
- The use of Job aids and educational materials can increase the quality of service in condom provision centers for key populations.

- The need for staff training in sexual health and comprehensive sexual education was emphasized.
- It seems that condom is better to be promoted within specific places such as pharmacies and big markets which provide the product. It is required to train pharmacies and markets staff on condom.
- FSWs claim that men should know how to use a condom properly, and in most cases, it is men who fail to use condoms.
- At least in Women Centers and VCT centers, condom training is provided individually or in groups, which has been difficult due to the COVID-19 pandemic in the last 1.5 years.
- In order to attract more key populations to receive condom services in the public sector, it is necessary to develop mobile services (outreach) and provide more support in various aspects such as logistics.
- Interestingly, in the few Women Centers that have access to a variety of condoms, customers prefer to use the classic type. This can be due to the lack of training on different types of condoms and the use of each of them in different situations.
- Providers of government condom provision outlets, especially Women Centers, say that their evaluation of the center's clients shows that in most cases, sex workers use condoms properly in their sexual relations.
- The Providers of the Women Centers believe that the most important reason for the low turnout of key populations and receiving services is the lack of information to the target groups and even the staff of other related departments, even in Medical Sciences Universities.
- Provider and consumer education about variety of condom, its quality requirements and condom specifications is needed. In most cases, providers and clients do not know what is more suitable for key populations and what should be expected from a quality condom.

Person

As was earlier mentioned in this report, PrEP and condom programming primary focus is on PLHIV and other fine key populations including FSW, MSM, PWID, prisoners and transgender. What key people want and need because of their specific circumstances, instead of trying to persuade them to buy condoms from the private sector in Iran, is to focus on the elements of the "marketing mix" to shift the focus to the consumer. By making the product attractive, reasonably priced or free, most importantly available to key groups. It is obvious that periodic reviews and monitoring of the "marketing mix" program based on continuous feedback from consumers on key populations can perpetuate this situation.

In reviewing condom outlet centers for key groups and reviewing available documentation, we sought to answer whether their "needs" had become "demand" for condom services and products, and whether customers were currently satisfied. If they are satisfied, we recommend that this access be continued and maintained, and that those who do not currently use the services and products but want or intend to use them, should be provided

access, from the public to the private sector. Our findings related to the “**Person**” element of the condom social marketing for different key populations are summarized as follows:

- As is shown in Table 3.2.3.6.1, proportion of condom users among FSW has increased significantly during the past decade, especially among their commercial sexual relations. The ratio of condom uses in the last commercial sexual intercourse of FSWs had increased from 30.6% in 2010 to 62.9% in 2020. Of course, this increase in non-commercial sexual relations of this group was not significant. This increase indicates a rise in demand which needs to be continuously addressed by an effective program.
- Most FSWs do not use condoms in their sexual relationship with their main sexual partner and usually use condoms with their clients. This finding was verified by some FSWs contracting STIs from their regular sexual partner.
- For women who play the role of marketers for FSWs (KHALEH), condoms are offered in as many as they want. Interestingly, the marketers themselves do not usually use condoms.
- The level of education and type of key population plays a role in the use of condoms and where they are preparing. High-level FSWs make condoms on their own or ask their client to bring a condom. Addicted sex workers use the freezer plastic bag when they do not have access to public condom outlets, not to prevent HIV/AIDS but to avoid getting pregnant.
- The reasons for not using condoms also vary in different key populations. FSWs often have difficulty bargaining and say that their regular sexual partner does not want to use a condom or that they prefer not to use a condom for more money. In dealing with their new client, the FSWs think that if they suggest using a condom, the client thinks that the sex worker is a professional or sick, and the client convinces him or her that none of them are sick and that they do not need to use a condom. FSWs are usually unable to satisfy their customers to use condoms due to probably decreasing enjoy the sexual pleasure that is so important to them. Male involvement can be used as a port of entry to involve males in HIV/AIDS prevention via condom use.
- Concerns about decreased sexual pleasure with using condoms are more common among men, but women who engage in sexual intercourse after using drugs (addicted FSW) do not like to be prevented from using the condom to enjoy the opportunity provided.
- Different key populations require specific trainings. There is a good platform in the public sector to cover most of the key populations in this regard. For example, Women Centers for FSWs, VCT centers for transgender and MSM, harm reduction centers for PWID, and triangular clinics of the prisons for prisoners. However, a significant portion of key populations in the private sector, especially pharmacies, receive condom services in which adequate capacity can be built.
- Some key population such as TG and MSM are either geographically or socially marginalized and therefore are hard to reach. It is important to identify their needs.

- There are only 40 active Women Center in the country, and if on average each of them covers about 300 FSW, then less than 10% of FSW in the country are cared for by condoms.

Period (Time)

The following results show the availability and also supply of condom where the key populations need:

- In Iran, service providers of the public condom provision outlets cannot do their jobs without the reliable operation of public sector supply chains delivering condoms at the right time, and in the right quantity. The results show that, apart from Women Centers, other public condom delivery channels are not available at all times and in sufficient numbers, especially in harm reduction centers and prisons. In Women Centers, in many cases, they are forced to impose restrictions due to the limited number of condoms they have.
- 26% of the FSWs had difficult access to condoms.
- Free condom delivery centers in the public sector are open during office hours. As a result, problems for key populations arise when condoms need to be used. As a result, 19.8% of FSWs had lack of access. And 78.3% of them provided condoms from the pharmacy (as the most important source of condom supply). In order to increase access, more exposure and visibility for condoms in pharmacies is required.

4.5.4. Condom Social Marketing Road Map for each Key Population

Summarizing the data set obtained for each of the key populations can guide the design of strategies and road maps.

Female Sex Workers (FSW)

Findings of this project showed that the prevalence of FSWs in Iran is about 1.43% of the 15-49 years and the population of them is about 322,623 (216,586-419,635). About 24.9% of FSW are a drug user and 20.4% of them are PWID concurrently. 96.6% of the FSWs ever hearing of HIV/AIDS, but comprehensive HIV Knowledge was very low (28.1%). Some important findings related to the FSW are as follows:

- The availability of condom by FSW is as follows:
 - Difficult access to condoms: 26.2%
 - Condom procurement from the pharmacy: 78.3%
 - Unavailability of condoms due to the price of the condoms: 41.7%
 - Receiving free condoms in the last three months: 37.9%
 - Lack of access: 19.8%
- Therefore, pharmacies (78.3%), Women Centers (33.2%) and sexual partners (18%) are the most important way for FSW to access condoms, respectively.
- Willingness of FSWs to use condom is as follows:
 - The decision to use a condom was made in 82.8% of cases by FSW and in 12.7% of cases by a joint decision.

- Among those who did not use a condom during their last sex, the main reason was the client's opposition (34.3%).
- The proportion of condom users among FSW has increased significantly during the past decade, especially among their commercial sexual relations. This increase indicates a rise in demand which needs to be continuously addressed by an effective program. Most FSWs do not use condoms in their sexual relationship with their main sexual partner and usually use condoms with their clients. Condom use in extramarital situations for FSW:
 - 43.6% of FSWs used condoms in sexual relationships with their paid customers, while 62.9% of them have used condoms in their last sexual intercourse.
- The most important reasons for the inability to use consistently condoms among commercial clients are:
 - Customer opposition (34.3%)
 - Lack of access (19.8%)
 - Decreased sexual pleasure if using a condom (13.2%)
- The most important reasons for the inability to use consistently condoms among non-commercial clients are:
 - Customer opposition (38.3%)
 - Confidence in a stable sexual partner (24.2%)
 - Decreased sexual pleasure if using a condom (10.2%)
- In Women Centers and VCT centers, compared to condoms provided to FSW by the MOHME with condoms provided by UNs, customers prefer the former because it has single packages and is easier for FSWs to store.
- After lack of access, being expensive was the most important reason for not using a condom by FSWs.
- The Women Centers do not cover all FSWs, and most clients are in middle-class. People in the lower and higher social classes do not come to these public centers.
- The staff of the condom delivery outlets stated that FSWs need to know different types of condoms.
- FSWs claim that men should know how to use a condom properly, and in most cases, it is men who fail to use condoms.
- The women who play the role of marketers for FSWs (KHALEH), do not usually use condoms.
- High-level FSWs make condoms on their own or ask their client to bring a condom. Addicted sex workers use the freezer plastic bag when they do not have access to public condom outlets, not to prevent HIV/AIDS but to avoid getting pregnant.
- The reasons for not using condoms also vary in different key populations. FSWs often have difficulty bargaining and say that their regular sexual partner does not want to use a condom or that they prefer not to use a condom for more money. FSWs are usually unable to satisfy their customers to use condoms due to probably decreasing enjoy the sexual pleasure that is so important to them.
- Some clients of Women Centers are referred from the private sector and only for screening for human papillomavirus infection because it is free. This provides a good opportunity to coordinate with the private sector to increase coverage for FSW.

People Who Inject Drug (PWID)

We found that the prevalence of PWID among the 15-49 years old population was 0.43% in Iran, and their estimated population was 197,985. The majority of PWID were male (97.6%) and more than half were aged ≥ 35 years old (55.5%). A last national survey showed that 54% of PWID had access to free-of-charge sterile needles and syringes, 51% used sterile needles and syringes in their last injection practice, and 33% used sterile needles and syringes in all injection practices in the past month⁸⁹. Some important findings related to the PWID are as follows:

- HIV prevalence among PWID has a decreasing trend in Iran from 15.3% in 2008 to 3.1% in 2019.
- Concurrent HBV infection was prevalent among PWID (30.9% in Males and 7.3% in females). The pattern of HCV infection among PWID has also a similar pattern (41.3% in males and 36.6% in females).
- Harm reduction centers were the main outlet of access to condoms by PWID.
- Prevention cascade for all HIV-negative PWID having sex with any partners:
 - 88% of whom knew that using condoms could reduce HIV transmission, 35% had access to free-of-charge condoms, 32% used condoms in their last sexual practice, and 18% used condoms in all their sexual practices with any partners in the past month.
- Prevention cascade for all HIV-negative PWID having sex with their spouse:
 - 83% of whom knew using condoms in sexual practices could reduce HIV transmission, 38% had access to free-of-charge condoms, 34% used condoms in their last sexual practice, and 15% used condoms in all of their sexual practices with their spouse in the past month
- Prevention cascade for all HIV-negative PWID having sex with non-paying partners:
 - 79% knew using condoms in sexual practices could reduce HIV transmission, 33% had access to free-of-charge condoms, 18% used condoms in their last sexual practice, and only 0.2% used condoms in all of their sexual practices with their spouses in the past month
- Prevention cascade for all HIV-negative PWID having sex with paying clients:
 - 85% of whom knew that using condoms could reduce the risk of HIV transmission, 47% had access to free-of-charge condoms, 27% used condoms in their last sexual practice, and 20% used condoms in all of their sexual practices with their spouses in the past month.
- more than half of PWID reported not having access to free-of-charge condoms. Harm reduction programs should facilitate access to condoms for PWID and improve efforts in raising awareness of the PWID with regard to the dual risk of sexual and injection pathways.

⁸⁹ Faghir Gangi et al. HIV prevention cascades for injection and sexual risk behaviors among HIVnegative people who inject drug in Iran. International Journal of Drug Policy 84 (2020) 102868.

Men who have Sex with Men (MSM)

Findings of this project showed that the prevalence of Men who have Sex with Men (MSM) in Iran is about 0.5% of the 15-49 years and population of them is about 117,410 (70,446-164,373). About 20.8% of MSM are drug user and 7.8% of them are prisoner, concurrently. Some important findings related to the MSM are as follows:

- There is not much information about MSM in Iran, but in different groups, the prevalence of HIV has been reported to 14.8% in the general population of MSM.
- Data shows that 12% of male, sexually experienced PWIDs have had same-gender sex, and HIV prevalence was high (19%).
- 6.1% (95% CI: 5.0, 7.3) of HIV-negative male PWID had sex with another man in the past year; 80% of whom knew that condoms could reduce the risk of HIV transmission, 45% had access to free-of charge condoms, and 13% used condoms in their last sexual practice.
- Condom use during the last sexual encounter was low (20%).
- Findings show that PWIDs who had sex with men (MSM PWIDs), compared to other sexually experienced PWIDs, are younger (AOR, 0.89; 95% CI, 0.81– 0.98), more likely to have used a shared needle/syringe for drug injection (AOR, 4.29; 95% CI, 1.82– 10.12), and have had more than 5 sexual partners in their lifetime (AOR, 2.71; 95% CI, 1.14–6.44).
- Among all sexually experienced MSM, 53% reported having ever used a condom during sexual intercourse. Meanwhile, consistent condom use was uncommon, as only 20% reported using a condom during their last sexual experience.
- Only 3% of the MSM had access to free condoms at the end of the Fourth NSP.
- Most of the MSM population are either geographically or socially marginalized and therefore are hard to reach.
- Taken together, these findings suggest that MSM IDUs with their high HIV prevalence, low rate of condom use, and multiple sex partners in their lifetime serve as a potential bridge for HIV transmission to their sexual partners, who could be members of the broader MSM community and/or their heterosexual networks.
- 87.7% of MSM reported having female partners in the last six months.⁹⁰
- The rate of basic knowledge about HIV was high, proportion of MSM reporting having ever heard of HIV was 82.4% in Iran.

Transgender

Findings of this project showed that the prevalence of Transgender women in Iran was 1 in 145,000. Other reliable documents showed that the prevalence of Male-to-Female Transgender (MFT) was 0.077, Female-to-Male Transgender (FMT) was about 0.029 and total Transgender was reported 0.053 of each 100 people in 15-49 years of the population. Overall, the estimated population of Transgender was 24,403 in Iran. 8.7% of the Transgender were history of drug using. Some important findings related to the Transgender are as follows:

- The prevalence of HIV among Transgender has been reported from 0.0% to 1.9%.
- In 18.1% of female transgender at least one symptom of STIs has been reported.

⁹⁰ Abu-Raddad L, et al. (2010) Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Strategic Action. Middle East and North Africa HIV/AIDS Epidemiology Synthesis Project, World Bank/UNAIDS/WHO Publication Washington DC: The World Bank Press.

