

**RAPID SITUATION ASSESSMENT (RSA)
OF
DRUG ABUSE IN IRAN
(1998-1999)**

**PREVENTION DEPARTMENT, STATE WELFARE ORGANIZATION,
MINISTRY OF HEALTH, I.R. OF IRAN**

AND

UNITED NATIONS INTERNATIONAL DRUG CONTROL PROGRAM

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Introduction

The Islamic Republic of Iran has a long history of combating drug abuse. Because of its geographical location, Iran is one of the major conduits for opium, morphine base and heroin of Afghani origin. A large proportion of opiates of Afghani origin passes through Iran and is destined to reach the lucrative market of Europe. Iran accounts for more than 85% of worldwide seizures of opium and more than 30% of worldwide seizures of heroin and morphine. Iran has also made huge financial investments in fortification of its more than 1000 kms long eastern border. Two thousand six hundred and sixty nine personnel of the law enforcement have lost their lives in the last 12 years in fighting drug trafficking and intercepting heavily armed drug caravans.

At the same time, Iran faces serious drug abuse problem in its populations. Recent studies conducted in Iran had implied grave dimensions of the drug problem in Iranian society. The common drugs of abuse in Iran were opium (*thariac*), opium residue (*shire* and *sukhte*), heroin and cannabis (*hashish*). Opium and opium residue had been traditionally smoked in opium pipes in old Persia and were still the major drugs of abuse in Iran.

Secondary data from treatment and rehabilitation centers also showed that three fourths of the attendees were opium users, which was also because of the referral system. Ten percent of outpatient treatment attendees reported drug injecting and the extent of drug injecting appears to be on the rise. Only 2% of the attendees in the outpatient treatment centers reported hashish as their problem drug. The extent of abuse of pharmaceutical agents such as codeine cough syrup or benzodiazepines was unknown.

Excessive opiate cultivation in Afghanistan (estimated half of the world's production) and its increased conduit through Iran would, by itself, sensitize high ranking policy makers. However, the inextricable negative consequences of migration, urbanization, unemployment, very young population, increase in crime and other social problems were all important warning signal about the potential of an outbreak of drug abuse and its health and other consequences in the country. The above facts and other studies on drug abuse recently conducted in Iran indicated the strong need for a comprehensive, national study on drug use. The

present Rapid situation Assessment (RSA) of drug abuse was the result of collaboration between the Government of Islamic Republic of Iran and United Nations International Drug Control Program (UNDCP) in this effort. The results of the study are expected to inform policy making, improve resource allocation in demand reduction and formulation of specific activities in drug abuse control.

Country Profile

Islamic Republic of Iran is located in southwest region of Asia with an area of 1,648,195 square kilometers. The Caspian Sea is located in its northern part and the Persian Gulf and Sea of Oman are in its south. The neighboring countries of Iran are Azarbayejan, Armenia and Turkmenistan in north, Turkey and Iraq in the west and Afghanistan and Pakistan in East. The 60 million population of the country is quite young with one half being under 19. The average growth rate of the population is about 1.5%. More than 60% of the population reside in urban areas. Over 99% of the population are Muslims, 91% being Shiee. The non-Muslim minority population includes Christians, Jews and Zorastrians. The common and official language of the country is Farsi (Persian), but other languages such as Turkish, Kurdish, Lori and Arabic are also being spoken by Turk, Kurd, Lor and Arab ethnic populations respectively.

Iran was ruled by a monarchy system till 1979 for more than 2500 years. The political system changed to the present Islamic Republic after the 1979 revolution under the leadership of late Imam Khomeini. The economy of Iran has been totally dependent on oil production and export for the past four decades. Under the current pressure of oil market, the economy is facing new challenges. In addition to oil production, agriculture, handicrafts, industry and trade are other bases of the economy of Iran. Of the 39.4% of the population over 15 years, who are economically active, 88% are male and 12% female. Of this population 44.5% work in public services sector, 30.7% in industrial sector and 22% in agricultural sector.

The indicators for health and education have improved dramatically during the recent years. Life expectancy rate at birth is 69 years. The infant mortality rate is 39 per 1000 live births. The adult literacy rate is 66.1% with 77.5% for men and 56.4% for women. While 97% of eligible children enter primary school, more than

90% complete primary education. According to the constitutional and other laws, nine years of free education is compulsory.

History of Drug Abuse in Iran and Drug Demand reduction activities in Iran

Drug abuse has a long history in Iran. The poppy plant has grown in the area and the pharmacological and psychotropic effects of opium were known for several thousand years. Although royal orders for restriction of drug use are documented as early as 400 years ago, the first legislation for banning drug abuse dates 90 years ago. Several consecutive legislations up to the present time have tried to restrict production and use of drugs. Iran had up to 33,000 hectares of poppy cultivation prior to the Islamic Revolution in 1979. After the Islamic Revolution (1979), opium poppy cultivation was banned and cultivation was totally eradicated by the end of 1980. Law enforcement activities to eradicate drugs became the dominant policy of the Government. The old system of providing cards to opium users was abolished during this time. Drug users were given 6 months time to ward off their habit and were allowed to avail coupons for opium tablets for a period of 2 ½ months to cut down the dosage. There were also provisions of treatment of opiate users with methadone and opium tablets. After this transitional period for about a year, all such public health services for drug treatment were closed for the next several years to come. Since then, the courts sent drug users either to the treatment and rehabilitation centers for mandatory detention and treatment or to prisons.

The recent history of intensified demand reduction activities in Iran started in 1994 with the development of out-patient treatment centers in all provinces of the country, employing specialists, designing prevention programs for the provinces, supporting development of Narcotic Anonymous and other self-help groups and publication of educational films and books (vide Draft Five year Demand Reduction Strategy of the Government 1998). The current amendment of the law, although considers drug use as a crime, allows drug users to seek treatment from Government licensed treatment centers. The treatment seeking drug users are also exempt from penal action as long as they seek treatment.

Despite all these efforts, it is reported that the phenomenon of drug abuse has increased in the recent years. One of the Government's estimation indicates that there are 1.2 million drug users in the country.

Existing Demand Reduction infrastructure and activities:

The following institutions and organizations were involved in the field of demand reduction activities in Iran:

Drug Control Headquarters: The president of the Islamic Republic of Iran heads this council and Ministers of Interior, Intelligence, Health, Islamic Guidance and Education are the members of this council. Other members are The Attorney General, Commander of Disciplinary Forces, Commander of National Forces of Volunteers (Basij), head of the National Radio and Television (IRIB), head of the Prisons and the head of Revolutionary Court of Tehran. The drug control headquarter was the nodal and coordinating agency in all drug control related matters in Iran including demand reduction and public awareness.

Treatment and Rehabilitation Center: The Prevention department of the State Social Welfare (under the Ministry of Health) were running the treatment and rehabilitation centers. There are 12 such centers in the country with one center especially for women. Twenty five to thirty thousand drug users had been referred to these centers for treatment in the recent years. Ninety percent of the admissions to these centers are by court order. The average duration of mandatory stay is 2 months. These centers had prison like infrastructure with basic facilities for health care, sports, counseling and psychosocial services and better facilities for work and vocational training. Often the centers were overcrowded upto three times their capacity with drug users. The State Social Welfare had recently decided to close down these centers. Currently therapeutic community model is being implemented.

Outpatient Treatment Center: Forty outpatient treatment centers had been established by the State welfare organization and were delivering drug treatment services for the last two years. Each province had one center and some districts like Tehran had more than one. Drug users seek treatment from these centers voluntarily and were often accompanied by their family members. The treatment

program consisted of medical detoxification (with clonidine, NSAIDs and phenothiazines or other tranquilizers). There are facilities for individual, group and family therapy. Often the drug users were referred to Narcotic Anonymous or self help groups after completion of the program.

