Journal of Iranian Medical Council, Volume 9, Issue no. 4
http://dx.doi.org/10.18502/jimc.v9i4.22476

Letter to Editor

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Establishing Positive Clubs to Provide HIV-Related Care to People Living with HIV (PLWH): Two Decades of Iranian Experience

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Dear editor

HIV care in Iran has evolved over the past two decades through the combined efforts of Voluntary Counselling and Testing (VCT) centers and Positive Clubs (PCs). Currently, there are 116 VCT centers and 38 PCs across the country, serving approximately 6,000 of the 24,000 diagnosed people living with HIV (PLWH) in PCs (1,2).

PCs were first established in 2004 in Tehran and Kermanshah and later expanded nationwide. Their foundation was encouraged by the United Nations, and they were recognized with the UN Red Ribbon Award for community leadership in 2012, 2014, and 2016 (2). Initially designed to provide psychosocial support, their mandate has progressively expanded to include empowerment of PLWH and families, life skills training, stigma reduction, and linkage to VCT services (3,4). In practice, they have also acted as a bridge to ensure continuity of care, including referral programs for individuals released from prison (5).

PCs in Iran have evolved through three stages. The first, from 2004 to 2016, involved establishment and expansion under the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), with technical guidance from UNAIDS and full financial support from GFATM. The second, the transition phase, transferred PCs to the Ministry of Health and medical universities, providing financial support while deciding whether clubs would remain or move elsewhere. The third, the stabilization phase, consolidated all PCs under the Welfare Organization to prevent overlapping activities, including those previously supervised by the Ministry, universities, or the Welfare Organization itself.

Perhaps the most notable contribution of PCs has been in promoting adherence to Antiretroviral Therapy (ART). Earlier studies estimated adherence rates in Iran at approximately 60% (6). More recent programmatic evaluations have suggested substantial improvements, with adherence reaching about 95%, accompanied by improved immunological outcomes such as higher CD4 counts. Subsequently, with increased adherence to treatment, the average CD4 level in Iran, which was about 300 *cells/µl*, has risen to about 700 *cells/µl* (4). While these indicators must be interpreted cautiously, they highlight the potential

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Received: 14 Jul 2025
Accepted: 18 Oct 2025

Citation to this article
SeyedAlinaghi SA, Mirzapour P, Jahanfar Sh. Establishing Positive Clubs to Provide HIV-Related Care to People Living with HIV (PLWH): Two Decades of Iranian Experience. *J Iran Med Counc.* 2026;9(4):1033-34.

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of community-based interventions in strengthening long-term treatment outcomes.

In recent years, the role of PCs has expanded further to address the needs of an aging HIV population. Alongside traditional support services, clubs now provide guidance and referral for non-communicable comorbidities, including cardiovascular diseases, diabetes, cancers, and psychiatric conditions (1,4). This shift reflects a growing recognition that HIV care must adapt to broader health challenges faced by PLWH.

The Iranian experience illustrates how Positive Clubs, as community-based structures, can complement formal healthcare systems. Their ability to reduce stigma, promote empowerment, and improve adherence demonstrates replicability for other resource-limited settings (4).

PCs, developed in Iran, can be adapted for other developing countries given local context and strategies. By combining psychosocial support with empowerment and linkage to clinical services, they offer lessons for developing countries seeking to strengthen patient-centered HIV programs. Key challenges include ensuring their even distribution nationwide so all cities can access services and securing sufficient resources to provide necessary care. Addressing these issues is essential for effective implementation and maximizing the clubs' impact on community-based HIV support.

Ethical Approval

Not applicable.

Funding

No funding was received.

Conflict of Interest

The first author has been a manager of Tehran Positive Club for six years and one of the authors of the Positive Clubs protocol.

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