- Data on condom use among transgender people are lacking, but there is evidence that condom use in this population is low.
- Of the transgender women who had been sexually active in the previous 12 months, 42.3% had vaginal intercourse and 63.6% reported never or rarely using condoms during that time. Receptive anal intercourse with either a non-paying partner, casual partner, and/or paying partner was the most common sexual practice in their recent sexual encounter. The prevalence of using condom in this most recent sexual contact with a non-paying partner, casual partner, and paying partner were respectively 39.7%, 34.6%, and 53.3%. Another recent study showed that of the sample who reported having sex in the past six months (n=42), only 19% reported using condoms.⁹¹
- The lack of condom use was due to either trusting non-paying partners or opposition from casual and paying partners.
- Among transgender who were sexually active in the prior 12 months, 13.7% participated in group sex, a sexual encounter that involved at least 3 people.
- A high percentage of transgender women in Iran engage in high-risk sexual behaviors including condomless receptive anal sex, which is of particular concern given the low rates of HIV testing.

Prisoners

Findings of this project showed that the prevalence of Prisoners in Iran is about 0.32% of the 15-49 years and population of them is about 128,920 (115,107-142,733). About 74.0% of Prisoners are drug user and 16.6% of them are PWID concurrently. 93.2% of the Prisoners ever hearing of HIV/AIDS, but comprehensive HIV Knowledge was very low (19.7%). Some important findings related to the Prisoners are as follows:

- The fact that at least 43% of Iran's prisoners are due to the drug-related victims, may well justify this high prevalence.
- Studies related to the prevalence of HIV in prisoners show a decrescendo trend. For example, in a large national study, the prevalence of HIV was 8.3% in 2008, down to 3.1% in 2011 and 1.2% in 2014.
- Of all prisoners with a history of unsafe sex during their lifetime, 53.7 percent had more than three sexual partners, and 53.4 percent never used condoms during unsafe sex in their lifetime.
- The VCT centers, harm reduction centers and triangular clinics of the prisons was the major rout of Prisoners` access for free condoms.

⁹¹ Jalali Nadoushan A, et al. High-Risk Sexual Behaviors Among Transgender Individuals in Tehran, Iran. Acta Med Iran 2021;59(2):113-117.

CHAPTER 5: PRE-EXPOSURE PROPHYLAXIS (PrEP)

5.1. Introduction

In September 2015, the WHO recommended Oral Pre-exposure prophylaxis (PrEP) as “an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.” Since then, a number of demonstration projects, research studies, and implementation initiatives have been conducted to introduce PrEP as a key tool in a combination HIV prevention strategy. Several clinical trials have shown that an antiretroviral (ARV) drug called Truvada (Emtricitabine/Tenofovir disoproxil fumarate) reduced the risk of HIV infection in both women and men, an approach known as PrEP. The number and scope of PrEP activities is increasing globally, while the scale and coverage remain limited. PrEP is a proven effective biomedical HIV prevention intervention that when taken consistently can decrease the risk of acquiring HIV from sex by up to 99%.⁹² The expanded indication for the use of PrEP in key populations is very recent.

For PrEP to have sustainable health impact, relevant knowledge, attitude, and beliefs need to be shaped at individual, community and policy level. Needed people must understand the benefits of PrEP and believe these outweigh any possible negatives.

Why PrEP is under consideration in Iran:

- **Achieving HIV prevention targets:** PrEP could help Iran achieve its commitments to global and national goals: 5th National Strategic Plan. In particular, PrEP is seen as a HIV prevention method with high potential to reach men and women, who are experiencing disproportionate and growing HIV rates.
- **Implementing combination prevention:** PrEP can provide additional choice and empowerment to those target populations who do not use other prevention methods as part of a combination prevention package.

5.2. Current PrEP context in Iran

- PrEP has been used in Iran since 2017 and has not been well developed for various reasons. While PrEP is a beneficial addition to the comprehensive prevention package, significant questions remain for key decision-makers around effectiveness for specific populations (e.g., MSM and FSW who are not using condoms routinely) and demand generation strategies.
- A National PrEP Technical Working Group has been established.
- National implementation guidelines drafted by CDC department of the MOHME are currently functional. Based on this guideline, PrEP target groups including:
 - MSM men and transgender women or men who have had condom-free sex with at least one random or HIV-infected partner who has not received antiretroviral or viral loading over 200 in the past 6 months.
 - Heterosexual men and women whose sexual partners are infected with HIV and do not take antiretroviral drugs or have a detectable viral load and do not use condoms.
 - Sexual partners of the Female sex-workers who have multiple unprotected contacts.

Therefore, the development of this method in the PrEP and condom programming is very necessary. Meanwhile, an evidence-based marketing and communications plan lays out the activities to ensure that PrEP is understood and used in ways that have an impact on HIV

⁹² Centers for Disease Control and Prevention. PrEP effectiveness. 2021 [cited 2021 Jan 4].

prevention. Review of the literature has shown that PrEP promoting plans work when they include the following:

- strategies for influencing social and behavior change in ways that support PrEP uptake and use,
- plans for creating demand among priority populations,
- training for providers, counselors, peer educators on how to talk about and provide PrEP and more.

In this project titled: “PrEP and Condom Programming Road Map for Key Populations in Iran”, we used following steps to create a marketing and communications plan to promote demand for and uptake of PrEP in the context of the country-level program:

1. Conducting a situation analysis
 - a. Systematically review information about PrEP that will help define and understand the problems and opportunities in introducing PrEP in Iranian context. This included an understanding of attitudes, knowledge, social norms and beliefs at individual, community and policy level.
 - b. Identify any gaps in knowledge and decide how we will address those gaps.
 - c. Define our target audiences
2. Developing a strategic plan for marketing and communications
 - a. Identifying key strategic objectives and goals.
 - b. Defining resource requirements (e.g., more personnel or training needs) and activities we will need to achieve strategic objectives.
 - c. Identifying key messages, we want our target audiences to hear, and what activities and communications channels are relevant for PrEP uptake and adherence.
 - d. Identifying people that influence PrEP users for PrEP uptake and adherence and plan how to positively impact their views about the value of PrEP.
 - e. Creating a work plan.
3. Offering some marketing and communications methods
4. Developing implement and monitoring strategy
5. Building an evaluation system

5.3. Findings of the Situational analysis of PrEP in Iran

Table 5.3.1. Key Populations for PrEP in Iran

	Men who have sex with men (MSM)	Female Sex workers (FSW)	Partners of the People Living with HIV (PLHIV)
Key indicators	<ul style="list-style-type: none"> Prevalence: 0.5% (0.3-0.7%)⁹³ Estimated population: 216,011 Prevalence of HIV infection: to 14.8% Condom use: 20% HIV programming for MSM as well as high-risk behavior have increased in recent years via NSPs. 	<ul style="list-style-type: none"> Prevalence: 1.43% (0.96-1.84%)⁹⁴ Estimated population: 322, 623 prevalence of HIV among FSWs decreased from 2010 to 2020, from close to 5% to 1.5% Comprehensive knowledge of HIV: 51.5% Condom use with most recent client in commercial sex: 62.9% 	<ul style="list-style-type: none"> Prevalence: Estimated population: 59,000 Condom use with most recent client in commercial sex: 37.2% consistent condom use: 25%
Prioritization	<ul style="list-style-type: none"> PrEP perceived to be cost-effective for MSM MSM is one of the target population to receive PrEP 	<ul style="list-style-type: none"> 5th NSP providing HIV prevention targets to all FSWs 40 active Women Centers providing STI/HIV prevention services for FSWs nationwide 	<ul style="list-style-type: none"> currently being considered for oral PrEP
Questions	<ul style="list-style-type: none"> How can Iran effectively activate channels already reaching MSM to deliver PrEP? 	<ul style="list-style-type: none"> What service delivery platforms are most effective in providing PrEP to the FSW population? 	<ul style="list-style-type: none"> What service delivery platforms are most effective in providing PrEP to the PLHIV?
	<ul style="list-style-type: none"> How will society and health providers address structural stigma to ensure reliable and effective access to PrEP for these populations? Will initial launch of PrEP in these populations stigmatize use of PrEP for other populations? 		

We identified five programmatic elements that are necessary for successful PrEP introduction and implementation:

- 1. Introduce PrEP extensively-** Broadly introduction of PrEP to build trust in PrEP and to avoid stigmatization. It could build confidence and trust in PrEP effectiveness, create excitement for the new product, and position it as a product for any HIV-negative person who wants to stay negative. Kenya is a good example that implemented a comprehensive advocacy and awareness strategy during the launch of PrEP. The national campaign was launched through mass media, social media

⁹³ Mauck DE, et al. Population-based methods for estimating the number of men who have sex with men: a systematic review. *Sexual health*. 2019;16(6):527-38.

⁹⁴ Sharifi H, et al. Population size estimation of female sex workers in Iran: synthesis of methods and results. *PLoS one*. 2017;12(8)

and print materials to introduce PrEP as a new category of treatments and focused broadly on all potential users of PrEP.

2. **Give potential customers a reason to value PrEP-** Avoid focusing on HIV risk, and instead respond to how PrEP fits within his/her relationships (with partners, parents, friends and others), and how it relates to his/her own identity. Use proactive, self-protective, and empowering messaging to frame PrEP in a positive way.
3. **Speak to potential customers-** Once a client cares about PrEP, help his/her find his/her internal motivation to act. Help his/her tap into a personal sense of purpose that will continue to motivate and reward his/her for using PrEP.
4. **Equip potential customers to make an informed choice-** While information alone is not enough for behavior change, basic knowledge is critical for potential customers to feel informed and confident. Share information about HIV and PrEP in a compelling, comprehensible, and memorable way so potential customers feel confident that they are making an informed choice and know they are protected.
5. **Right Person, Right Time-** Equip key influencers (peers, nurses, community health workers) to be both knowledgeable and empathetic, and to meet potential customers where they are with informed and compelling information.

Value Chain for PrEP



5.3.2. Resources and Gaps for PrEP

Value Chain for PrEP	Expected Strengths	Emerging Key Considerations
Planning & Budgeting	<ul style="list-style-type: none"> PrEP rollout initiated as part of HIV prevention strategy PrEP introduction plans underway for MSM, FSW, and PLHIV CDC department supportive of PrEP as part of combination prevention PrEP is seen in the Fifth NSP 	<ul style="list-style-type: none"> There is need for more evidence before providing PrEP to target groups via campaigns Participation of end users and civil society groups in planning activities could expand
Supply Chain Management	<ul style="list-style-type: none"> Truvada have been approved for prevention by CDC Established ARV procurement system Infrastructure for domestic manufacturing? 	<ul style="list-style-type: none"> Truvada not approved for ages <18 or pregnant women Concerns about providing free medicine to all target groups if welcomed
PrEP Delivery Platforms	<ul style="list-style-type: none"> Clinical guidelines developed; training curriculum underway? CDC implementing new distribution models Strong existing channels for target groups via VCT centers and Women Centers 	<ul style="list-style-type: none"> New channels may be needed for PWID Increased burden on healthcare system as uptake increases; could strain limited delivery capacity
Individual Uptake	<ul style="list-style-type: none"> Developed clinical guideline could also enable PrEP roll-out Strong uptake expected in MSM and FSW 	<ul style="list-style-type: none"> The 5th NSP suggest low compliance among PLHIV to ARV drug treatment Stigma associated with HIV and HIV medication Some user preference for injectable products
Effective Use & Monitoring	<ul style="list-style-type: none"> Call for harmonized, effective M&E in the Fifth NSP could be prioritized in current PrEP and Condom road map Lessons from previous projects can inform strategies for effective use in key populations 	<ul style="list-style-type: none"> Inconsistent adherence/ effective use amongst key populations No patient single identifier system M&E infrastructure improvements needed System capacity for initial and ongoing HIV and other testing

5.3.3. Key Questions for PrEP Roll-out

Value Chain for PrEP	Key Questions for PrEP Roll-out
Planning & Budgeting	<ul style="list-style-type: none"> • For which segments of the target populations will it be cost-effective and/or most impactful to deliver PrEP? • What are the incremental costs of PrEP delivery? • What sources of funding will be available for PrEP? How will the scale-up for FSW, MSM, and PLHIV after implementation phase?
Supply Chain Management	<ul style="list-style-type: none"> • Will generic oral PrEP options be branded and packaged substantially differently from treatment medications (e.g., to be smaller, come in more discrete packaging)? • How will PrEP be integrated into existing procurement and distribution mechanisms?
PrEP Delivery Platforms	<ul style="list-style-type: none"> • To what extent do existing channels reach target populations? How might these channels need to be modified? What new channels will be needed (e.g., for PLHIV)? • What can be learned from the FSW rollout to inform broader healthcare worker engagement?
Individual Uptake	<ul style="list-style-type: none"> • How will CDC effectively identify those at significant risk? • How might initial rollout plans (e.g., to sex workers, MSM) stigmatize PrEP for other needed populations? • How will stigma and community buy-in be addressed for PrEP? • What are the most effective demand generation strategies to reach target populations? • Is there enough laboratory capacity to support effective PrEP initiation?
Effective Use & Monitoring	<ul style="list-style-type: none"> • Call for harmonized, effective M&E in the Fifth NSP could be prioritized in current PrEP and Condom road map • Lessons from previous projects can inform strategies for effective use in key populations

5.3.4. Key Stakeholders for PrEP



<p>CDC guides national plans/priorities, oversees policy and guidelines, coordinates technical HIV programming, manages supply chains and capacity-building, guides and oversees health care worker training and M&E</p>			
National stakeholders	<p>PrEP Technical Working Group provides leadership and strategic guidance in the creation of clinical and implementation guidelines for PrEP, coordinates stakeholders, leverages resources to ensure timely and efficient roll-out of PrEP to target populations</p>		
	<table border="1"> <tr> <td> <p>CDC- develops National Strategic Plan</p> </td> <td> <p>National government- Coordinates multi-sector demand generation support</p> </td> </tr> </table>	<p>CDC- develops National Strategic Plan</p>	<p>National government- Coordinates multi-sector demand generation support</p>
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<p>Deputy Minister of Medicine and Food of MOHME approves all new medications</p>			
Local implementers	<p>Provincial Governments and Medical Sciences Universities- responsible for the implementation of the National Strategic Plan, receive and distributes ARVs to care centers/ARV outlets, coordinates and funds delivery of HIV services to PLHIV, coordinates and delivers training, M&E</p>		
	<p>Health care facilities (public and private)- provide core HIV/AIDS and health services (VCT centers, Women Centers, Harm Reduction centers, and some Prisons)</p>		
	<p>Civil Society/ Community based organizations (non-profit, faith-based, advocacy groups)- trusted organizations that can reach target populations with PrEP and generate demand</p>		
Others	<p>Donors (The Global Fund, ...)</p>		
	<p>International organizations (WHO, UNAIDS, UNFPA, ...)</p>		