Role of NGOs, private sector: No non-governmental organization or voluntary organization is yet involved in prevention, treatment and rehabilitation of drug abuse. Recently there have been a lot of interests among a few NGOs in drugs. The private sector had currently initiated delivering treatment services.

Narcotic Anonymous and Self-help groups: The Narcotic Anonymous (NA) and other self help groups currently operated in most provinces. The prevention department of Social welfare provided venues for meetings of NA and self-help groups. The activities of these groups were complementary to the drug treatment services.

Drug abuse prevention initiatives: Comprehensive community based prevention programs were being implemented by the State Welfare Organization, which was one of the organizations under the Ministry of Health. This program was first adopted in 1996 by the province of Kermanshah, and five other provinces namely Hormozgan, Kerman, Fars, Yazd and Mazandaran have consecutively adopted the program during the past two years. Based on the prevention program of these provinces, different preventive measures such as training the industrial and governmental managers, school teachers and parents were already in action. In addition to the comprehensive prevention program, the State Welfare Organization has introduced an awareness program with the objective of promotion of knowledge and attitude on drug abuse in the community. This program is supposed to start in other twenty two provinces of the country throughout the year of 1999. In recent years the National Radio and Television (IRIB) and the Ministry of Education have also become involved in prevention of drug abuse. Drug issues were often covered in print, radio and electronic media. The Government was also planning to start drug education as part of the curricula in high schools.

HIV prevention programs among drug users: There were limited HIV prevention programs among drug users in place. HIV outbreak was already reported to be a problem in the prison.

National Five year Program in demand reduction 1999-2003:

The Ministry of Health had also prepared a national five-year program in demand reduction, which had the following long term and sub objectives:

Long term objective: To reduce the demand for illicit narcotic drugs and psychotropic substances through prevention efforts and provision of treatment and rehabilitation facilities to drug abusers.

Sub objectives:

To reduce social acceptance of drug consumption

To reduce drug consumption by strengthening protective skills of individuals and groups

To reduce drug addiction by providing counseling and assistance to individuals at risk

To prevent misuse and illegal use of legal drugs

To provide treatment services to drug addicts

To provide after care and re-socialization services to treated drug addicts

To reduce health hazards associated with drug consumption (HI/AIDS, hepatitis B and C)

To reduce crime associated with drug abuse

The budget for implementation of the five year demand reduction strategy had a budget of 40 billion rials in the first year and the money will be procured from raising tax on cigarette sales.

Legislation and international treaties

Although the history of official campaigns against drug abuse in Iran dates back to a few hundred years ago, the first legislation in this regard was adopted in 1910. During the next decades, at least 10 other laws have been legislated, with an ever-increasing tendency towards stricter drug control and punitive measures.

The Anti - Narcotics Drug Law of the Islamic Republic of Iran, 1988 covers all aspects of drug control including production, cultivation, importing, exporting, possession, using, distribution, sale and running premises for the use of drugs. The law has provisions for offences for causing the escape of drug offenders, giving protection to them or destroying or concealing evidence.

The punishment for drug use/ dealing varies from paying fines, firing from government jobs, lashes, imprisonment and, in severe and repeated cases of drug trafficking, capital punishment. All form of drug abuse and possession of drug paraphernalia (such as opium pipes) is illegal in Iran.

A recent amendment of the law has decriminalized drug abuser who voluntarily enters into treatment or rehabilitation. The age of criminal responsibility is 16. The Revolutionary Courts dealt with all drug-related cases.

Iran is a signatory of the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971 and the Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988. Iran is a member of Interpol (ICPO) and the World Customs Organization (WCO).

In May, 1994, a Memorandum of Understanding (MOUs) was signed between the Governments of Iran, Pakistan and UNDCP agreeing co-operation in a number of drug control areas. Pakistan and Iran will sign a new Memorandum of Understanding aimed at co-operation in combating illicit trafficking and abuse of narcotic drugs and psychotropic substances.

Iran has signed memorandum of understanding (MOUs) in drug related matters with Turkey, Azerbaijan, Turkmenistan, India, Russia, Kuwait, Bangladesh, Afghanistan and Italy. Similar arrangements are in process with Saudi Arabia, the United Arab Emirates, Oman, Armenia and other CIS States. The arrangement with Afghanistan is currently non-operative. Iran is also one of the founder members of the Economic Cooperation Organization.

Objectives of the study

The major objectives of the present RSA study were:

To study the trends and patterns of drug abuse Iran

To study the changes in trends of patterns of drug abuse in Iran

To examine the adequacy of drug demand reduction responses that have already taken place in Iran

To examine what intervention activities are required in drug abuse prevention, treatment, relapse prevention, rehabilitation and prevention of health consequences of drug abuse.

This study examined the extent of drug abuse problem in Iran, socio-demographic characteristics of drug abusers, factors contributing to initiation of drug abuse, availability of drugs, patterns of abuse as well as probable changes in the patterns, probable factors behind changes in patterns of drug abuse, drug related and sexual risk behaviors of drug users, harmful health consequences of drug abuse, knowledge and attitude of drug abusers about consequences of drug abuse, drug abuse treatment seeking and identification of the resources already available for drug treatment. The study also explored the perceptions and opinions of key informants from law enforcement, judiciary and community.

Methodology

'Rapid situation assessment (RSA) methods can be compared to a physician's quick assessment of a patient's condition in a busy hospital emergency care section in order to arrive at a provisional diagnosis, to recommend further investigation and simultaneously to plan appropriate action' (ODCCP guideline on drug abuse rapid situation assessments and response, 1999). Drug abuse is a hidden and criminalized behavior and therefore traditional epidemiological survey techniques often lead to varying degrees of under reporting. RSA has the advantage of using both qualitative and quantitative research techniques and several categories of primary and secondary data and are ideally suited for conducting research among 'hidden' or marginalized populations. In addition, RSAs have lower costs, can be implemented rapidly and are intimately linked to intervention development.

The following methods were adopted for the present RSA study:

SECONDARY DATA COLLECTION AND ANALYSIS

All research activities start with systematic gathering of information and data (secondary data) that were already available. This activity helped in the formulation of precise research questions and contributed enormously to the design of the study. All types of secondary data, were classified region wise (by study region) and by time series (yearly).

Several types of secondary data that were examined were as follows:

Treatment and rehabilitation center data

Prison data

Court data

Outpatient treatment center data

Updated drug seizure data

Updated data related to drug related arrests

Policy documents including the new law

Study of the memorandum of understanding with international organization

Data on law enforcement casualties Narcotics HQ documents describing the details of border control activities, fortification etc.

Prevention education documents

National surveillance data on HIV/AIDS

Research publications

SELECTION OF THE STUDY AREA

Iran is divided into 28 provinces, which have large diversities in social, cultural and demographic characteristics of the population. To accommodate these factors in selecting the sites of the study, the whole country was divided into 10 blocks according to their common cultural and social characteristics and roughly having the same population of 6 million for each region. The major urban center from each of the region was thereafter selected as the site for the study. Table 1 shows the classification of regions and sites of the study.

DESIGN, SIZE AND SELECTION OF THE SAMPLE

One of the major approaches of RSA studies is to collect and examine data and information from multiple sources and multiple categories of key informants. The data gathered thereby is triangulated and reliability of the data is checked across multiple sources and multiple categories of key informants. In the present RSA study, drug users, members of their families and other categories of key informants were interviewed. The distribution of the numbers of drug abusers or family members of drug abusers and types and numbers of key informants interviewed for the study have been described in table 2.

Because of the above mentioned difficulties of recruiting drug users by a traditional random sampling method, drug abusers were recruited for the study from the following places in each site by the following innovative sampling strategy:

The selection method in treatment centers was based on inclusion of all newcomers attending the center during the period of the study

Drug abusers in prison: Recruitment was based on inclusion of all new inmates who were registered in the prison 30 days prior to the day of the study and going back one day at a time till the predetermined sample size of 50 from each site was reached.