CHAPTER 6: GOALS AND RELATED OBJECTIVES, STRATEGIES, AND INDICATORS OF PROGRESS

Pre-Exposure Prophylaxis and Condom Programming for Key Populations: Roadmap to End the HIV Epidemic in Iran 2022-2026

This PrEP and Condom Programming for key populations, builds on the lessons learned and in line with Iran's fifth National Strategic Plan of HIV prevention and seeks to leverage opportunities and address the challenges that remain. It provides a national roadmap for continuing the coordinated response to HIV and puts the country on the path to end the HIV epidemic in Iran by 2030. The HIV Plan is guided by this vision statement:

VISION

- Iran will be a place where new HIV infections are prevented among key populations and their partners, every person have access to PrEP and high-quality condoms and lives free from stigma and discrimination.
- This vision includes all key populations and their partners, regardless of age, sex, gender identity, sexual orientation, ethnicity, religion, disability, geographic location, or socioeconomic circumstance

Goal 1: Prevent New HIV Infections through the use of key populations of male condoms

THE OPPORTUNITY

Condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs). The most effective ways to reduce new HIV infections are to ensure timely diagnosis and engagement in care and treatment for people with HIV; and ensure that the most effective prevention strategies are prioritized and widely implemented. An ongoing emphasis on primary prevention remains important. Not having sex is a 100% effective way to prevent getting or transmitting HIV through sexual activity. Also, for those engaging in sexual activity, reducing the number of sexual partners, choosing sexual practices with less risk of transmission, and using PrEP are reliable ways to avoid HIV. Also, correct and consistent use of condoms is highly effective in reducing HIV transmission⁹⁵.

Because of advances and innovations during the past decade, an array of HIV prevention options, for use in combination or on their own, are available to people with or at risk for HIV, including the following: HIV treatment as prevention (PrEP); HIV testing and linkage to care; PrEP; syringe services programs (SSPs) and other harm reduction services; Post-exposure prophylaxis (PEP); and condoms. Changing behavior to promote safer sexual practices, including condom use, is fundamental to controlling the epidemic. In Iran, the Government's commitment to control HIV/AIDS, and consequently, to recognize and support the supply of condoms to key populations is a great opportunity for national planning of condom supply strategies for these vulnerable populations.

During the last decade, GOI has changed population policies from anti- to pro-natalist and consequently, significant limitations have taken place in access to contraception including condoms in the public sector. These restrictions have raised concerns about access to condoms for HIV/AIDS prevention nationwide. Meanwhile, controlling HIV/AIDS is one of the priorities of the GOI and, consequently, providing condoms as one of the most important methods of HIV prevention, especially for key populations, is one of the priorities of the Iranian government and has created a good opportunity for condom programming at the national level.

⁹⁵ What can decrease HIV risk? Centers for Disease Control and Prevention HIV Risk Reduction Tool. Accessed October 1, 2021. <https://hivrisk.cdc.gov/can-decrease-hiv-risk/>

CHALLENGES

To achieve the goal of “Prevent New HIV Infections through the use of key populations of male condoms”, the following challenges must be addressed:

- Limited national stewardship of the national condom market as key government agencies focused on direct implementation through the public sector especially for key populations and there is weak cooperation responsible public and private organizations in this regard.
- There is limited use of marketing and consumer research data to inform consumer segmentation and condom brand positioning.
- There is sustained access to condoms when and where key populations need them, but there are some challenges regarding the quality and quantity of condoms in the public supply chain.
- High-impact demand creation programs have not been extensively shared and scaled across the country, and cultural barriers continue to inhibit the translation of individuals’ knowledge into action.
- Insufficient targeting of key and vulnerable populations with demand creation and distribution tailored to their needs. For example, there is no service for MSM and transgender. Inadequate investment in promoting the importance of a healthy condom market in achieving equitable and sustainable condom Programming. Lack of market development approaches means. Some key populations are often without condoms.
- Many key populations in Iran still do not have the basic facts about HIV, including information on the latest prevention options and the effectiveness of condoms in the prevention.
- The percentage of sexual partners of PWID who are covered by a standard service package and receive a free condom each month according to the standard is reported to be zero.
- The goal to get free condoms for PWID at the end of the Fourth NSP was 45%, which only 36% achieved.
- The goal to get free condoms for high-risk women via Welfare Organization at the end of the Fourth NSP was 20%, which only 11% achieved.

Goal 1: Prevent New HIV Infections through the use of key populations of male condoms

Objectives:

1. To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026
2. To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026
3. To increase access and availability of male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026

- The goal to get free condoms for MSM at the end of the Fourth NSP was 3%, which only 6.5% achieved.
- Only 38% of people who need to receive a free condom in the form of harm reduction have received a condom.
- 41.7 percent of FSWs did not have access to condoms because of their high price.
- For 78% of FSW, getting a condom from a pharmacy has been the most important source of condom supply,
- Consistent condom use has been reported by 25% of PLHIV.
- Regarding FSWs, the most important reason for the inability to use consistently condoms for commercial and non-commercial clients was customer opposition.
- After lacking access, being expensive was the most important reason for not using a condom among key populations,
- Thirty-eight percent of those receiving harm reduction services received safe sex counseling and condom use.
- Service providers complain about the lack of training aids to teach them how to use condoms.
- Service providers complain about the lack of comprehensive sexual education and training.

SUMMARY OF OBJECTIVES

The following objectives are critical to achieving the goal of **“Prevent New HIV Infections through the use of key populations of male condoms”**:

1. To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026
2. To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026
3. To increase access and availability of male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026

Table 6.1: Outcomes, Indicators and Targets

National PrEP and Condom Program- 2022-2026

Outcome	Indicator	Baseline	Target 2026
50% of organizations with capacity to manage Condom Program by 2026	Proportion of organizations with capacity to manage the condom program	TBD	50%
Increased Condom Use at last high risk sex	<p>- Percentage of adults who use a condom at the last high risk sex</p> <p>- Percentage of adults engaged in high risk sex reporting consistent condom use</p> <p>- Percentage of adults who know that HIV can be prevented by using condoms</p>	<p>PLHIV: male 26.6% Female: 4.3%</p> <p>MSM: 20%</p> <p>FSW: Commercial: 62.9% Non-Com.: 38.4%</p> <p>PWID: Male: 32%</p> <p>TG: Non-paying partner:39.7% Causal partner: 34.6% Paying partner: 53.3%</p> <p>Prisoners: TBD</p> <p>PLHIV: with spouse: male 54.1% Female: 68.1% Total: 59.7%</p> <p>Other than spouse: Male: 13.7% Female:13.1% Total: 13.5%</p> <p>MSM: 13%</p> <p>FSW: Commercial: 43.6% Non-Com.: 23.5%</p> <p>PWID: Male: 32%</p> <p>TG: 19%</p> <p>Prisoners: TBD</p> <p>PLHIV: 90%</p> <p>MSM: TBD</p> <p>FSW: 87.6%</p> <p>PWID: 90.1%</p> <p>TG: TBD</p> <p>Prisoners: 84.3%</p>	<p>PLHIV: male 33.3% Female: 5.4%</p> <p>MSM: 25%</p> <p>FSW: Commercial: 78.6% Non-Com.: 48.0%</p> <p>PWID: Male: 40%</p> <p>TG: Non-paying partner:49.6% Causal partner: 43.3% Paying partner: 66.6%</p> <p>Prisoners: TBD</p> <p>PLHIV: with spouse: male 67.6% Female: 85.1% Total: 74.6%</p> <p>Other than spouse: Male: 17.1% Female:16.4% Total: 16.9%</p> <p>MSM: 16.3%</p> <p>FSW: Commercial: 54.5.6% Non-Com.: 29.4%</p> <p>PWID: Male: 40%</p> <p>TG: 23.8%</p> <p>Prisoners: TBD</p> <p>PLHIV: 95%</p> <p>MSM: TBD</p> <p>FSW: 92.6%</p> <p>PWID: 95.1%</p> <p>TG: TBD</p> <p>Prisoners: 89.3%</p>
Increased access and availability of male condoms	<p>- The proportion of key populations having access to condoms</p> <p>- Proportion of condoms distributed through the commercial channels against procured</p>	<p>Access to condoms: 73.8%</p> <p>Access to free condoms: FSWs: 33.2% (monthly) PWID: 35.0% (monthly) MSM: 3% (monthly) PLHIV (partners): TBD TG: TBD Prisoners: TBD</p> <p>TBD</p>	<p>Access to condoms: 100%</p> <p>Access to free condoms: FSWs: 48.4% (monthly) PWID: 52.5% (monthly) MSM: 4.5% (monthly) PLHIV (partners): 70% TBD: 30% Prisoners: 100%</p> <p>90%</p>

Target Groups

National PrEP and Condom Program- 2022-2026

Target groups for increased condom use shall be clearly identified and their specific characteristics understood in order to ensure effective and appropriate communication. Targeting specific population groups increases the impact and effectiveness of interventions. This is because prioritizing interventions to the population groups in which increased condom use will have the greatest preventive and protective value, results in the greatest number of infections being averted. In addition, the targeting of specific population groups allows the government to plan adequate supplies and implementers to design interventions using the most appropriate methods and materials for each group, thereby increasing the effectiveness of the interventions.

Fortunately, target populations for male condom use in Iran are determined. The following have been identified as target populations including five key populations and PLHIV and their partners at high risk of HIV transmission or acquisition highlighted within the 5th NSP for HIV Prevention for Iran:

1. Female Sex Workers (FSW), and their clients and regular partners;
2. Men who have Sex with Men (MSM), and their regular and non-regular partners;
3. People Who Inject Drug (PWID), and their regular and non-regular partners;
4. prisoners, and their regular and non-regular partners;
5. Transgender (TG), and their regular and non-regular partners; and
6. PLHIV couples, discordant & concordant couples.

OBJECTIVES AND STRATEGIES

Objective 1: To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026

The Ministry of Health has the overall responsibility for the management and coordination of strategic condom activities across all areas of implementation; from forecasting, procurement, standardization of service delivery to monitoring and evaluation. To meet this goal, MOHME should operate as the main leadership and coordination structure with clear roles and responsibilities at the national and provincial levels based on the tasks set by the Fifth NSP, in Iran. The findings of this project demonstrated some Condom Market Failures in Iran as follows:

- **Leadership & Coordination Capacity**
Limited national stewardship of the national condom market as key government agencies focused on direct implementation through the public sector especially for key populations and there is no common vision for a healthy condom market.
- **Financing**
While the Iranian government allocates domestic resources for goods, it also enjoys the support of different UN agencies, especially UNAIDS.
- **Policy and Regulation**
We concluded significant support from the policy level, especially for high-risk groups. Supervising implementation of the Program (SIP) at the national and provincial level which is foreseen in the 6th NSP is a good sample but in a passive function.
- **Market Analytics**

Limited use of marketing and consumer research data to inform consumer segmentation and brand positioning.

- **Supply**

Supply chain challenges in the public sector are limited due to the change in the population policies in Iran since 2014. There is sustained access to condoms when and where populations need them, who prefer to access condoms discreetly outside of clinical facilities. Key populations have free access to male condoms via Women Centers, VCT centers, DICs, and prisons.

- **Demand**

Lack of adequate coordinated efforts to address access and affordability barriers among key and vulnerable populations. Social marketing organizations do not coordinate.

- **Sustainability**

For key populations, there is no problem in maintaining condom access and sustainability of the service, even if UN agencies cut off their support.

- **Equity**

Insufficient targeting of key and vulnerable populations with demand creation and distribution tailored to their needs. Inadequate investment in promoting the importance of a healthy condom market in achieving equitable and sustainable condom programming. Lack of market development approaches means some key populations are often without condoms.

Fortunately, in the framework of the Fourth NSP of HIV/AIDS Program in Iran, a committee called “Supervising Implementation of the Program (SIP)” has been formed at the national and provincial levels to carry out all HIV/AIDS control activities, including condoms, between relevant organizations. These measures include coordination between organizations, tracking, and accountability, performance monitoring, strengthening capacity for institutions, and supply chain and commodity security. The SIP Committee is scheduled to be formed and activated in the fifth NSP. The operation of these coordination mechanisms will be tracked, and the national and provincial focal points will support district-level staff to ensure that CCP is effectively rolled out within the district and in communities. These entities including the SIP committee will ensure that CCP is mainstreamed in policies, plans, and budgets in relevant sectors, including Welfare Organization, education, prisons, police, and health network.

Condom provision for most of the key target populations for HIV/AIDS are covered by the following outlets in the public sector in Iran:

- **Women Centers** cover at-risk populations in three groups including pure FSWs, FSWs who are addicted (injectable or non-injectable), and women whose sexual partners belong to key people at risk of HIV/AIDS. These centers are under MOHME.
- **VCT centers** cover all of the at-risk populations and are supported by the CDC department of MOHME.
- **DIC centers** via outreach and peer education programs distribute condoms within the frame of harm reduction programs to cover PWID, TG, and other key populations. DIC centers are created by the Welfare Organization (WO) and supported by the CDC department of the MOHME.
- **Prisons** are another convenient place to provide counseling and condoms to one of the most important key populations offered in the rooms with their sexual partners.

Condom Program Management efforts must engage people and organizations who shape and influence knowledge, attitudes, beliefs, and behaviors, particularly among key populations at risk of HIV to reach the highest number of people at relevant access points.

Strategies and priority areas:

1.1 Strengthening Leadership and Coordination structures at all levels

Successful strategy execution requires the following:

- Coordination and Program Governance (understanding who is doing what in which location)
- Strengthen Policies and Regulations: (tracking and accountability, performance monitoring, and active knowledge sharing to inform strategy update)

1.2 Facilitate National Condom Program Support Systems (In the context of the SIP Committee)

- Deepen advocacy for the national condom program for key populations
- Strengthen capacity for related organizations
- Strengthen the national condom performance monitoring

1.3 Strengthen Supply Chain and Commodity Security

- Effective Quantification and Forecasting
- Increase condom storage capacity and improve storage efficiency
- Implement the condom distribution plan
- Establishing variety in types of condoms to create the right of choice in customers
- Creating the Condom Logistics Management Information System (CLMIS)

Objective 2: To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026

Condom Use among key Populations: Condoms are most effective when they are used consistently rather than occasionally. Condom use among sex workers in Iran is 62.9% almost double that of women 19-29 in their last extra marriage life (35.1%). Condom use among MSM (20%) is considerably lower compared to men in the youth population (38.5%). Condom use among PLHIV couples is low at 37.2%. Condom use with the most recent sex partner among was reported 32%. Condom use among transgender people is lacking, but there is evidence that condom use in this population is low.

Nearly four decades into the HIV epidemic, too many people still lack essential information about HIV or hold misconceptions about the virus, including how it is prevented and transmitted. The resulting misperception of self-risk and perpetuation of HIV-related stigma and discrimination can deter people from learning their status, accessing prevention services, seeking or using condoms as a powerful prevention option. More must be done to increase HIV awareness among everyone, but especially among key populations and the health workforce where HIV is most heavily concentrated. Messaging must be clear, specific,

consistent, and culturally and linguistically appropriate and must reflect today's scientific knowledge of HIV prevention methods including condoms. Health education based on the public condom provision outlets helps prevent HIV among key populations by providing them with the knowledge and skills to help them be healthy and avoid HIV. HIV prevention education including comprehensive sexual education and condom effectiveness implemented in the condom outlets includes curricula that are medically accurate, developmentally appropriate, affirming, and culturally relevant with content and skills that target key behavioral outcomes such as condom use. Suitable HIV prevention education approaches focused on key populations should be age-appropriate, linguistically and culturally informed, community-centered, inclusive, stigma-reducing, and grounded in science and medicine.

Effective condom programs must overcome all of the potential barriers to condom use by:

- Creating a reliable supply of good-quality condoms by improving stock management and storage conditions;
- Making condoms readily available even for spontaneous users;
- Promoting demand for condoms by raising awareness of HIV/STI risks and teaching people how to use condoms correctly and consistently;
- Working to eradicate the social stigma associated with condoms; and
- Promoting a supportive environment by advocating for HIV prevention and condom use in the broader community.

Strategies:

2.1 Increase Demand for Condoms in Key Populations and Remove Barriers to Access and Use

- More investment in demand-generation activities to ensure that the key populations have the knowledge, skills, and ability to use condoms correctly and consistently. (Strengthening Advocacy)
- Investing in communication leads to changes in social behaviors associated with condom use by key populations
- Build capacity of service providers for male condom quality service provision

Objective 3: To increase access and availability of free male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026

Today, a range of highly effective HIV prevention methods are available for use in combination or on their own. However, they do not yet reach everyone who needs them. Scaling up scientifically proven, cost-effective interventions such as consistent condom usage targeted to the key populations in the right geographic areas is key to preventing new HIV infections. Condoms must be available to people who need them in a variety of public condom provision outlets as well as private and commercial settings. Public health and health care systems can better meet the HIV prevention needs of the people they serve by

developing or adopting culturally competent and linguistically appropriate approaches and policies to service design and delivery. Examples of interventions include the development and adoption of models that allow for low-barrier access to condom provision services such as expanded service hours, drop-in appointments, telehealth, peer navigators, out-reach health workers, and co-located service delivery. Given that 78.3% of FSWs buy condoms from pharmacies, it is important to pay attention to the private sector and create a favorable environment for the commercial sector to grow.

Availability of condoms for key populations was as follows:

- Among FSWs, 26.2% reported difficult access to condoms, in 78.3% the pharmacy was like the most important source of condom supply, and in 33.2% the Women Centers was the most important way to access condoms.
- Women's centers, VCT centers, and other condom outlets in the public sector usually do not have a problem in providing condoms for their applicants, but this access to condoms is a classic type and is not varied and applicants cannot choose.
- Of course, this constant availability of condoms does not mean that customers will be provided with as many condoms as they request, but providers are forced to manage demand and deliver fewer condoms to customers when there is a shortage.
- Women Centers do not cover all FSWs, and most clients are middle-class. People in the lower social classes do not come to these public centers because they do not care about their own health. People with the high social class also do not go to government centers and receive services from the private sector. The problem with these high-class groups is that they do not receive training.
- All public condom delivery channels are not available at all times and in sufficient numbers, especially in harm reduction centers and prisons. In Women Centers, in many cases, they are forced to impose restrictions due to the limited number of condoms they have.
- Free condom delivery centers in the public sector are open during office hours. As a result, problems for key populations arise when condoms need to be used. In order to increase access, more exposure and visibility for condoms in pharmacies are required.

Strategies

3.1 Increasing Access to Male Condoms

- Strategically expand condom distribution through the public, social marketing organisation/NGO, and commercial sectors

3.2. Improving Utilization of Male Condoms

- Measures to increase the use of condoms in the conditions in which access is provided

3.3. Grow the Market Size

- Strengthen social marketing brand management and sustainability

- Achieve the right size the free condom market
- Creating a favorable environment for the growth of the commercial sector in the condom market

PRIORITY INTERVENTIONS

Objective 1: To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026

Strategy 1.1: Strengthening Leadership and Coordination structures at all levels

Priority 1.1.1: Coordination and Program Governance

1.1.1.1 Establishment of the condom coordination structures (Establishment of a **PrEP and Condom Technical Group** under the SIP Committee at MOHME), to develop and implement program management action plans and targets and hold regular monitoring and evaluation.

1.1.1.2 Integrating condom programming in the health network of the MOHME and related organizations including Social Security Organization, Red Crescent, Welfare Organization, Prisons Organization, Ministry of Interior, and so on.

1.1.1.3 Strengthen coordination of key stakeholders from government, City Council, and commercial private sector to address programming gaps at national and provincial levels.

1.1.1.4 Build capacity for leadership and coordination of comprehensive condom programming at the provincial level, through SIP Committee and orientation on current condom programming for comprehensive PrEP and Condom HIV prevention, appreciation of roles and responsibilities, and operationalization of provincial SIP committees.

Priority 1.1.2: Strengthen Policies and Regulations

1.1.2.1 Advocate at the highest level policy-makers within GoI, for the role of condoms in HIV prevention among key populations, to address health outcomes and impacts.

1.1.2.2 Advocacy for resource mobilization, including the institutionalization of a budget line, to support commodity procurement capacity.

1.1.2.3 Advocate for tracking and accountability, performance monitoring, and active knowledge sharing to inform strategy updates.

Strategy 1.2: Facilitate National Condom Program Support System for the key population (In the context of the SIP Committee)

Priority 1.2.1: Deepen advocacy for the national condom program for key populations

1.2.1.1 Implement a condom-related incentive program for providers and customers to positively influence the attitudes and perceptions of stakeholders as well as various policymakers about condoms

1.2.1.2 Develop and implement campaigns to increase awareness and commitment between the government and experts at all levels to reduce barriers to condom planning and increase condom access and use (taking into account community sensitivities).

1.2.1.3 Build partnerships through networking and engagement with all public, and private sector stakeholders, NGOs, community groups and other sectors of society to support condom planning.

1.2.1.4 Provide evidence-based information and modeling on the importance of condoms to influence health policymakers and planners.

Priority 1.2.2: Strengthen capacity for related organizations

1.2.2.1 Develop and implement a strategy to increase capacity and standard training materials for relevant stakeholders for use in condom programming.

1.2.2.2 Capacity building for comprehensive condom programming at the national and provincial levels, including the designation of human resources in MOHME and related organizations at the national and provincial levels supported by the government, and facilitating the implementation of their activities.

1.2.2.3 Define and implement minimum standards for condom program performance across the country and provinces in terms of human resources, action planning, goal setting, M&E mechanisms, and coordination of participation and performance appraisal.

1.2.2.4 Develop the capacity of relevant NGOs through training and social contracting to implement the national condom program to gain their support and participation.

1.2.2.5 Regularly and continuously review the capacities related to the condom program to identify strengths and areas for improvement and, if necessary, to pay attention to and support it.

Priority 1.2.3: Strengthen the national condom performance monitoring

1.2.3.1 Establish a national framework for condom monitoring and evaluation, including strategies related to the HIV prevention program and within the framework of the Fifth NSP, with annual national and provincial goals.

1.2.3.2 Strengthen the capacity of MOHME to manage, monitor and evaluate the national condom program, including human resource training and the institutionalization of data management tools.

1.2.3.3 Holding annual condom program review meetings at the national and provincial levels to evaluate the annual performance of the condom program and how to achieve the goals and determine the policy for the coming years.

1.2.3.4 Establish observation bases to track condom use by key populations in selected sensitive and problem areas.

Strategy 1.3: Strengthen Supply Chain and Commodity Security

Priority 1.3.1: Effective Quantification and Forecasting

1.3.1.1 Use of tools approved by reputable organizations to estimate the need for condoms for key populations across the country.

1.3.1.2 Establish coordination between key departments in MOHME, to carry out annual forecasts of male condoms separately for different public sector organizations providing condoms for key populations, for national consumption and reflected in the annual procurement programs of MOHME.

1.3.1.3 Establish and support the "Quantification and Procurement Planning" unit for quantification in the provinces and at the national level facilities.

1.3.1.4 Improve condom information management system, for reliable forecasting and measurement, by training relevant teams in relevant organizations on the use of designated tools at national and sub-national levels.

Priority 1.3.2: Increase condom storage capacity and improve storage efficiency

1.3.2.1 Mobilize resources to increase the storage capacity of public sector condoms (Ministry of Health and related organizations in providing condoms to key populations) including cooperation with other partners (international organizations and the private sector) to cooperate.

1.3.2.2 Planning and participation of all public and non-governmental sector partners to adhere to supply programs, ensure condom availability, and efficient use of storage space.

1.3.2.3 Conduct a nationwide survey of all governmental and non-governmental organizations consulting on the provision of condoms to key populations to assess the availability of storage facilities and the quality of condom stores in the public, private and commercial sectors (post-market surveillance).

1.3.2.4 According to WHO recommendations, regular and continuous "instant checks" of condom quality and storage and warehousing at the national and regional levels are essential.

Priority 1.3.3: Implement the condom distribution plan

1.3.3.1 The National Condom Distribution Program for access to key populations needs to be designed, implemented, and continuously updated, (One Warehouse One, Health Facility Policy).

1.3.3.2 Searching for alternative condom provision outlets for free condoms to key populations is essential in areas or areas where groups of key populations have less access to condoms.

1.3.3.3 Increase the number, coverage, monitoring and completion of free condom distribution outlets in the public sector and at strategic points to ensure greater access to key populations.

1.3.3.4 Expand condom distribution beyond traditional government channels (public condom provision outlets) to non-traditional channels such as charities, NGOs, town and village councils, community and livelihood groups to participate in private sector condom distribution to key populations.

1.3.3.5 Perform analysis of the final impact of condom programs such as social marketing of condoms in difficult areas and additional costs.

Priority 1.3.4: Establishing variety in types of condoms to create the right of choose in customers

1.3.4.1 Targeted distribution of condoms to public outlets and direct to users through community-based agents

1.3.4.2 Providing branded, subsidized condoms in public outlets within the context of social marketing within justified contexts (i.e., where it will not result in crowding out of commercial sector options). The use of subsidies to support commodity and packaging should be justified based on key populations` desires.

1.3.4.3 Support for storage and distribution of condoms in under-served, prioritized areas.

1.3.4.4 Performance-based incentives, if needed, to initiate expanded condom availability in under-served areas and outlets

Priority 1.3.5: Creating the Condom Logistics Management Information System (CLMIS)

1.3.5.1 Create a robust CLMIS for key populations in the country including capacity building for service providers.

1.3.5.2 Strengthen and institutionalize the created CLMIS dashboard include tracking key populations and linking to national health sector web mechanisms

1.3.5.3 Regularize condom distribution reporting for the governmental and non-governmental sectors through the CLMIS

1.3.5.4 Build capacity of related service providers on the use of CLMIS tools and supply planning to increase accuracy.

Objective 2: To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026

Strategy 2.1: Increase Demand for Condoms in Key Populations and Remove Barriers to Access and Use

Priority 2.1.1: More investment in demand-generation activities to ensure that the key populations have the knowledge, skills and ability to use condoms correctly and consistently. (Strengthening Advocacy)

- 2.1.1.1** Define all key target populations of the condom program for targeting and planning
- 2.1.1.2** Increase the targeted capacity of the public sector and create demand for access to all key populations that for various reasons, such as low financial capacity, geographical access, and other barriers, do not have access to condom services in the public sector.
- 2.1.1.3** Supporting social marketing organizations by respecting the constraints and sensitivities of the community to improve targeting, expand coverage and create condom demand in key populations
- 2.1.1.4** Support the commercial sector related to the condom market and create demand
- 2.1.1.5** Setting Up and Strengthening Social Marketing of Condoms for key populations
- 2.1.1.6** Provide partner services for key populations who visit public condom providing outlets
- 2.1.1.7** Make the outlet condom friendly
- 2.1.1.8** Ensure that high-quality condoms are always available

Priority 2.1.2: Investing in communication leads to changes in social behaviors associated with condom use by key populations

- 2.1.2.1** Prepare and implement a Condom-Related Communication guide (CRCG) for various stakeholder groups, standardize, localize, and regularly review the concepts of condom advertising messaging for key populations among the public, civil, and private sector actors.
- 2.1.2.2** Conducting awareness and condom education campaigns for key populations and taking into account the existing sensitivities in the community with the aim of marketing condoms for a healthy lifestyle and ensuring fair information coverage.
- 2.1.2.3** Strengthen community participation in condom campaigns for key populations, such as funding related NGOs to conduct the community-owned campaigns.
- 2.1.2.4** Sensitizing society to the promotion and use of condoms by key populations to cultural and social experts.