Drug abusers in the streets: For drug abusers who were not in any kind of treatment, a snowball sampling strategy (chain referral) was implemented. Ex-drug using key informants who were part of the research team (and who were often recruited from the Narcotic Anonymous or other self help groups) introduced other current drug users (and they referring others) to the research team.

The idea of recruiting drug abusing respondents of similar sample size from all the three places (treatment center, prison, streets) of each site was to increase the representativeness of the sample. This was also the first time in Iran that drug users from the streets, who were not in contact with law enforcement and treatment agencies, were recruited for a research study. All data was stratified by places of recruitment and sites of the study.

For selection of family members of drug abusers, the first degree relatives or spouses of treatment seeking drug abusers (in treatment centers) were chosen. An important part of the study dealt with interviewing key informants. The key informants were selected among the responsible persons in different governmental sectors, directly involved in drug abuse control. The key informants were anti-narcotics headquarter personnel, directors of provincial anti-narcotics coordination committees, commanders and personnel of law enforcement, judges of revolutionary courts, directors and personnel of prisons, specialists at treatment centers and private practicing psychiatrists. A purposive sampling strategy (using the best judgement regarding who could be knowledgeable about the research questions) was adopted for recruiting key informants in the study.

METHODS AND INSTRUMENTS OF DATA COLLECTION

The following methods were used to collect primary data

Focus groups: Focus groups with drug using inmates at the prison and outpatient treatment center were conducted at each of the ten sites based on a prepared agenda.

Structured interviews of drug using respondents with the questionnaire: Drug using respondents were recruited for the above purpose from the prisons, outpatient treatment centers and from the streets. In addition, women drug users can also be recruited. The questionnaire was drafted based on the list of research questions. Each item of the questionnaire was discussed among the core team members and the second draft prepared. The questionnaire was then pre-tested among a group of drug using respondents in the treatment centers and thereafter finalized. At the beginning of the study there was some hesitation in the research team about whether respondents would answer the section on sexual behavior. So, the section on sexual behavior of the questionnaire was made optional. However, three-fourths of the respondents answered the section. This was also the first time that data on sexual behavior was collected.

In-depth interviews: In-depth interviews were conducted with drug users recruited from the streets and members of 5 families attending the outpatient treatment centers.

Key Informant interviews: Interviews with key informants were conducted using a semi-structured schedule for each category of key informants, which were prepared similarly as the structured questionnaire.

Ethnographic Observations: The field team has also been trained in ethnographic fieldwork. The field team with the help of ex or current drug using guides visited drug using venues, witnessed drug use in natural settings, observed the context of drug use and interviewed drug users by the methods mentioned above. The research teams also mapped the cities in terms of drug using venues.

Various instruments and methods of the study explored the following: socio-demographic characteristics of drug abusers, initiation and patterns of drug abuse and any changes in the patterns, expenditure on drugs, factors and behaviors related to IV drug abuse, history of drug abuse in the close family and friends of drug abusers, the response of the family to drug abuse, sexual behaviors of drug abusers, history of sexually transmitted diseases as well as medical complications of drug abuse, the level of information of drug abusers about negative consequences of drug abuse, history of crime, history of treatment trials, factors related to relapse, pattern availability of drugs, methods of drug smuggling and its probable changes, law enforcement activities, correctional programs, treatment facilities and public awareness programs, prevention and treatment programs, voluntarily treatment seeking, HIV/AIDS, drugs seized by law enforcement, crime and incarceration related to drug abuse, and human resource losses of the country combating drug abuse. The perspective of drug users' and opinions of policy makers and specialists on drug abuse were also simultaneously examined.

ETHICAL CONSIDERATIONS:

All recruitment for the study was done absolutely on a voluntary basis. Confidentiality was ensured and no names or identification information were recorded. Extreme care was taken to provide a private place of interview, particularly in the prison. Care was taken not to endanger the respondents because of participation or refusal in the study

IMPLEMENTATION OF THE STUDY

After completing the preliminary stages of the study, namely the process of designing the study, selection and preparation of appropriate instruments, selecting the sites of data collection, the research team of each region, was formed. The research team at each site comprised of the regional supervisor and appropriate number of interviewers and ex-drug using guides (a member of self-help group). The members of regional research teams were generally from social science background or were drug abuse treatment specialists, who were familiar with the research issues and had skills of communication with drug abusers.

Training in RSA: All members of regional research teams participated in training workshops for the RSA study in Tehran. The method of training was both didactic and participatory. There was detailed discussion on the methods and every item of all the instruments. During these discussions, clarifications were made and misunderstanding corrected. Role-plays, mock and real interviews, group work, presentation after the group work, interviews with drug users were used to make the training lively and participatory.

The contents of the training were as follows:

Magnitude and pattern of drug abuse in Iran, types of drug problem in Iran, basic concepts related to drug control (Supply, demand and harm reduction) and their interrelationships, details of drug treatment and rehabilitation, RSA methods in general – their advantages and limitations, objectives and goals of the present study, management aspects of the project along with the schedule for field work for each site, responsibilities of all members of the team, detailed discussion on each instrument / method of data collection (see the list of the instruments/guidelines developed for the study), recruitment of participants – methods, ethical issues, safety and security in the field

The training also consisted of training in ethnographic observations and actual hands on data gathering in the streets. Each team was divided into several groups for training in ethnographic fieldwork. Each team completed its preparation before actually going out into the field. Ex user guides were selected for each group. The city of Tehran was also mapped with the help of ex user guides in terms of drug using venues such as hashish selling areas, opium or

heroin using areas. Background information regarding the drug scene was collected. An appropriate timing for the fieldwork was also chosen. During this training, all the field investigators visited parks, drug selling neighborhoods and streets and were trained in contacting drug users, seek their cooperation in agreeing to be interviewed, safety and security, interviewing drug users and key informants and write field notes. These field notes were an additional source of qualitative data.

Qualitative (descriptive) data analysis workshop and training: The training lasted for a week with the core members of the national team who later actively participated in data analysis. The training consisted of didactic lectures on the theoretical underpinnings of qualitative data analysis, practical demonstration of some of the methods that would be applied to the data and several practice and data analysis sessions under supervision. Since all qualitative data had been collected in Farsi, it did not make sense to translate a large volume of data into English so that qualitative data analysis software could be used. All qualitative data analysis was done manually.

The following were the orientation and steps of qualitative data analysis training:

Theoretical framework of qualitative data analysis, induction, reliability, validity and generalizability, descriptions and their interpretations, indigenous typologies and sensitizing concepts (which the analyst brings into the data), strategies of analysis (case analysis, cross case analysis, content analysis, analysis of observational data, methods and steps in analysis (indexing, making photocopies of the raw data for coding and labeling, reading and re-reading of the data, getting the sense of the data, development of detailed code lists, labeling of the data, commenting on the data as analysis goes on, separating interpretations from descriptions, looking for indigenous typologies, seeking clarification of the data which can not be classified, finding emergent patterns and classificatory systems, cross checking across various data sources, linking data, look for additional data), cutting labels and preparing folders with headings – sometimes the same material goes to different folders, checking the inter-rater reliability in classification by discussion and group work, classification of the ethnographic (observational data) in modular format, re-classification based on further information from additional sources, identifying analyst's own preoccupations

Strategies of analysis of the quantitative (questionnaire) data: The code list for entering the structured data in the computer program was prepared. The computer entry was checked by randomly checking a proportion of the data to find out mistakes in the computer entry, cleaning of the data by looking at the frequency tables and going back to the questionnaire. The data was stratified according to sites (10 sites of the country from where data had been collected) and places of recruitment (prison, treatment center and street) from where drug users had been recruited for the study. The female respondent data was also separately analyzed. The Statistical Package for Social Sciences (SPSS) software was used.