2.1.2.5 Reposition condoms as a way of life, especially among key populations, through integration into the social and economic programs and initiatives that target them.

2.1.2.6 Conduct a further assessment of condom uses by the target population, especially among key populations.

2.1.2.7 Discover innovative mechanisms for promoting condoms in key populations, including the use of media technology platforms to provide information and access to condoms

Priority 2.1.3: Build capacity of service providers for male condom quality service provision

2.1.3.1 Educating and skills training of condom provision outlets providers (in the private and public sector) on the correct use of condoms, types of condoms available in the market, the use of each of the available condoms and other technical and practical aspects.

2.1.3.2 Re-orient service providers to promote condoms and PrEP for dual protection and as a lifestyle, especially for young people in key populations.

2.1.3.3 Organizing national and regional symposia to share experiences related to condom advertising for key populations by experts and community scientists

2.1.3.4 Use of appropriate training aids for skills training in condom use by service providers (such as WHO-Decision Making Tools (DMT))

2.1.3.5 Development of standardized and evidence-based “toolkits” for condom promotion and their use to make it easier for condom outlets to sustain high-quality interventions with key populations.

2.1.3.6 Information and communication on safer sex, community-level, and social media condom promotion for key populations

2.1.3.7 Adherence to 5 key steps of service delivery by employees to key populations, including the following:

Step 1: Make the outlet condom friendly

Step 2: Ensure that high-quality condoms are always available

Step 3: Counsel clients about condoms

Step 4: Reach out to the community

Step 5: Check progress

Objective 3: To increase access and availability of free male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026

Strategy 3.1: Increasing Access to Male Condoms

Priority 3.1.1: Strategically expand condom distribution through the public, social marketing organization/NGO, and commercial sectors

- 3.1.1.1** Male condoms shall be made regularly available in all condom provision outlets in all geographical areas for the key populations.
- 3.1.1.2** Making condom-friendly service outputs to ensure increased availability and accessibility of key populations.
- 3.1.1.3** There shall be continued use of community-based distributors (e.g. outreach service providers) in the distribution of condoms as well as promotion of a key population-friendly condom distribution system.
- 3.1.1.4** The implementing partners such as NGOs, Welfare Organizations, Prison Council, and Civil Society Organizations shall have access to public sector condoms at no cost for distribution to clients.
- 3.1.1.5** Condoms shall be made available to all key populations through their residential, potential meeting places, as well as high-risk settings via outreach service providers.
- 3.1.1.6** Regular supply of male condoms, as well as condom IEC materials, shall be made to targeted key population outlets
- 3.1.1.7** Finding alternative condom provision strategies and outlets

Strategy 3.2: Improving Utilization of Male Condoms

Priority 3.2.1: Measures to increase the use of condoms in the conditions in which access is provided

- 3.2.1.1** Correct and consistent use of male condoms shall be fostered by providing a regular, continuous supply of condoms and related commodities, such as lubricants.
- 3.2.1.2** Demonstrations on the correct use of male condoms shall be performed during service delivery outlets
- 3.2.1.3** The packaging of the public sector condoms shall be improved (including acceptable branding) so as to be more appealing to the users
- 3.2.1.4** Implementing partners shall publicize the fact that the public sector brand condoms have been paid for by the government and are intended for distribution at no additional cost to the end-user.
- 3.2.1.5** The packaging of the public sector condoms shall be improved (including acceptable branding) so as to be more appealing to the users.

3.2.1.6 Supplying condoms in different sizes, different flavors, different heads, different brands, delayed and modern types can lead to increased condom use in key populations.

Strategy 3.3: Grow the Market Size

Priority 3.3.1: Strengthen social marketing brand management and sustainability

3.3.1.1 Supporting social marketing organizations to develop tailored business programs for key populations and social conditions in Iran and mobilizing resources to support sustainable condom collections.

3.3.1.2 Provide facilities and support to social marketing organizations to create condom brands and introduce different types at different prices to key populations.

3.3.1.3 Supporting social marketing organizations to adopt hybrid models and develop cost-effective alternative distribution channels for key populations with poor social and economic status.

Priority 3.3.2: Achieve the right size of free condom market

3.3.2.1 To determine the needs of condoms by key populations and distribution channels for each as well as existing markets, conduct market segmentation studies.

3.3.2.2 Define and prioritize different groups of key target populations, for each market segment by prioritizing free condoms for people with difficult and vulnerable access to ensure equity.

3.3.2.3 Regularly evaluate the situation of the condom market in the public and private sectors against condom distribution and use targets to find out the size of the free condom market.

Priority 3.3.3: Creating a favorable environment for the growth of the commercial sector in the condom market

3.3.3.1 To reduce the cost to business investors, prioritize business condoms for post-shipment testing.

3.3.3.2 Develop and facilitate condom campaigns for key populations that promote condom access in the open market at affordable prices

3.3.3.3 The Governmental sector should support the introduction of condoms in the private sector in such a way that the private sector can provide condoms at a reasonable price for key populations by increasing its sales in the open market.

3.3.3.4 Determining the goals and participation of private sector partners to develop meeting programs with them and participating in condom coordination platforms for key populations

Goal 2: Prevent New HIV Infections through the Use of Target Populations of PrEP

THE OPPORTUNITY

Today, a range of highly effective HIV prevention methods are available for use in combination or on their own. However, they do not yet reach everyone who needs them. Scaling up combinations of interventions targeted to the right key populations in the right geographic areas is key to preventing new HIV infections. Especially important is scaling up highly effective, biomedical interventions such as PrEP along with other highly effective prevention interventions including correct and consistent condom usage.

Uptake of daily oral PrEP, which reduces the risk of getting HIV from sex by about 99% when taken daily, has climbed in recent years. After reviewing the available research on PrEP, in June 2019 the U.S. Preventive Services Task Force (USPSTF) issued a Grade A recommendation for providers to offer PrEP to people at high risk for HIV. In addition, in 2019 FDA approved a second drug for PrEP and a generic version of the original drug became available, increasing options for people who wish to use PrEP. For PrEP to have a sustainable health impact, relevant knowledge, attitude, and beliefs need to be shaped at the individual, community, and policy levels. Needed people must understand the benefits of PrEP and believe these outweigh any possible negatives.

CHALLENGES

Iran's 5th NSP of HIV/AIDS control endorses PrEP and is in progress on the roll-out of oral PrEP to priority populations. However, a number of outstanding questions remain:

- The CDC Department of MOHME developed the Policy and Guidelines for the introduction of oral PrEP and immediate test and treat. The guidelines were specific for the rollout to include four groups of the key populations, including MSM, transgender, sexual partners of the PLHIV, and sexual partners of the Female sex workers who have multiple unprotected contacts.
- The strongest existing channels for HIV care delivery to target populations are currently those for sex workers (SW), MSM, PWID, and for PLHIV, most of the identified as the target populations to receive PrEP.

Goal 2: Prevent New HIV Infections through the Use of Target Populations of PrEP

Objectives:

1. To achieve high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026.
2. To increase awareness, adherence and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026.

- While PrEP is a beneficial addition to the comprehensive prevention package, significant questions remain for key decision-makers around effectiveness for specific populations (e.g., MSM and FSW who are not using condoms routinely).
- Remaining questions for exploration include:
 - How to effectively identify those at significant risk, and what are the most effective and efficient service delivery channels to reach them? What are the most effective messages and strategies for demand creation for PrEP?
 - What are the barriers to, facilitators of, and strategies for oral PrEP uptake, adherence, and retention? What are the providers' knowledge, attitudes, practices, and behaviors with regards to oral PrEP delivery?
 - Strategies for influencing social and behavior change in ways that support PrEP uptake and use,
 - Training for providers, counselors, peer educators on how to talk about and provide PrEP, and more.

SUMMARY OF OBJECTIVES

The following objectives are critical to achieving the goal of “**Expand and improve implementation of PrEP as an effective HIV prevention intervention in Iran**”:

1. To achieve high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026.
2. To increase adherence and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026.

Table 6.2: Outcomes, Indicators and Targets

Outcome	Indicator	Baseline (2020)	Target 2026
Increased PrEP uptake among all target populations by 2026	Percentage of adults who use PrEP	MSM: 2% FSW: 0% TG: 0% PLHIV partners: 0%	MSM: 10% FSW: 25% TG: 25% PLHIV partners: 90%
Increased adherence for PrEP among all target populations by 2026	Percentage of adults who reported always using PrEP in the last month	MSM: 0% FSW: 0% TG: 0% PLHIV partners: 0%	MSM: 80% FSW: 80% TG: 80% PLHIV partners: 80%
Increased awareness about PrEP among all target populations by 2026	The proportion of target populations having comprehensive awareness about PrEP	MSM: 0% FSW: 0% TG: 0% PLHIV partners: 0%	MSM: 80% FSW: 80% TG: 80% PLHIV partners: 80%

Target populations

National PrEP and Condom Program- 2022-2026

In order to implement PrEP as a new HIV prevention method in Iran, National Implementation Guidelines drafted by the CDC department of the MOHME are currently functional. Based on this guideline, PrEP target groups include:

1. MSM who have had condom-free sex with at least one random or HIV-infected partner who has not received antiretroviral or viral loading over 200 in the past 6 months.
2. Transgender women or men who have had condom-free sex with at least one random or HIV-infected partner who has not received antiretroviral or viral loading over 200 in the past 6 months.
3. Heterosexual men and women whose sexual partners are infected with HIV and do not take antiretroviral drugs or have a detectable viral load and do not use condoms.
4. Sexual partners of the Female sex-workers who have multiple unprotected contacts.

OBJECTIVES AND STRATEGIES

Objective 2.1: To achieve high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026.

HIV Pre-Exposure Prophylaxis (PrEP) is a preventive measure that consists of administering antiretroviral drugs to uninfected individuals who engage in high-risk sexual behavior in order to avoid infection. The WHO recommends offering PrEP to people at “substantial” risk of infection who belong to population groups in which the incidence of HIV is over 3 infections per 100 person-years (PY) as well as other preventive measures such as condom use, screening for other STIs, and universal access to early diagnosis and ART⁹⁶. PrEP has been used in Iran since 2017 and has not been well developed for various reasons. Since the most relevant indications for PrEP use in MSM, TG, and PLHIV are condom-less sex with multiple partners, the addition of the PrEP to the comprehensive HIV prevention package is a beneficial addition. In all settings, adding PrEP to the condom program as a complement to each other is essential in preventing HIV/AIDS. Our situational analysis data on PrEP utilization from HIV surveillance data and government data on healthcare providers indicate a confluence of factors in Iran that are likely limiting PrEP uptake. A variety of approaches are needed to address the complex challenges to PrEP implementation in Iran. Meanwhile, an evidence-based marketing and communications plan lay out the activities to ensure that PrEP is understood and used in ways that have an impact on HIV prevention.

There are at least five programmatic elements that are necessary for successful PrEP introduction and implementation:

1. Introduce PrEP extensively,
2. Give potential customers a reason to value PrEP,
3. Speak to potential customers,
4. Equip potential customers to make an informed choice, and
5. Right Person, Right Time.

⁹⁶ World Health Organization. WHO Expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). November; 2015.

Overcoming the structural, capacity, and policy challenges to increasing PrEP uptake in Iran will require innovations in defined strategies, clinical approaches and policy changes.

Strategies

2.1.1 Improve supply chain management to provide and distribute oral PrEP in sufficient quantity to meet projected demand by appropriate delivery platform

- Coordination and Program Governance
- Advocacy and education to create the political will to engage policymakers
- Strengthen the national PrEP performance monitoring
- Effective Quantification and Forecasting
- Implement the PrEP distribution plan
- Using novel methods to improve PrEP supply chain

2.1.2 Demand creation using culturally competent and linguistically appropriate approaches for PrEP and remove barriers to access and begin using

- More investment in demand-generation activities to ensure that the target populations have the knowledge and attitudes to use PrEP correctly and consistently. (Strengthening Advocacy)
- Highly targeted interpersonal communication leads to changes in social behaviors associated with PrEP use by target populations

Objective 2.2: To increase adherence and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026.

Several of the key barriers to PrEP uptake discussed above have also been reported to hinder continued PrEP use (adherence). A study of 7148 individuals who initiated PrEP in the USA reported only 56% persistence in year 1, 63% in year 2, and 41% from initiation to year 2, with the lowest persistence in women and individuals aged 18-24 years. Factors predicted to contribute to PrEP cessation included financial barriers, changes in perceived risk, and difficulties accessing healthcare services⁹⁷. Overcoming barriers to PrEP uptake may therefore have a concurrent positive impact on adherence to PrEP.

Strategies

2.2.1 Increasing the providers' knowledge, attitudes, practices, and behaviors with regards to oral PrEP delivery.

- Build capacity of service providers for PrEP quality service provision

2.2.2 Scale-up uptake, adherence, and retention of oral PrEP for target populations for effective use and monitoring

⁹⁷ Coy KC, et al. Persistence on HIV preexposure prophylaxis medication over a 2-year period among a national sample of 7148 PrEP users, United States, 2015 to 2017. *J Int AIDS Soc.* 2019;22:e25252.

- Measures to increase the use of PrEP in the conditions in which access is provided
- Strengthen social marketing brand management and sustainability

PRIORITY INTERVENTIONS FOR PrEP ROLL-OUT

Objective 1: To achieve high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026.

Strategy 1.1: Improve supply chain management to provide and distributed oral PrEP in sufficient quantity to meet projected demand by appropriate delivery platform

Priority 1.1.1: Coordination and Program Governance

1.1.1.1 Establishment of the PrEP coordination structures (Establishment of a **PrEP Technical Group** under the SIP Committee at MOHME), to develop and implement program management action plans and targets and hold regular monitoring and evaluation.

1.1.1.2 Integrating PrEP programming in the health network of the MOHME and related organizations including Welfare Organization, Prisons Organization, Ministry of Interior, and so on.

1.1.1.3 Strengthen coordination of key stakeholders from government, City Council, and commercial private sector to address programming gaps at national and provincial levels.

Priority 1.1.2: Advocacy and education to create political will to engage policymakers

1.1.2.1 Implement a PrEP-related incentive program for providers and customers to positively influence the attitudes and perceptions of stakeholders as well as various policymakers about PrEP

1.1.2.2 Develop and implement campaigns to increase awareness and commitment between the government and experts at all levels to reduce barriers to PrEP planning and increase PrEP access and use

1.1.2.3 Build partnerships through networking and engagement with all public and private sector stakeholders, NGOs, community, and other sectors of society to support PrEP planning.

1.1.2.4 Provide evidence-based information and modeling on the importance of PrEP to influence health policymakers and planners.

Priority 1.1.3: Strengthen the national PrEP performance monitoring

1.1.3.1 Establish a national framework for PrEP monitoring and evaluation, including strategies related to the HIV prevention program and within the framework of the Fifth NSP, with annual national and provincial goals.

1.1.3.2 Strengthen the capacity of MOHME to manage, monitor and evaluate the national PrEP program, including human resource training and the institutionalization of data management tools.

1.1.3.3 Holding annual PrEP program review meetings at the national and provincial levels to evaluate the annual performance of the PrEP program and how to achieve the goals and determine the policy for the coming years.

Priority 1.1.4: Effective Quantification and Forecasting

1.1.4.1 To estimate the need for PrEP for target populations across the country.

1.1.4.2 Establish and support the "Quantification and Procurement Planning" unit for quantification in the provinces and at the national level facilities.

1.1.4.3 Improve PrEP information management system, for reliable forecasting and measurement, by training relevant teams in relevant organizations on the use of designated tools at national and sub-national levels.

Priority 1.1.5: Implement the PrEP distribution plan

1.1.5.1 Searching for alternative PrEP provision outlets for free drugs to target populations is essential in areas or areas where groups of target populations have less access to PrEP drugs.

1.1.5.2 Increase the number, coverage, monitoring and completion of free PrEP outlets in the public sector and at strategic points to ensure greater access to target populations.

1.1.5.3 Expand PrEP beyond traditional government channels (public PrEP Provision outlets) to non-traditional channels such as private clinics, private and public hospitals, pharmacies, telehealth.

Priority 1.1.6: Using novel clinical approaches to improve PrEP supply chain

1.1.6.1 Using emerging alternatives to daily oral PrEP prescription such as "on-demand" PrEP, which has been shown to have at least comparable effectiveness to daily oral PrEP.

1.1.6.2 Increased STI testing frequency and linkage to PrEP

1.1.6.3 Frequent PrEP Screening and Repeat PrEP Offering: PrEP assessment and offering must be a sustained process for those at the highest risk for HIV infection

1.1.6.4 Streamlining clinical procedures: Minimize repeat clinic visits, Same-day PrEP initiation

1.1.6.5 Using Peer Navigators for PrEP initiation

1.1.6.6 Create seamless pathways for entry to PrEP care from existing public health touchpoints (e.g., STI or family health clinics)

1.1.6.7 Generic oral PrEP options should be branded and packaged substantially differently from treatment medications (e.g., to be smaller, come in more discrete packaging)

Strategy 1.2: Demand creation using culturally competent and linguistically appropriate approaches for PrEP and remove barriers to access and begin use

Priority 1.2.1: More investment in demand-generation activities to ensure that the target populations have the knowledge and attitudes to use PrEP correctly and consistently. (Strengthening Advocacy)

- 1.2.1.1** Increase the targeted capacity of the public sector and create demand for access to all target populations that for various reasons, such as geographical access and other barriers, do not have access to PrEP services in the public sector
- 1.2.1.2** Supporting social marketing organizations to improve targeting, expand coverage and create PrEP demand in target populations
- 1.2.1.3** Setting Up and Strengthening Social Marketing of PrEP for target populations
- 1.2.1.4** Make the outlet PrEP friendly
- 1.2.1.5** Ensure that PrEP drugs are always available

Priority 1.2.2: Highly targeted interpersonal communication leads to changes in social behaviors associated with PrEP use by target populations

- 1.2.2.1** Prepare and implement a PrEP-Related Communication guide (PRCG) for various stakeholder groups, standardize, localize, and regularly review the concepts of PrEP advertising messaging for target populations among public, civil, and private sector actors.
- 1.2.2.2** Conducting awareness and PrEP education campaigns for target populations with the aim of marketing PrEP for ensuring fair information coverage.
- 1.2.2.3** Strengthen community participation in PrEP campaigns for target populations.
- 1.2.2.4** Sensitizing society to the promotion and use of PrEP by target populations to cultural and social experts.
- 1.2.2.5** Discover innovative mechanisms for promoting PrEP in target populations, including the use of media technology platforms to provide information and access to PrEP

Objective 2: To increase adherence and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026.

Strategy 2.1: Increasing the providers' knowledge, attitudes, practices, and behaviors with regards to oral PrEP delivery.

Priority 2.1.1: Build capacity of service providers for PrEP quality service provision

2.1.3.1 Educational interventions targeted to primary care providers, including training to increase PrEP knowledge and to alleviate concerns regarding PrEP safety.

2.1.3.2 Organizing national and regional symposia to share experiences related to PrEP advertising for target populations by experts and community scientists

2.1.3.3 Use of novel ways to enhance PrEP education of the providers and appropriate training aids for skills training in PrEP use by service providers

2.1.3.4 Development of standardized and evidence-based “toolkits” for PrEP promotion and their use to make it easier for PrEP outlets to sustain high quality interventions with target populations

2.1.3.5 Adherence to 5 key steps of service delivery by employees to target populations, including the following:

Step 1: Make the outlet PrEP friendly

Step 2: Ensure that PrEP drugs are always available

Step 3: Counsel clients about PrEP

Step 4: Reach out to the community

Step 5: Check progress

Strategy 2.2: Scale-up uptake, adherence, and retention of oral PrEP for target populations for effective use and monitoring

Priority 2.2.1: Measures to increase the use of PrEP in the conditions in which access is provided

2.2.1.1 Correct and consistent use of PrEP drugs shall be fostered by providing a regular, continuous supply of drugs.

2.2.1.2 Demonstrations on the correct use of PrEP drugs shall be performed during service delivery outlets, considering flexible PrEP regimens (e.g., on-demand PrEP, long-acting PrEP)

Priority 2.2.2: Strengthen social marketing brand management and sustainability

2.3.1.1 Supporting social marketing organizations to develop tailored business programs for target populations and social conditions in Iran.

2.3.1.2 Provide facilities and support to social marketing organizations to introduce drugs to private and public sector.

CHAPTER 7: IMPLEMENTATION AND RESPONSIBILITIES

The Implementation of the National PrEP and Condom Strategy

The National PrEP and Condom Strategy will be implemented in partnership with several stakeholders ranging from the Government, NGOs, Private Sector, and International Agencies. Public and private partnership principles will be employed in the execution of the strategy to enhance program efficiency and effectiveness.

7.1. The Role of the Stakeholders in the Implementation Strategy

The role of MOHME: The Ministry of Health and Medical Education has the overall responsibility for the management and coordination of strategic PrEP and condom activities across all areas of implementation; from forecasting, procurement, standardization of service delivery to monitoring and evaluation.

1. The National level coordinating mechanism(s) will be strengthened to coordinate the multi-sectoral response to condom programming, and this activity will be replicated at the provincial level.
2. Through the PrEP and Condom Technical Group, SIP, and the CDC Department, MOHME will handle all policy and program issues that relate to the PrEP and male condoms, including ensuring availability of the right quantities and quality of PrEP drugs and condoms in the country.
3. The National the PrEP and Condom Technical Group will provide a platform for all partners from the public, civil society, and private sector for in-depth discussions on PrEP and condom programming, provide operational and technical advice that presents issues of policy and strategic nature, to the mentioned technical working groups, for consensus and clearance.
4. Provide multi-sectoral oversight on program implementation, by multi-sectoral partners including line ministries and Research Deputy, to ensure achievement of set targets in the NSP.
5. Participate in mobilizing resources including funds for procurement and distribution of needed PrEP drugs and Condoms to facilitate implementation of combination HIV prevention interventions.

The role of the Iranian Research Center for HIV/AIDS (IRCHA):

1. Provide a platform for sharing outcomes from research and strategy implementation including at the Joint annual AIDS review sessions.
2. Conducting applied research related to the goals of the NSP of the HIV/AIDS and PrEP and Condom Program.

Deputy Minister of Medicine and Food of MOHME

The Deputy Minister of Medicine and Food of MOHME sets and enforces manufacturing and testing standards in line with WHO/UNFPA/ISO requirements for all PrEP drugs and

condoms produced in the country. It will also be facilitated to conduct post-market surveillance to ensure Drug and condom quality at user pick points.

The role of the Social Marketing Organizations

1. Create and promote brands, promote and create demand for the male condoms for the key population with considering sensitivities of the Iranian community. They will ensure the availability of private sector condoms, responding to the generated demand in sub-sectors of the key populations.
2. Maintaining high levels of social marketing condom stocks, at various types of retail outlets for key populations, through consistent distribution at affordable consumer prices.
3. Motivating the private sector's involvement in condom distribution and promotion by providing adequate profits for wholesalers and retailers and establishing partnerships for procurement, distribution, sales, and advertising for key populations.
4. Assisting government in marketing, distribution, and promotion of public sector free condoms, particularly for key populations, as well as building local capacity for social marketing in the country.
5. The government will continue supporting the Social Marketing Organizations initiatives through the provision of technical support, sharing of best practices, and including social marketing organizations in the National Technical Working Group for PrEP and Condom Programming.

Role of the Commercial Sector

The commercial sector, including brand holders, pharmacies, supermarkets, and other commercial outlets, will increase the availability and distribution of condoms and expand coverage in urban and rural areas for key populations. All private sector condoms must be tested for quality. Commercial sector partners will support market analysis and segmentation efforts and adequately provide condoms to cover their market share. This will include installment and replenishment of condom vending machines, promotion of condom uses for key populations as a lifestyle and specifically for the brands. Public, and private sector partnerships should be strengthened.

Other line Ministries

Relevant organizations and ministries also support the strategic condom plan in the framework of the 5th NSP of HIV/AIDS control. The most important related organizations are the Prisons Organization, the Welfare Organization, and the Ministry of the Interior.

The role United Nations Agencies

Various United Nations Agencies cooperate with MOHME of Iran in connection with the HIV/AIDS program, and the most important role is played by the UNAIDS, and this project is carried out with the technical and financial support of UNAIDS. Various agencies need to provide their support in full coordination with UNAIDS and the CDC Office of MOHME.

1. These will be guided by the 5th NSP, PrEP and Condom Programming Strategy and National procurement and supply Plan, to inform their contribution towards procurement and supply of both male condoms, PrEP, drugs and provision of support for the implementation of the PrEP and Condom program.
2. United Nations Agencies and development partners will engage with the government to develop a transition plan from external to domestic financing of the PrEP and condom program.
3. Implementing Partners supported by United Nations Agencies, operating at regional and provincial levels will provide support and carry out activities for advocacy, PrEP, and condom promotion, education and distribution at the community levels, in close collaboration with the provincial Health office.

7.2. Prerequisites for implementing a strategic PrEP and condom program

- Implementation of the PrEP and Condom Program should begin with a meeting to officially launch the program. This meeting should involve political, health, and related organizations officials. This may be an event with media coverage and IEC activities.
- A senior officer, such as the Deputy of health, or provincial health official, should lead the meeting. This official should announce the official start of the *PrEP and Condom Program*, citing the benefits of the program and reminding the owners and managers of entertainment establishments of the consequences of not cooperating with the program.
- STI services should be strengthened to support the program by providing treatment, counseling, and education to key populations and their clients. STI clinics may need to be reinforced with additional staff, equipment, and drugs. Clinical training and counseling courses may be needed to upgrade staff skills. Standard medical forms should be introduced to simplify case reporting. Further training in analysis and reporting may also be needed for selected staff.
- The main source of information for monitoring and evaluation will be the information system set up by the PrEP and Condom Technical Group.
- A monitoring committee should be formed at the national and provincial levels. Members should include national and local leaders, public health officials, representatives of related organizations, and health workers. The committee should supervise the implementation of the program, make regular site visits to entertainment establishments, follow up on compliance, organize outreach educational activities. The monitoring committee should meet regularly to review program progress and to address any identified problems. They should report monthly to the provincial governor or another appropriate authority.
- Investments in condom programming should aim to increase condom use equitably and sustainably among at-risk groups to reduce HIV and STI incidence. Programs should achieve increases inconsistent condom use in high-risk partnerships. While increases in condom availability and motivation to use condoms are important intermediate outcomes, investments should result in increased condom use.
- Evaluation: The goal of the PrEP and Condom Program, is to prevent the sexual transmission of HIV among key populations and their clients, resulting in further

prevention of HIV infection in the general population. The objective of the program is to enforce condom use in any sexual intercourse and also use PrEP drugs by the target group. Evaluation of the PrEP and Condom Program focuses on four indicators:

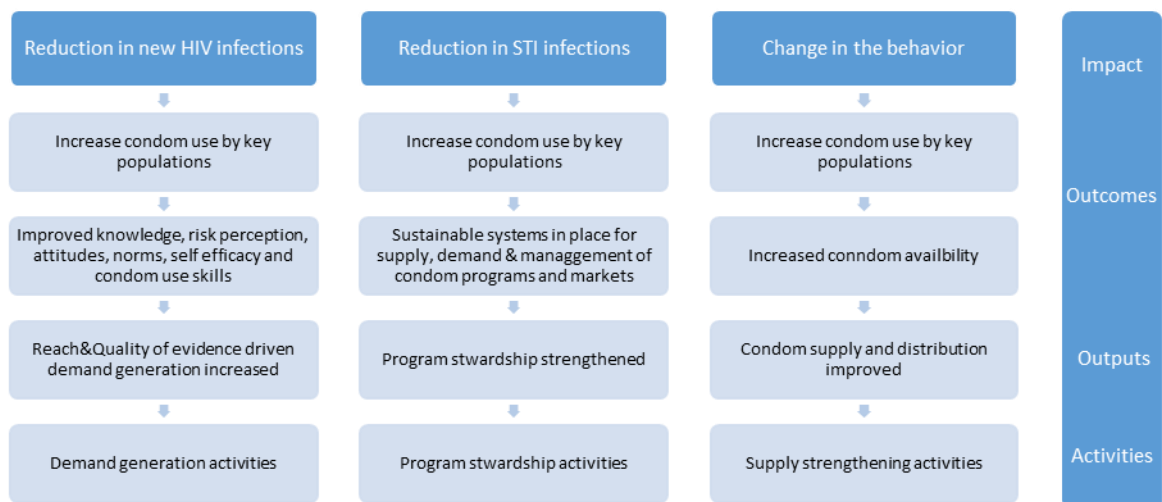
- condom use;
- Using PrEP Drugs;
- incidence of STI among SWs; and
- behavioral change

7.3. Monitoring and Evaluation (M&E)

A strong strategic program is critical for the monitoring for management, and evaluation of PrEP and condom interventions. Data should provide feedback on the impact of interventions on PrEP and condom use and the factors that influence PrEP and condom use.