The fieldwork was conducted during November and December 1998, under the direct supervision of the national research team.

LIMITATIONS OF THE STUDY

The study had the following shortcomings:

It did not figures of drug abuse prevalence, although estimation methods using secondary data will yield rough estimated figures

Ten major urban sites of the country were studied. It did not reveal the pattern drug abuse in the rural areas or other urban areas of the country.

Although care was taken to have a representative sample of drug users, the sample in this study was of unknown representativeness.

Results

Extent of Drug Abuse problem in Iran:

Three sets of secondary information were available and were used in estimation of the extent of drug abuse for Iran:

Estimation No.1 The following secondary data available for drug screening before marriages, government jobs and obtaining licenses was an indicator of prevalence of drug abuse among the general population in Iran. Such testing is

mandatory in Iran and analysis of the secondary data provided a window of opportunity to look at the prevalence of drug abuse. Most of the data shows that 1.3-2.1% of those screened were positive for opiates in the recent years. The data also showed a trend that as we pool more and more data (i.e. adding license testing data to marriage & job data or adding driving and other licensing data with marriage, jobs and licenses data) the proportion of positive opium tests increased. This probably showed that as we went on pooling data, we added selectively more adult males, thereby increasing the positivity rate. Data for opium tests before marriage would be more gender balanced than other data sets. The age or sex of the secondary data was not available and so the hypothesis could not be tested. However, those who were screened by this method were aware of the implication of a positive test and so chances of under estimation using this method would be high.

Table of secondary data showing positive opium tests in the last two years

<i>Category</i>	<i>Year 1376</i>		<i>Year 1377 (six months)</i>	
	<i>No. tested</i>	<i>% positive</i>	<i>No. tested</i>	<i>% positive</i>
Marriage & Govt. jobs	768525	1.3 (95%CI 1.30-1.36)	196549	1.2 (95%CI 1.23-1.33)
Marriage & Govt. jobs + Licenses for free trade	962284	1.5 (95% CI 1.48-1.53)	248276	1.4 (95% CI 1.41-1.50)
Marriage & Govt. jobs + Licenses for free trade + Licenses for driving and others	1101125	2 (95% CI 2.00-2.17)	320890	3.3 (95 % CI 3.3-3.4)

Estimation 2. One of the estimates of the Drug Control headquarters based on case enumeration techniques calculates the prevalence figures for drug abuse to be 1,200,000. Considering the population of Iran being 60,000,000, the prevalence figures with this method would be 2% .

Estimation 3. The method used in this estimation was the multiplication technique (ODCCP guidelines on Rapid Assessment of Drug Abuse and Responses). From the total number of respondents in the present RSA study we knew that

(described later) 24.2% of them had ever been (lifetime) in a treatment and rehabilitation center. The mean age of the sample was 33.6 years and the mean age at onset of drug abuse in the sample was 22.2 years which implied that the mean duration of drug use was 11 years on average roughly in the RSA sample. The total numbers of people in the treatment and rehabilitation center in the last 11 years (not updated) were 1,97,109. We know from the secondary data that about 10% of admissions in the treatment and rehabilitation centers were re-admissions. So the numbers of people excluding 10% in the treatment and rehabilitation centers would be 177398. Now we know that about one-fourth of our sample had been in a treatment center which corresponds to 177398. Multiplying this number with multiplier 4 gives us a figure of 709592. The prevalence figure of drug abuse assuming the population of Iran to be 60,000,000 was calculated to be 1.18% (95% CI 1.15-1.21)

However, all the above three estimation methods indicate that the prevalence figures for severe forms of drug abuse, particularly that for opiates, varied between 1-2% in the general population. The figures would be several times for males or adult males. The above figures only denoted severe forms of drug abuse.

The extent of moderate forms or purely experimental or recreational abuse is largely unknown. The present figure does not give us an idea of such a figure.

Characteristics of drug abusing respondents:

The study revealed that majority (68.1%) of the total number of 1472 respondents, who were interviewed with questionnaire, were between 20 to 40 years of age. Twenty percent of the sample was in the age group of 25-29. The mean age (\pm S.D) of drug abusers in this study was 33.6 (\pm 10.5) years with mean age figures varying from 31.7 in Kerman to 35.5 in East Azebayejan. Majority of key informants reported that most of the opium and heroin users were in the age group of 20-30 years and from poorer socio-economic backgrounds. They also reported that adolescents and students and people from middle class background use more hashish.

An overwhelming majority of the respondents in the sample (93.4%) were male. There were 97 women respondents in the sample. The mean age of the women sample was Most secondary data sources indicate that drug users in treatment centers were largely male (upto 95%). Many key informants also believed that the extent of drug abuse among women in Iran is underestimated.

Over half (56.7%) of the sample was married, over one-tenth (12.4%) illiterate. Most of the literate respondents were educated at a level below high school. One-fifth of the participants in the sample were unemployed, the proportions varying from 6.5% in Semnan to 32 % in Tehran. One-fourth of the respondents were workers. Family was the source of support for more than 50% of unemployed drug abusers. One-fourth of those who were unemployed had illegal means of income. Several categories of key informants reported that heroin use was more common among the unemployed people.

Most of the respondents (94%) lived with their families. Over 40% were living in their parent's home, 25% living in rented houses and the rest owned houses or apartments. The proportion of people living in alone was highest for Khozestan and Tehran (17.4% and 12.9% respectively). The total monthly income of more than half of drug users in this study was reported to be between 200,000 to 799,990 rials, the mean income reported being 7477020 (\pm 811440) rials.

Drug users recruited from the streets were older, more employed, living alone in more proportions. Although they were more employed than those recruited from treatment centers, a major proportion of them reported illegal means as a source of income. The treatment center sample were more married, were more dependent on their families (among those who were unemployed), and more living with their families. Those who were recruited from prisons were relatively younger, more proportions having a working class background and less unemployed. Table 3 and 4 describes the characteristics of the sample in the study.

Initiation of drug abuse

Overwhelming majority of drug using respondents (94.4%) in the sample had history of smoking cigarette. The mean age at onset of smoking in the sample

18.8 (\pm 5.67) years. Sixty three percent of the respondents also had history of drinking alcohol. The mean age at onset of alcohol drinking was 18.9 (\pm 4.15) years. The mean age at onset of starting an illicit drug was 22.2 (\pm 7.1) years. The mean age at onset of smoking, drinking and using illicit drugs were higher in women, 24.9, 22.2 and 27.5 years respectively.

About sixty percent of respondents reported opium to be the first drug of abuse. Over 30% of respondents started drug abuse with hashish and a minority of drug abusers (5.6%) in the sample started with heroin. Heroin as the first drug was most common (10.1%) in Khozestan site. Smoking was reported by the majority (93.5%) as the route of intake of the first drug, ingestion was reported by 5.9% and injecting rarely reported (0.4%) as the first route of intake of drugs. The situations or places where drugs were used the first time were 'in a party with friends' (33.4%), at home (19.5%) and 'public places' (15.7%). Other reported places were workplace, 'in a family party' or a soldier's camp. Among the 97 women respondents, more than half had used drugs for the first time in their homes. Other major responses by the women respondents were 'in a party with friends' (23.7%) or family parties (17%).

The commonest reasons cited as the reason for starting drug abuse were 'influence of friends' (61.4%), curiosity (20.2%) or pleasure and fun (18.9%) and others such as relief of physical pain, family problems, lack of love and, kindness, unemployment or disappointment in love. For women respondents, the common reasons reported for starting drugs were treatment of physical pain (47.4%), familial problems (41.2%), easy availability of drugs (34%), curiosity (24.7%), lack of familial control (23.7%), pleasure and fun (20.6%) and others. In more than half of the cases, women respondents had picked up drug abuse from a male family member. In-depth interviews of drug users revealed that they perceived social and emotional factors to be important factors behind initiating drug use. Families of drug abusing perceived the major reasons to be 'company of drug abusing friends' and free leisure time. Other key informants cited unemployment, availability of drugs, lack of familial control or pleasure and fun seeking to be major reasons for starting drug abuse. Table 5 and 6 describes the pattern and factors of initiation of drug abuse in the study.

Pattern of Drug Abuse during last one month of the interview.

The common drugs of abuse reported by the respondents during the last month of the interview were as follows: opium- *thariac* (73.3%), opium residue- *shireh* and *sukhte* (21.9%), heroin (39.4%) and hashish (12.6%). Proportions of respondents who had used heroin during the last month were comparatively more in Kermanshah (66.7%), Tehran (57.3%), Khorasan (56.1%). Much less heroin use was reported from Semnan (7.4%) and East Azerbayejan (15.2%). Over 60% reported to be using one drug and the rest of the sample reported using more than one substance in the last one month. Common routes of intake of drugs reported were smoking (79%) and oral ingestion (44.9%).

Over 16% of the respondents had injected any drug during the last month. The figures for injecting were particularly high for Mazandaran (30.8%), Tehran (26.7%) and Khorasan (20.3%) and low for Semnan (3.3%) and East Azerbayejan (8.3%). Injecting drugs was comparatively more reported by the respondents in prison and those recruited from the streets. The extent of drug injecting available from secondary data of outpatient treatment center records showed that 10% of respondents had history of drug injecting. The figures in the present study analyzed according to the sites of recruitment showed similar figures (i.e. 11.6% among those recruited from the treatment centers). However, the study showed that the extent of drug injecting is much higher than previously reported and particularly higher in some of the sites of the country. It was also noted in the study with grave concern that drug injecting was prevalent to a varying extent in all urban sites of the study.

Most respondents (96.2%) reported using drugs more than once daily. More than half of the sample reported to be using one route of intake of drugs currently. Opium or opium residue was reported to be commonly smoked in opium pipes. Opium was also orally ingested, commonly dissolved in tea. In-depth interviews revealed that opium or opium residue was rarely injected, particularly inside the prison. Heroin was smoked, snorted or injected. Hashish was smoked in a 'joint' rolled as a cigarette. All key informants reported opium and heroin to be the major drugs of abuse. Ethnographic studies also revealed that opium, heroin and hashish were the common drugs of abuse. Table 7 and 8 describes the patterns of drug abuse in the sample.

Life time Drug Abuse pattern

The drugs commonly used during lifetime were opium - *thariac* (94.6%), opium residue - *shireh* and *sukhte* – (50.1%), hashish (47.5%) and heroin (43.5%). The lifetime methods of intake of drugs were smoking (96.1%), oral ingestion (63.2%), or injecting (21.9%). Only one fourth of the sample reported to have had used one route of intake of drug in contrast to be current use pattern. Higher lifetime rates of heroin use were similarly reported at Kermanshah (70%), Khorasan (62.7%) and Tehran (60%). Lower rates were reported for Semnan (14.6%). The same across the site pattern for lifetime use was observed regarding drug injecting.

The key informants reported changes in patterns of drug abuse in the form of rising heroin and hashish use. They also reported rising trend of injecting drugs.

The average monthly cost of expenditure in drugs reported in the sample was 346240 (\pm 280000) rials with higher expenditure reported for Kermanshah and Tehran site. Table 7 and 8 describes the life time patterns of drug abuse in the sample.

Injecting Drug Use

Of 1472 interviewed with the questionnaire, 323 respondents (21.9%) had ever injected any drug. The mean age of the drug injectors in the sample was 31.7 (\pm 8.66) years in the sample. The mean age at onset of injecting any drug was 26.3 (\pm 6.70) years. Eighty percent of the respondents had started to inject any drug before the age of 35. More than half of the respondents reported to have been commonly injecting 2-3 times a day.

Drugs of injection were commonly heroin and opium or opium residue rarely. The quality of heroin available in Iran was of 'No. 3' variety and drug users used citric acid (*johare limu*) or drops of lemon juice to dissolve heroin into an injection solution. When opium or opium residue was injected, an aqueous solution was prepared by heating the opium or opium residue in a cooker and then the solution drawn into the syringe filtering through a cotton wool. Pharmacies were the commonest sources (92%) of syringes and needles. Almost always

intravenous route was used for injection. The common sites of injection in the body were veins of the arms and legs, deep veins of the groins or sometimes the veins of the testes. Typically syringes were used more than once. About half of the sample reported to have shared syringes and needles. Sharing of needles generally were reported by 70% of the drug injector respondents recruited from the streets, which also included borrowing and lending injecting equipment. Of those who usually shared needles, some sort of cleaning was practiced by 87.8% of the respondents. The methods of cleaning include wiping by fingers or cloth, by saliva, by plain water and hot water.

The situation when first injecting took place was in a party with friends (38%) or in the home (25.9%). Table 19 and 20 describes the profile of injecting drug users in the sample and behaviors related to drug injecting. In-depth interviews with drug using respondents and key informants explored the factors behind switching to drug injecting. The following pattern behind switching to injecting was delineated:

Almost all drug users had been using an opiate for 5 to 15 years on an average through non-injecting route such as opium smoking or heroin smoking. With time, supporting opium habit became difficult because of increasing price. And non-injecting methods were not able to give enough 'high'. Treatment center key informants interpreted this phenomenon as 'tolerance'. However, changing levels of purity of street drugs had not been examined. Heroin was becoming increasingly available and supporting a heroin habit and particularly injecting heroin became a cheaper option for many. Most commonly a friend suggested about the method.

Key informants in the prison opined that despite strong security and control measures drug injecting infrequently took place inside the prison. The injection equipment used in the prison were used needles, hand made needles (known as *pomps*) and droppers.

Availability of drugs and the street drug scene:

Most respondents (70.9%) reported buying their drugs from the street dealers. Very rarely (0.9%) drugs were obtained from the pharmacies (Table 7 and 8).

Drugs bought from the pharmacies for abuse include codeine containing syrups or analgesics. Ethnographic studies revealed that parks, deserted buildings, gardens or parks in the suburban areas of the cities were common sites for using drugs. Opium was most commonly used in the privacy of the home because it involves the use of paraphernalia such as smoking pipe, charcoal fire. Hashish was used commonly in parties. Heroin was snorted for convenience in the streets. Opium was also orally ingested with tea in the coffee or teashops. Ethnographic studies in one of the study sites made some of the following observations of the street drug scene:

Day 3. Our 'guides' were describing the characteristics of the place of our visit while we drove eastwards. The place had developed after the revolution. The residents of the place had migrated from outside the city and many of them were 'gypsies'. This was a cheap place where many people from outside the city could come and hire a cheap room to stay. The neighborhood had high drug use and crime rates that also contributed to cheaper real estate prices. We parked our car in the junction of two roads and set out in two teams. The place looked run down, dirtier and poorer than other parts of the city.

Ex-user guide of our team went ahead of the group and we followed him from a distance. We went round and round the alleys. The kids were playing soccer in the streets and people gathered around a few restaurants. Within 5 minutes, he picked up a man standing in a street corner and started talking to him. We observed signs of fear in the face of the man. But our guide made him comfortable and we observed them laughing and talking. They started walking and we followed them from a distance. Ultimately, we all met at a junction of roads.

Another young man with a limping gait intercepted us and asked 'what do you want? We replied: 'what do you have?' He replied 'only hashish, but I can take you to the place where you can sit and use both heroin or opium', pointing to the direction of the alleys we have crossed before. We introduced us and explained to him the purpose of research. He appeared uncomfortable and said 'if you want information find out somebody appropriate and treat him with some kababs and then ask'. He said he doesn't know much about hard drugs and left us hurriedly.