We used a Results Framework that reflects the PrEP and Condom Program Pathway. Figure 7.1 provides the structure for a Results Framework in which activities (grouped by broad intervention areas: program stewardship, demand, and supply) lead to outputs, which lead to lower-level outcomes (factors that influence PrEP and condom use), which in turn lead to higher-level outcomes (changes in and PrEP condom use in key populations) and health impact.

Figure 7.1. National Condom Strategy- Model Results Framework



The categories, indicators, and recommended data collection tools are presented in Table 7.3.1.

Table 7.3.1. The categories, indicators, and recommended data collection tools

Higher level outcomes		
Category	Indicators	Data Collection Tools
<p>Condom Use</p> <p>Increased PrEP uptake</p>	<ul style="list-style-type: none"> - Percentage of key populations who use a condom at the last high risk sex, separately - Percentage of key populations engaged in high risk sex reporting consistent condom use - Percentage of adults who use PrEP 	<p>DHS</p> <p>Bio-behavioral Surveys (BBS) for KPs</p> <p>Other quantitative population-based surveys (It is critical for programs to collect these data more frequently than every five years.)</p>
Lower level outcomes		
<p>Program Stewardship</p>	<p>The monitoring objective at this category is to measure the effectiveness and sustainability of program stewardship efforts (leadership & coordination; planning & forecasting; favorable policy environment).</p> <p>Sustained execution of the national condom strategy with active participation of all actors in the condom ecosystem is the most basic measure of the effectiveness of program stewardship.</p> <p>Effective program stewardship should also lead to greater sustainability as measured by the decreasing dependence on non-domestic funding for PrEP and condom programming and decreasing commodity subsidy in the condom market.</p> <p>The following indicators measuring the components of program stewardship are considered at the output level:</p> <p>Leadership & Coordination:</p> <ul style="list-style-type: none"> • Presence of an active technical working group coordinating PrEP and condom programming separately with supporting initiatives linked to the NSP • % of stakeholders who value participation in coordination mechanisms and contribute actively • Condom needs estimates and targets updated in the past 12 months, reflecting latest data on use and supply levels; forecasting adjusted as needed <p>Program Analytics:</p> <ul style="list-style-type: none"> • Existence of a nation-level strategic information plan supported by stakeholders with data collated and reviewed on a regular basis • Total market analysis conducted in last 3 years and regularly updated with relevant data • Identified studies supporting program management are conducted and inform programmatic decisions 	<ul style="list-style-type: none"> • Programmatic reports • Verification by existence of plans, policies, regulations • Other document review • Stakeholder survey to assess perceived value of stewardship

	<p>Policies & Regulation:</p> <ul style="list-style-type: none"> • Policies in place that enable programs to reach priority populations • Presence of government regulatory, and quality assurance policies that create an even playing field for all sectors, and are not excessively inhibitive 	
Demand	<p>Programs will track factors associated with condom use, HIV-related knowledge, risk perception, attitudes, social norms, self-efficacy and condom use skills. Data will be disaggregated by priority audience, which will likely include age, geography, wealth, etc.</p> <p>Sample indicators:</p> <ul style="list-style-type: none"> - Percentage of adults who know that HIV can be prevented by using condoms - % of target population who feel confident negotiating condom use with a partner - % of target population who perceive themselves to be at risk of HIV - % of target population who have comprehensive knowledge of HIV prevention <p>The monitoring objective in this category is to measure changes in factors that are associated with condom use in a particular group (ideally also measuring whether changes are attributable to condom program interventions)</p> <ul style="list-style-type: none"> - Increased adherence for PrEP - Increased awareness about PrEP 	<p>Factors associated with condom use in a particular context can be identified through the studies outlined under 'Condom Use' above and through qualitative methods</p>
Supply	<p>In this category, M&E will aim to measure both physical availability and the target audience's perceptions of availability.</p> <p>Sample indicators:</p> <ul style="list-style-type: none"> • Perceived availability: % of target population that report condoms are available "where and when I need them" • Coverage: % of appropriate outlets (i.e., delivery points across sectors) that carry condoms (does not need to be 100%, but should be high enough to remove access as a barrier to condom use; where users and non-users of condoms perceive the same level of availability, consider whether coverage may already be sufficient) • Coverage: Proportion of health facilities stocked out of condoms • Coverage: The proportion of target areas meeting established coverage standards (e.g., x number of condom-selling outlets per X number of households) • Distribution: Total number of condoms distributed in the past 12 months (often tracked at output level) 	<p>Perceived Availability</p> <ul style="list-style-type: none"> • Tools cited in Condom Use section above. <p>Coverage</p> <ul style="list-style-type: none"> • Outlet surveys, retail audits • Program records (data reported from public, social marketing and private sectors should be aggregated)

Annex 1: Condom Program Operational Plan

Description of priorities	Key annual outputs				
	2022	2023	2024	2025	2026
Objective 1: To establish Functional Capacity for Condom Program Management for key populations in 50% of the related organizations by 2026					
Strategy 1: Strengthening Leadership and Coordination structures at all levels					
1.1.1: Coordination and Program Governance	Creating Condom Technical Group	Condom Technical Group's 2-yr Priority Action Plan (2023/24) detailing program outputs, outcome targets and partner accountability framework developed	Condom mid-term review report compiled defining revised targets	The condom program review report is reviewed and approved by the SIP	The condom program review report in place
			Annual stakeholder validated Comprehensive Condom Programming review report in place	Condom Technical Group's 2-yr Priority Action Plan (2025/26) detailing program outputs, outcome targets and partner accountability framework developed	
		comprehensive condom programming integrated in 10% of the related organizations	comprehensive condom programming integrated in 20% of the related organizations	comprehensive condom programming integrated in 30% of the related organizations	comprehensive condom programming integrated in 50% of the related organizations
	Minimum functional capacity for provincial Condom Programming defined	10% of provinces especially those covering hotspots supported to establish minimum capacity for	20% of provinces especially those covering hotspots supported to establish minimum capacity for	30% of provinces especially those covering hotspots supported to establish minimum capacity for	50% of provinces especially those covering hotspots supported to establish minimum capacity for

		Condom Programming	Condom Programming	Condom Programming	Condom Programming
1.1.2: Strengthen Policies and Regulations	5 th NSP 2019/2023 features condom as a priority primary prevention intervention for key populations			Health sector budget earmarks funds for procurement of free to user condoms for the most key populations	Stakeholder agreed new generation National Condom Programming strategy in place
	highest level policy-makers within Gol agreed, MoH endorsed National Condom Programming in place				NSP for HIV control 2025/2029 features condom as a priority primary prevention intervention
	National Condom needs assessment conducted				
Strategy 2: Facilitate National Condom Program Support System for the key population (In the context of the SIP Committee)					
1.2.1: Deepen advocacy for the national condom program for key populations		Condom programming advocacy action plan developed		MOHME build partnerships through networking with all public and private sector stakeholders to support condom planning	
	The use of the Total Market Approach for condom programming has been approved by the MOHME				
	Media capacity engagement drafted (with considering sensitivities)	Capacity of 200 activists from the governmental media houses in condom promotion and education for key	Capacity of 200 activists from the governmental media houses in condom promotion and education for key		

		populations built	populations built		
1.2.2: Strengthen capacity for related organizations	Condom Programming Partner Accountability Framework drafted	Strategy for capacity building of the various condom programming players at national and provincial level and standardized training materials in place	Condom program players in 50% of the provinces oriented	Condom program players in all of the provinces oriented	
	At least one NGO contracted to run a condom programming campaign for key populations	Designated and functional condom focal points at 20% of the provinces	Designated and functional condom focal points at 50% of the provinces	Designated and functional condom focal points at 80% of the provinces	Designated and functional condom focal points at 100% of the provinces
	Condom reporting tool for HIV Implementing Partners and non-health sector partners drafted	At least 150 players oriented with developed tools & 10% of provinces mentored and supported to run a province-led condom program	30% of provinces mentored and supported to run a condom program	40% of provinces mentored and supported to run a condom program	50% of provinces mentored and supported to run a condom program
1.2.3: Strengthen the national condom performance monitoring	10 NGOs and Civil Society Organizations contracted to run a condom programming campaign		Annual condom program review meetings at the national and provincial levels to evaluate the annual performance of the condom program held		
		Training for province focal point persons in 20% provinces	Training for province focal point persons in 50% provinces		
		Condom sentinel sites established for		Condom sentinel sites established for	

		key populations in 50 hotspot urban centers		key populations in 50 more hotspot urban centers	
Strategy 3: Strengthen Supply Chain and Commodity Security					
1.3.1: Effective Quantification and Forecasting	Annual MOHME interdepartmental forecasting and quantification conducted	Annual MOHME interdepartmental forecasting and quantification conducted	Annual MOHME interdepartmental forecasting and quantification conducted	Annual MOHME interdepartmental forecasting and quantification conducted	Annual MOHME interdepartmental forecasting and quantification conducted
	10 national level partners trained on the use of the condom quantification methodology	Build capacity for quantification at province and health facility levels in 10% provinces	Build capacity for quantification at province and health facility levels in 20% provinces	Build capacity for quantification at province and health facility levels in 40% provinces	Build capacity for quantification at province and health facility levels in 50% provinces
		The "Quantification and Procurement Planning" unit for quantification in the provinces and at the national level facilities established.			
1.3.2: Increase condom storage capacity and improve storage efficiency	At least one post market surveillance exercise in the national level drafted and conducted	At least one relevant Drug management staff member in each province has been trained to regularly monitor post-market condoms			
		At least one post market surveillance Exercises conducted and reports delivered to the National Condom Technical Group	At least one post market surveillance Exercises conducted and reports delivered to the National Condom Technical Group	At least one post market surveillance Exercises conducted and reports delivered to the National Condom Technical Group	At least one post market surveillance Exercises conducted and reports delivered to the National Condom Technical Group
	Regular and continuous	Regular and continuous	Regular and continuous	Regular and continuous	Regular and continuous

	"Instant Checks" of condom quality, storage and warehousing at national and regional level	"Instant Checks" of condom quality, storage and warehousing at national and regional level	"Instant Checks" of condom quality, storage and warehousing at national and regional level	"Instant Checks" of condom quality, storage and warehousing at national and regional level	"Instant Checks" of condom quality, storage and warehousing at national and regional level
1.3.3: Implement the condom distribution plan	Advocacy for special handling of the condom in implementation of the One Warehouse One Health Facility Policy conducted	Reviewed National Condom Distribution Plan aligned to the One Warehouse One Health Facility policy in place	conduct an assessment of social marketing on condom availability for key populations in hard to reach areas	The final impact analysis of condom programs such as social marketing of condoms was done through new routes and additional costs.	National Condom Distribution Plan revised
	At least one innovation exploiting new outlets on condom distribution with the private sector developed and implemented	Coverage of new outlet targeted condom distribution innovations expanded to 10% of provinces	Coverage of new outlet targeted condom distribution innovations expanded to 30% of provinces	Coverage of new outlet targeted condom distribution innovations expanded to 50% of provinces	Coverage of new outlet targeted condom distribution innovations expanded to 60% of provinces
	2% of key populations were covered by condoms through new outlets.	5% of key populations were covered by condoms through new outlets.	10% of key populations were covered by condoms through new outlets.	20% of key populations were covered by condoms through new outlets.	30% of key populations were covered by condoms through new outlets.
1.3.4: Creating variety in types of condoms to create the right of choose in customers	Condom distribution program control drafted.	At least one national and provincial condom distribution program control exercise has been performed.	At least one national and provincial condom distribution program control exercise has been performed.	At least one national and provincial condom distribution program control exercise has been performed.	At least one national and provincial condom distribution program control exercise has been performed.
	In 10% of public and private distribution outlets, condoms are purposefully distributed with the participation of NGOs.	In 30% of public and private distribution outlets, condoms are purposefully distributed with the participation of NGOs.	In 45% of public and private distribution outlets, condoms are purposefully distributed with the participation of NGOs.	In 60% of public and private distribution outlets, condoms are purposefully distributed with the participation of NGOs.	In 80% of public and private distribution outlets, condoms are purposefully distributed with the participation of NGOs.

1.3.5: Creating the Condom Logistics Management Information System (CLMIS)	CLMIS was Set up with appropriate indicators	Launch the CLIMS dashboard linked the custom health software available			
	CLMIS rolled out in 10% provinces	CLMIS rolled out in 30% provinces	CLMIS rolled out in 50% provinces	CLMIS rolled out in 80% provinces	CLMIS rolled out in 100% provinces
		capacity building in 10 % provinces for providers on the use of CLMIS	capacity building in 30 % provinces for providers on the use of CLMIS	capacity building in 50 % provinces for providers on the use of CLMIS	capacity building in 70 % provinces for providers on the use of CLMIS
Objective 2: To Increase Condom Use at last high risk sex for each of the key groups to 25% from a 2020 baseline by 2026					
Strategy 1: Increase Demand for Condoms in Key Populations and Remove Barriers to Access and Use					
2.1.1: More investment in demand-generation activities to ensure that the key populations have the knowledge, skills and ability to use condoms correctly and consistently. (Strengthening Advocacy)	National Condom Program defines targeted beneficiaries	A condom market segmentation study was conducted for key populations	Condom Distribution Programs (CDP) conducted		Second condom market segmentation study was conducted for key populations
	Various outlets employed to get free and discounted condoms to key populations	Stakeholder partner agreed market segmentation for free, social marketing and private sector in place to cover more key populations		Assessment on performance of the condom market following the support of commercial sector conducted	
		National mapping of community socio-economic coalitions, networks, groups and recreation facilities to exploit for condom program for key populations conducted			
2.1.2 Investing in communication	National Condom-Related	CRCG featuring key message concepts			

leads to changes in social behaviors associated with condom use by key populations	Communication Guide (CRCG) guidelines on HIV endorsed as a guide for Condom Program	cleared by government for all partners developed			
	Targeted condom promotion campaigns in partnership with NGOs reaching 10% of key populations	Targeted condom promotion campaigns in partnership with NGOs reaching 15% of key populations	Targeted condom promotion campaigns in partnership with NGOs reaching 20% of key populations	Targeted condom promotion campaigns in partnership with NGOs reaching 25% of key populations	Targeted condom promotion campaigns in partnership with NGOs reaching 30% of key populations
		Cultural, religious and other community gatekeepers sensitized on condoms in 10% provinces.	Cultural, religious and other community gatekeepers sensitized on condoms in 20% provinces.	Cultural, religious and other community gatekeepers sensitized on condoms in 30% provinces.	Cultural, religious and other community gatekeepers sensitized on condoms in 50% provinces.
		Formative survey on the uptake of condoms by the target key populations conducted	Condom use at last high risk increase by 15%		Condom use survey conducted among priority target beneficiaries
2.1.3: Build capacity of service providers for male condom quality service provision	Condom training service provider mapping tool developed	trainings for condom distributors (all sectors) conducted in 30% provinces	trainings for condom distributors (all sectors) conducted in 50% provinces	trainings for condom distributors (all sectors) conducted in 70% provinces	trainings for condom distributors (all sectors) conducted in 100% provinces
	10% of trained condom distributors equipped with demonstration tools and job aids	30% of trained condom distributors equipped with demonstration tools and job aids	50% of trained condom distributors equipped with demonstration tools and job aids	70% of trained condom distributors equipped with demonstration tools and job aids	100% of trained condom distributors equipped with demonstration tools and job aids
Objective 3: To increase access and availability of free male condoms for each of key populations through public channels to 50% from a 2020 baseline by 2026					
Strategy 1: Increasing Access to Male Condoms					
3.1.1 Strategically expand condom distribution through the public, social marketing organization/N	At least 5 local NGOs and CBOs trained on condom demand generation for key populations	At least 10 local NGOs and CBOs trained on condom demand generation for key populations	At least 15 local NGOs and CBOs trained on condom demand generation for key populations	At least 20 local NGOs and CBOs trained on condom demand generation for key populations	At least 30 local NGOs and CBOs trained on condom demand generation for key populations

GO, and commercial sectors	At least 20 new condom providing service delivery points were set up nationwide.	At least 40 new condom providing service delivery points were set up nationwide.	At least 80 new condom providing service delivery points were set up nationwide.	At least 150 new condom providing service delivery points were set up nationwide.	At least 200 new condom providing service delivery points were set up nationwide.
Strategy 2: Improving Utilization of Male Condoms					
3.2.1 Measures to increase the use of condoms in the conditions in which access is provided	Condom quality improvement strategies were designed for key populations.	Quarterly condom post-market surveillance was done	Coordination with condom manufacturers was done to package public sector condoms in a way that would be more appealing to users.		
Strategy 3: Grow the Market Size					
3.3.1 Strengthen social marketing brand management and sustainability	At least 2 social marketing firms sustain business in the country	Condom social marketing priority plan for key populations and resource mobilization proposal presented to government and partners	Condom-related social marketing organizations support at least 2 social media brands from partners/ government		
	At least 4 Social marketing brands on the market	At least 2 social market brands adopted hybrid models and developed cost-effective alternative distribution channels for key populations with poor social and economic status		At least 2 Social marketing brands transitioned to full recovery	
	Socially marketed brands market for key populations share at 10%	Socially marketed brands market for key populations share at 15%	Socially marketed brands market for key populations share at 20%	Socially marketed brands market for key populations share at 25%	Socially marketed brands market for key populations share at 30%
3.3.2 Achieve the right size of free condom market	Targeted HIV programming for key populations utilized to	Condom market segmentation study conducted		Condom market audit conducted to assess	

	distribute free condoms			effectiveness and efficiency	
		Channels and targets for distribution of condoms to reach key populations developed and agreed with partners			
3.3.3 Creating a favorable environment for the growth of the commercial sector in the condom market	Private sector condom partners engaged on the 5 th NSP platform	conduct an assessment of the private condom sector brands		Public condom campaign programs promote free, socially marketed and private sector condoms for key populations	
		Targets for private sector partners for condom distribution for key populations in designated markets set and agreed	Private sector condom messaging promoting condom as a lifestyle for key populations discussed and cleared by government	Private sector condom messaging promoting condom as a lifestyle for key populations discussed and cleared by government	Private sector condom messaging promoting condom as a lifestyle for key populations discussed and cleared by government
	Private sector condom dispenser coverage for key populations in designated market segment at 1%	Private sector condom dispenser coverage for key populations in designated market segment at 5%	Private sector condom dispenser coverage for key populations in designated market segment at 10%	Private sector condom dispenser coverage for key populations in designated market segment at 20%	Private sector condom dispenser coverage for key populations in designated market segment at 40%

Annex 2: PrEP Program Operational Plan

Description of priorities	Key annual outputs				
	2022	2023	2024	2025	2026
Objective 1: To achieve high scale of PrEP coverage for all target groups from a 2020 baseline of almost zero percent by 2026					
Strategy 1: Improve supply chain management to provide and distributed oral PrEP in sufficient quantity to meet projected demand by appropriate delivery platform					
1.1.1: Coordination and Program Governance	Creating PrEP Technical Group	PrEP Technical Group's 2-yr Priority Action Plan (2023/24) detailing program outputs, outcome targets and partner accountability framework developed	PrEP mid-term review report compiled defining revised targets	The PrEP program review report is reviewed and approved by the SIP	The PrEP program review report in place
	Minimum functional capacity for provincial PrEP Programming defined	10% of provinces especially those covering hotspots supported to establish minimum capacity for PrEP Programming	20% of provinces especially those covering hotspots supported to establish minimum capacity for PrEP Programming	30% of provinces especially those covering hotspots supported to establish minimum capacity for PrEP Programming	50% of provinces especially those covering hotspots supported to establish minimum capacity for PrEP Programming
1.1.2: Advocacy and education to create political will to engage policymakers	5 th NSP 2019/2023 features PrEP as a priority primary prevention intervention for key populations			The Health sector budget earmarks funds for procurement of free to user PrEP for the most key populations	Stakeholder agreed on new generation National PrEP Programming strategy in place
	highest level policy-makers within GoI agreed, MoH endorsed National PrEP Programming in place				NSP for HIV control 2025/2029 features PrEP as a priority primary prevention intervention
	National PrEP needs assessment conducted				

1.1.3: Strengthen the national PrEP performance monitoring	10 NGOs and Civil Society Organizations contracted to run a PrEP programming campaign		Annual PrEP program review meetings at the national and provincial levels to evaluate the annual performance of the PrEP program held.		
		Training for province focal point persons in 20% of provinces	Training for province focal point persons in 50% of provinces		
		PrEP sentinel sites established for key populations in 50 hotspot urban centers		PrEP sentinel sites established for key populations in 50 more hotspot urban centers	
1.1.4: Effective Quantification and Forecasting	Annual MOHME forecasting and quantification conducted	Annual MOHME forecasting and quantification conducted	Annual MOHME forecasting and quantification conducted	Annual MOHME forecasting and quantification conducted	Annual MOHME forecasting and quantification conducted
	10 national-level partners trained on the use of the PrEP quantification methodology	Build capacity for quantification at province and health facility levels in 10% of provinces	Build capacity for quantification at province and health facility levels in 20% of provinces	Build capacity for quantification at province and health facility levels in 40% of provinces	Build capacity for quantification at province and health facility levels in 50% of provinces
		The "Quantification and Procurement Planning" unit for quantification in the provinces and at the national level facilities established.			
1.1.5: Implement the PrEP distribution plan	Advocacy for special handling of the PrEP conducted		conduct an assessment of social marketing on PrEP	The final impact analysis of PrEP programs such as social	National PrEP Distribution Plan revised

			availability for key populations in hard to reach areas	marketing of PrEP was done through new routes and additional costs.	
	At least one innovation exploiting new outlets on PrEP distribution with the private sector developed and implemented	Coverage of new outlet targeted PrEP distribution innovations expanded to 10% of provinces	Coverage of new outlet targeted PrEP distribution innovations expanded to 30% of provinces	Coverage of new outlet targeted PrEP distribution innovations expanded to 50% of provinces	Coverage of new outlet targeted PrEP distribution innovations expanded to 60% of provinces
	2% of key populations were covered by PrEP through new outlets.	5% of key populations were covered by PrEP through new outlets.	10% of key populations were covered by PrEP through new outlets.	20% of key populations were covered by PrEP through new outlets.	30% of key populations were covered by PrEP through new outlets.
1.1.6: Using novel clinical approaches to improve PrEP supply chain	PrEP novel clinical methodologies drafted.	At least one national and provincial PrEP novel clinical methodologies exercise has been performed.	At least one national and provincial PrEP novel clinical methodologies exercise has been performed.	At least one national and provincial PrEP novel clinical methodologies exercise has been performed.	At least one national and provincial PrEP novel clinical methodologies exercise has been performed.
	In 10% of public and private provision outlets, PrEP is purposefully distributed with the participation of NGOs.	In 30% of public and private distribution outlets, PrEP is purposefully distributed with the participation of NGOs.	In 45% of public and private distribution outlets, PrEP is purposefully distributed with the participation of NGOs.	In 60% of public and private distribution outlets, PrEP is purposefully distributed with the participation of NGOs.	In 80% of public and private distribution outlets, PrEP is purposefully distributed with the participation of NGOs.
Strategy 2: Demand creation using culturally competent and linguistically appropriate approaches for PrEP and remove barriers to access and begin use					
1.2.1: More investment in demand-generation activities to ensure that the target populations have the knowledge and attitudes to use PrEP correctly and consistently.		PrEP programming advocacy action plan developed		MOHME build partnerships through networking with all public and private sector stakeholders to support PrEP planning	
	The use of the Total Market Approach for PrEP programming				

(Strengthening Advocacy)	has been approved by the MOHME				
	Media capacity engagement drafted	The Capacity of 50 activists from the governmental media houses in PrEP promotion and education for key populations built	Capacity of 50 activists from the governmental media houses in PrEP promotion and education for key populations built		
1.2.2 Highly targeted interpersonal communication leads to changes in social behaviors associated with PrEP use by target populations	National PrEP-Related Communication Guide (PRCG) guidelines on HIV endorsed as a guide for PrEP Program	PRCG featuring key message concepts cleared by the government for all partners developed			
	Targeted PrEP promotion campaigns in partnership with NGOs reaching 10% of key populations	Targeted PrEP promotion campaigns in partnership with NGOs reaching 15% of key populations	Targeted PrEP promotion campaigns in partnership with NGOs reaching 20% of key populations	Targeted PrEP promotion campaigns in partnership with NGOs reaching 25% of key populations	Targeted PrEP promotion campaigns in partnership with NGOs reaching 30% of key populations
		Cultural, religious and other community gatekeepers sensitized on PrEP in 10% of provinces.	Cultural, religious and other community gatekeepers sensitized on PrEP in 20% of provinces.	Cultural, religious and other community gatekeepers sensitized on PrEP in 30% of provinces.	Cultural, religious and other community gatekeepers sensitized on PrEP in 50% of provinces.
		Formative survey on the uptake of PrEP by the target key populations conducted	PrEP use increase by 15%		PrEP use survey conducted among priority target beneficiaries
Objective 2: To increase adherence and continued use of PrEP, from a 2020 baseline of almost zero percent by 2026					
Strategy 1: Increasing the providers' knowledge, attitudes, practices, and behaviors with regards to oral PrEP delivery.					
2.1.1: Build capacity of service providers for PrEP quality	PrEP training service provider mapping tool developed	Trainings for PrEP providers (all sectors) conducted in 30% of provinces	trainings for PrEP Providers (all sectors) conducted in 50% provinces	trainings for PrEP Providers (all sectors) conducted in 70% provinces	trainings for PrEP Providers (all sectors) conducted in 100% provinces

service provision	10% of trained PrEP Providers equipped with demonstration tools and job aids	30% of trained PrEP Providers equipped with demonstration tools and job aids	50% of trained PrEP Providers equipped with demonstration tools and job aids	70% of trained PrEP Providers equipped with demonstration tools and job aids	100% of trained PrEP Providers equipped with demonstration tools and job aids
Strategy 2: Scale-up uptake, adherence, and retention of oral PrEP for target populations for effective use and monitoring					
2.2.1 Measures to increase the use of PrEP in the conditions in which access is provided	PrEP quality improvement strategies were designed for key populations.	Quarterly PrEP post-market surveillance was done	Coordination with PrEP manufacturers was done to package PrEP in a way that would be more appealing to users.		
2.2.2 Strengthen social marketing brand management and sustainability	At least 2 social marketing firms sustain business in the country	PrEP social marketing priority plan for key populations and resource mobilization proposal presented to government and partners	PrEP-related social marketing organizations support at least 2 social media items from partners/ government		
	Socially marketed brands market for key populations share at 10%	Socially marketed brands market for key populations share at 15%	Socially marketed brands market for key populations share at 20%	Socially marketed brands market for key populations share at 25%	Socially marketed brands market for key populations share at 30%