We, now a group of five, returned to the place where we have parked our cars. We had to again convince the person whom our ex-user friend had picked up that we are not from the disciplinary forces. After some time he started talking 'I'm under treatment and I want to give up'. He brought out tablets of codeine, diazepam and trimipramine from his pocket and showed us. As the

conversation became more free flowing he talked about his drug use: 'I used to take heroin by snorting ... those houses over there sell heroin and opium'. The current street price of 5 grams of heroin and opium were 20 US\$ and 4 US\$ respectively, he reported. He continued: 'young people inject heroin.... they go to a nearby jungle to inject ... if you mix hot water to prepare heroin it becomes sterile ... they use white part of 'Antipyrin' (aspirin) tablets or more commonly 'johare limu' (citric acid powder) to dissolve heroin ... sometime they become unconscious ... generally your friends help but once all the money a guy was carrying was stolen when he became unconscious regular fights occur here between drug dealers, no guns - with knives and soda bottles ... even the kids and women sell here. When asked about illness, he responded that injectors get all sorts of skin problems (abscess).

The other team joined us by this time. They were very excited. The ex user guide of the other team said: 'the place has changed considerably in the last couple of years – a young guy was injecting openly in the alley ... we wanted to talk to him but he said that the dealer may not like it and he refused'.

Our drug user respondent continued with his story: 'lot of cops here but most drug selling takes place early in the morning before cops get up from their sleep'. He laughed and said: 'isn't funny that heroin users get up earlier in the morning than cops!' We asked him about sex work and he grinned: 'you get both women and heroin'. While we slowly drove back through the alleys we saw women with cheap and thick make up sitting in the roadside in front of their houses with glassy eyes, some of them with eyes half-closed and dozing of because of the dope they had. Groups of 3 or 4 kids were playing around them. One of our guides commented: 'they are sort of gypsies, look at the make up, they use and sell heroin'.

Day 5. We were sitting in the city square. The square had a few fountains and many people were leisurely sitting in the benches, gossiping or reading newspapers. Mr. F, our guide today, started talking to an elderly man. We joined later. Our respondent was an elderly man, unshaven, unkempt and looked weak and sad. He answered in a low tone and mostly answered in monosyllables. He is not from this city. He owns a house in a small town and he has rented a part of it. His family (wife and children) survives on the income of the rent. He used to work as a cook but he is jobless now and lives in a cheap motel in this city. He started to use opium rather late (10 years back) and he looked much older than his stated age of 45 years. To give up opium, he said, he needs admission in a center with treatment facilities. He does not know exact location of any such center and he had never been to any kind of drug treatment. Mr. F gave him his

telephone number and also distributed his narcotic anonymous pamphlets like he did every time he talked to a drug user.

Day 4. Our respondent today was a young man. We had met him at the park and he agreed to talk. We climbed a few stairs with him in a spot where we could talk privately. Our young respondent looked frail, was balding and wore jeans jacket and a pair of dirty sports shoes. He has a bachelor degree in political science and he has no job. He started to use opium while in college. It was easy for him to use drugs because he used to live in a house alone. His grand father and his uncles used opium. Gradually he shifted to heroin and currently injects a gram of heroin a day (costing about 4 US\$). He injects 5-6 times every day using lemon juice to dissolve his heroin. He has heard of HIV/AIDS from radio and television and he injects alone generally in his home. His family members know that he uses opium but they don't know that he injects heroin. He had tried to give up by taking medicines, even methadone. He said 'there are two types of methadone in the black market – the brown tablets and white tablets they sell ... giving up is not a problem, the problem is relapse' He also commented that he wants to give up and showed a strip of amitriptyline tablets he was currently taking.

While we were talking, an elderly person joined us. He appeared to be homeless and was carrying a large plastic bag. Our young respondent introduced him as an opium user. He interfered in our discussion and commented: 'drug addiction is a complicated problem – much more complex than you people think ... opium is good for hair, you'll hardly find a bald opium user ... they have two types of treatment - in one you pay lot of money and in another they dump you in an overcrowded place ... bad food, no real treatment'. By this time a small crowd of 5 or 6 gathered around us and volunteered various kinds of information on the drug scene.

Day 1. We were sitting in the park bench drinking tea. A young man kept a close watch on our group. Mr. H, our 'guide', went up and tried to talk to him asking him to join us for tea. He was unwilling and then Mr. H. told him something (telling him that one of us wants to buy some hashish) and he immediately came and joined the group. He took out a small piece of hashish from his jacket and gave it to one of the members of our team while shaking hands. He joined us in drinking tea and we started talking. He said that he used to use opium before but now he uses only hashish. But never during the time of business. He goes back home after his business and then rolls his joint. His brother is in jail and he also has to support his brother's family (brother's wife and two kids). Another young man, who appeared to be university student, shouted at our respondent from a distance inquiring 'where is Hammed?' Our respondent shouted back: 'he's in jail'. He continued his story. He has never used heroin. He had been to prison once for some

petty crime. He reported that there is some opium injecting specially in the prison, not much otherwise: 'there is no choice inside the prison than to use the same syringes and needles'. He also recollected that many drug using inmates during his stay in the prison got a disease where 'your eyes becomes yellow and you become sick'. The price of drugs inside the prison, he reported, was 4-10 times higher in the prison and it was usually new prisoners or prison guards who brought in drugs in the prison.

When we were coming out of the park, a young boy (13 or 14 years age) followed us and started to hang around the field team. He asked us repeatedly that if we want hashish, he would arrange some. He thought that educated people used hashish more and they come to this park. The sellers often keep their stock under some tree and after the money was paid would ask the buyer to collect it from a specific place under a tree. He also reported: 'you can find male and a few female prostitutes in the park at night ... you can have sex in the park ... there was a big fight between two (ethnic) groups of drug sellers few days before....one group lost, drug sale in this park now controlled by the '

Patterns of drug trafficking:

Various and inconsistent opinions were expressed regarding the nature of drug dealing networks by different categories of law enforcement key informants. Some opined that trafficking networks are small consisting of only a few persons, while others commented that there were large networks (large bands) consisting of big dealers to small dealers in the streets. However, most key informants were consistent in their response that most drug users law enforcement encounters are small dealers who also use drugs (*'khordephurush'*).

Impressive law enforcement activities were described by all categories of law enforcement key informants regarding interception of armed gangs of drug caravans entering Iran from the eastern borders of the country. Drug caravans with several motor vehicles or camels, concealment in vehicles, body concealment, postal parcels were reported to be common methods of drug transport and trafficking.

Drug Use among the family and friends:

Of the total 1472 respondents interviewed by the questionnaire, 61.2% (n = 901) respondents reported cigarette smoking among family members, 21.8% (n = 291) reported drinking alcohol. Male family members such as the father or the brother were commonly reported to be smoking or drinking alcohol.

Over 46% (n = 686) of the respondents also reported history of an illicit drug in at least one member of the family. Brothers and fathers again were commonly reported to be the drug abusing family member. Most families (76.5%) had only drug abusing family member. The common drugs used in the family were opium (81.9%) and heroin (21.3%). Majority of the family members (77.6%) used one drug.

Respondents also reported smoking in over 88% of their friends and drinking alcohol in more than half of their friends. Table 9 and 10 describes drug using pattern among family members and friends of the respondents.

During in-depth interviews, many respondents described their experience of preparing charcoal for opium smoking by their fathers when they were young. For many this was the occasion when they came into contact with drug abuse. Many had also witnessed opium smoking in many social or family parties. This closely parallels social use of alcohol in many other settings particularly in the west. Focus group discussion with drug users also revealed the same familial drug use pattern.

Sexual behavior of drug using respondents:

About seventy three percent of the respondents interviewed by questionnaire agreed to respond to the section on questions of sexual behavior. The mean age at onset of sexual intercourse in the sample was 18.9 (\pm 3.29) years. The mean ages when the sample was stratified by marital status were 19.5 (\pm 4.19), 18.0 (\pm 2.73) and 19.4 (\pm 4.25) years for married, single and separated / divorced respondents respectively. Over 56% of the respondents who responded to this section of the questionnaire became sexually active between 17 to 22 years of age. One-third of the married respondents reported to have had sexual intercourse outside marriage. Over half of divorced/ separated respondents had experience of sexual intercourse after they were separated from their spouses.

Over 70% of unmarried respondents also reported to have sexual intercourse. The most common sex partners were prostitutes (73.9%). Over 30% also reported to have homosexual experience.

Three fourths of married drug abusers, 84.6% of single respondents and over 80% of divorced / separated drug users had heard of condoms. More than 60% of the married drug users, 42.5% of single drug users and 66.7% of divorced / separated drug users had ever used a condom while having sex. The rates for condom use at the time of having sex last time were 32% for the single and 20% for the divorced / separated respondents. Table 11 and 12 describes the sexual behavior of the respondents under study.

History of sexually transmitted diseases and other diseases:

Six hundred and 33 respondents agreed to respond to this section of the questionnaire. Table 13 and 14 describe lifetime occurrences of sexually transmitted diseases (genital ulcers, genital discharge, and growth in the genitalia) in the sample. Over 10% of the sample had also suffered from symptoms suggestive of hepatitis, abscess, tuberculosis or endocarditis.

HIV/AIDS among drug users:

Till 1997, 1473 cases of HIV infections (including AIDS) have been reported by the Iranian National Committee on AIDS. Over two thirds of the reported cases had drug use, particularly drug injecting use, as the possible route of infection. Examination of the time trends in the secondary data showed a rising trend of HIV infection. HIV outbreak among drug abusers in two prisons due to unsafe drug injecting had also been reported. Cumulative HIV prevalence rates among drug users tested (total number of blood samples tested were 140277) was 0.72% (95% CI 0.67 – 0.76%). The Iranian National Committee on AIDS has been established in 1997, which is implementing six different programs. These programs were health education, human resource management, training, blood and blood product safety, follow up of infected individuals and data gathering. It appears that systematic HIV surveillance is not in place.

Over 20% of drug using respondents in the sample had not heard of HIV/AIDS. Table 15 and 16 describes different components of knowledge about HIV/AIDS in the sample. Over 20% and 30% of the respondents who had heard of AIDS reported no knowledge of the transmission of HIV/AIDS through sexual route and sharing injection equipment route. The common sources of AIDS information among those who has heard of AIDS was radio or television (71.2%), from other people (55.9%), posters and brochures (25.8%) and books (16%). Fifteen percent of 1124 respondents who had heard of AIDS had ever been tested for HIV/AIDS. Over half of these testing were voluntary. Over two-thirds of those tested were not accompanied by any pre or post test counseling (table 15, 16). Over one-fourth of injecting drug users had ever been tested for HIV of which more than half had been done compulsorily. As mentioned in the earlier section of the report, there were no HIV prevention programs in place among drug users or drug injectors in Iran.

Several categories of key informants felt the need for detailed and systematic studies on HIV and hepatitis among the drug users. Majority of the key informants from the outpatient treatment centers opined that: 'although we provide health education for drug abusers in treatment and during group therapy, whatever little is done is done in a very unsystematic way. We don't have any printed material on HIV/AIDS for drug users'.

Attempts to give up drugs:

Over three fourths of the respondents interviewed with the questionnaire in the study had a history of giving up drugs for varying duration. Most had given up more than once. Majority (90%) reported to be suffering from various withdrawal symptoms as the major problem when giving up drugs. The commonly reported withdrawal symptoms were feeling sad (91.4%), muscle pain and spasm (90.2%), restlessness (85.7%), sleep disturbances (85.3%), watering from nose (80.3%), continuous sneezing (79%), yawning (75.1%), watering from the eyes (73.6%), diarrhea (70.9%), tremulousness(61.8%), abdominal pain (53.7%), pilo-erection (51.3%) and palpitation (43.6%). Most respondents had reported 4 and more of the above withdrawal symptoms. Sixty nine percent of drug users had managed to give up drugs for varying periods by themselves. The reported methods used were stopping drugs gradually or abruptly. Over 39% of drug

users had been to an outpatient center for treatment in the past, 4.5% had been hospitalized and 24.2% had been to a treatment and rehabilitation center.

Outpatient treatment centers:

The infrastructure and activities in demand reduction have been described in the earlier section of the report. Here we have examined the activities of the outpatient treatment centers in more details. Information described in this section was gathered by key informant interviewing. Outpatient treatment centers have the following categories of staff: deputies of the prevention department who are overall in charge of the center, manager, psychiatrists, clinical psychologists and social workers. Abstinent ex-users also occasionally work with the center on a contract basis. The staff patient ratio ranged from 1:7 to 1:25 depending on the site. The components of treatment include detoxification with clonidine and other drugs, individual counseling, group therapy, family therapy. The duration of treatment varies generally between 3-6 months. Detoxification and physical treatment continues for about 3 weeks and psychosocial interventions are generally continued for 4 months. Referrals to narcotic anonymous or other self-help groups were often made. Attempts were made to follow up after the period of treatments. Drug users were referred to the outpatient treatment centers by drug abusers themselves, other health facilities of the city and by the police and court.

The key informants of the outpatient treatment centers reported the following types of problems, which could be listed and classified as follows:

1) Administrative and structural problems:

Instability of employment, most specialists worked on contract basis

Lack of adequate number of specialists

Problems of space

Lack of equipment

All staff could not be vaccinated (e.g. for hepatitis B)

Lack of medication

Lack of laboratory support

Lack of coordination with other departments

Lack of routine feedback from monitoring or evaluation

2) Problems related to treatment

Opium test was expensive

Difficulties in follow up due to fewer staff

Lack of epidemiological information on drug abuse

`Drug abusers don't believe in psychotherapy'

`Working with drug addicts is very hard'

3) Problems related to after care

Efficacy of treatment unsatisfactory in the long run

Lack of idea about the efficacy of treatment due to difficulties of follow up

The above list of problems was general in nature and does not reflect difficulties that were faced by any particular center. Nor were all the items valid for all of the centers studied.

Regarding relapse rates, the difficulties of follow up were cited as the major problem. In absence of hard data, key informants reported their impressions. Relapse rates reportedly varied from 60-80% depending on the site and duration of follow up. When asked regarding the perception of the staff regarding their efficacy, one of the key informants remarked `we're good in detox, not so good in preventing relapse'. Most informants felt successful and adequate considering lack of trained personnel and inadequate infrastructure. Regarding evaluation of the outcome of the treatment program, comments made were `we've internally evaluated but no formal or documented evaluation reports are available' or `we don't have an evaluation document.'

Private treatment of drug abuse

Several psychiatrists were also interviewed as key informants. The treatment services provided by the psychiatrist included physical and mental evaluation, evaluation of co-existent mental illness, detoxification, psycho-diagnostic evaluation, and psychotherapy (individual and group). One of the respondents

mentioned relaxation techniques and the other mentioned electro-sleep therapy. One of the respondents described his treatment program as detox 1 week, antidepressant 2 months, relaxation 2-4 months and follow up. Referrals to psychiatrists were generally done by other doctors, drug abusers themselves, other health units and by families and friends. The difficulties in managing drug abuse that were reported by private practicing psychiatrists were: lack of follow up facilities, lack of familial participation in the treatment process, lack of admission facilities, lack of coverage of drug abuse treatment by health insurance (all Government employees are insured in Iran and they get part reimbursement even when seeking private treatment). Regarding relapse rates, anecdotal reports varied from 60-90%. Unemployment and adverse social situation were cited as reasons. No formal evaluation reports were available. Some of the comments made were: 'when they come to me for the first time, the results are good but it fades away in the long run', 'I've treated 700 addicts in 12 years, I can describe many of their characteristics but no evaluation', 'addicts are happy to meet me and I think I'm successful'.

Crime and Incarceration of Drug Abusers:

Fifty nine percent (n = 869) of the sample interviewed by the questionnaire had ever been to a prison which included 506 respondents recruited from the prison. If the sample recruited from the prison was excluded, 37.5% of the sample recruited from the streets and treatment centers had a history of being in a prison. Over 80% of drug abusing respondents mentioned drug use as being the major reason for being in prison where as about over 18% mentioned drug buying and selling being the major reason. However, over 95% commented that the reasons for arrest were both uses of drugs as well as buying or selling. Focus group interviews inside the prison revealed that 60% of incarceration was due to drug use. In-depth interviews with drug users attending treatment centers revealed that one third had a history of arrest. Common reasons include use of drugs and possession of drugs. Prison key informants were inconsistent in their responses when asked about the proportion of drug traffickers among prisoners with drug related offenses. Figures ranged from 20% to 80%, indicating the problem of definition of 'traffickers'.

Secondary data available from prison records indicated that 60% of all prisoners in Iranian jails were due to a drug-related offense. Three fourths of those in prison due to a drug offense were due to a drug dealing offense. The present law has stressed more on fines and corporal punishment and therefore relatively lesser numbers of drug users were currently being incarcerated.

It appears from these figures and interviews with several key informants that there needs to be clear definition of drug trafficking. As mentioned earlier in the report, major numbers of people encountered by the law enforcement agencies were drug users buying and selling in small quantities (*khordephurush*). Secondly, the investigators could not delineate clearly from key informants about categorization of a drug using person arrested in possession of a small amount of drugs. It would be more useful to separate *khordephurush* from bands of traffickers arrested carrying several hundreds of kilograms of narcotics. Currently, there were 8000 foreigners in Iranian prisons due to drug trafficking offenses.

Imprisonment was also due other petty crimes such as theft, pick pocketing, gambling and indecent relationships. The key informant from disciplinary forces reported other crimes that were related to drug abuse, which included car breaking, robbery, prostitution, fighting between them and buying and selling of stolen or robbed materials. Many opined that drug users change the view of the city as they beg in the streets, clean the windshields of cars standing on traffic signals and make the streets unsafe.

It was also interesting to observe here that there were no significant differences in the proportions of respondents with occupations among the respondents recruited from prison (28%), treatment centers (22.2%) and from the streets (25.5%) ($\chi^2 = 4.44$, d.f = 2, $p < 0.1$).

When key informants from the prison were asked regarding drug use inside the prison, responses varied between non-existent to very rare. Eighty percent of prison key informants opined that drug use is rare in prison where as 13% opined that it was non existent. Only 7% commented that this was common. Injecting was thought even more rare. Common drugs of abuse in prison reported were hashish and opium. Sources of bringing drugs inside the prison reported were by

jail guards, body concealment by new prisoners, supply from families along with food and other things, throwing drugs inside the prison from outside and by prisoners when coming back to the prison from hospitals. Other behavior problems inside the prison reported by the key informants were fights, behavior problems during withdrawal, homosexuality and use of abusive language. Regarding HIV/AIDS and hepatitis inside the prison, the prison key informants opined that although testing everybody was not possible, when `suspected' cases were tested, very low rates had been found. However, many key informants were worried about such a possibility in future.

When asked how incarceration might help a drug user, a variety of opinions were expressed. Some of the comments made were: `we only keep here, we don't have services for them', `it separates them from their habit only for a while' or `they can use the services of the doctor to ease the pains of withdrawal'. The key informants described the facilities inside the prison which included medical help, facilities for cultural programs and entertainment, religious programs (reading holy Koran, praying, *doyaekhomel*, *thabasole*, *nodbe*), vocational programs, sports facilities, classes of holy Koran and moral behavior and facilities for primary education (reading and writing). When the prison key informants were asked about human and other rights of drug abusing prisoners, variety of responses made were as follows: `should have no special rights, they should receive punishment and we should implement it', `they have all the rights of a citizen and we must obey the law during arrest and legal procedure, `we should help them to give up drugs, a drug user has all the rights of a citizen'.

Drug Abusers in the Criminal Justice System

Several categories of key informants from `disciplinary forces' and judges of the revolutionary courts revealed the following:

Police identified drug users by combination of methods which included appearance (40% of key informant responses), were introduced to the law enforcement by their family members or friends (40% of key informant responses), from complaints or information received by neighbors (35% of key informant responses). After arrest, body searches were made to find drugs and injection track marks in the body were also searched. Drug users often confess

of drug abuse and opium test was ordered. Arrests were commonly made from the streets, alleys and parks (60%), places where drug users gather such as dilapidated houses, buildings under construction or coffee shops (5%) and from their houses (35%). The police prepared the case including obtaining opium test records.

The judge of the revolutionary courts reviewed the case, talked to the person, reviewed the life situation and criminal records of the person and sentences were given. No legal separation was generally made between an 'abuser' and an 'addict' legally. Disciplinary forces commented that it depends on the judge to distinguish whether the person is an 'addict' or a 'trafficker'. A positive opium test clearly proved that the person was an addict, and possession of drug proved that the person a trafficker. Depending on the amount of drug a person was possessing sentences were given. Purity of confiscated substances was not a consideration in giving sentences. The sentences were less for someone convicted for the first time or with opium related offenses. Fines ranges from 1000,000 to 5000,000 rials, corporal punishment (lashes) or imprisonment. The judges had the discretion of choosing what sentences were appropriate for the person. Usually, drug abuse cases were quickly disposed within 1-3 days. Key informant judges reported that they felt no problems with the procedure of judgement. When asked regarding the new law of 1988 several comments were made. Some of them were; 'they should have consulted experts before passing the law', 'the discretionary power of judges is not clear in the new law', 'beautiful law – punishment is mainly administered to the person and not to the family, lashes affect you and not your family', 'it pays attention that addicts are patients and numbers of prisoners are going down'. Opinions expressed also included that fine was not the solution (as financial punishment has been given precedence over corporal punishment in the new law) because traffickers could pay it easily where as a drug user or a *khordephurush* would find it difficult. However, most key informants were reserved about the efficacy of the new law, commenting that it was new and would take some time to find out how it works.

Implications of major findings and recommendations

- 1) The RSA identified the following groups who are either vulnerable or at high risk of becoming involved in and/or are substantially effected by drug abuse

and its adverse social and health-related consequences: youth, workers, women who live with a drug abusing member, families with drug abusing members, injecting drug users, and drug abusers in prison. Appropriate interventions targeting all these groups are urgently needed.

- 2) Many anti-drug abuse posters and billboards in Iran portray messages such as “drug addiction destroys, kills, society becomes barren like a desert” with pictures of broken homes, scorpions, skull and dead person's legs. There is now the need to move away from such unrealistic messages to dissemination of accurate and positive information about prevention of drug abuse and addiction to the public.
- 3) Targeted education programs involving peer groups such as young people educating young people, ex drug users educating drug users, women reaching out to women, etc. are needed.
- 4) Currently, there are no community-based treatment and rehabilitation programs in place. As part of the RSA, drug users recruited from the streets of ten major cities of the country were asked about their ideas and needs regarding drug treatment. Only a few indicated treatment and rehabilitation centers as a choice.
- 5) There are very limited provisions for private treatment and only a few NGOs or voluntary organizations are as yet involved in prevention, treatment or rehabilitation initiatives. The current Government policy supports community-based activities by NGOs in the drug field. Since drug prevention, treatment and rehabilitation NGOs are new in Iran, some time will be needed to generate their capacity (with specific reference to their training needs) to effectively deliver drug abuse prevention, treatment or rehabilitation services. Similar capacity building is also needed for the private sector who are and will be involved in delivering drug abuse prevention, treatment and rehabilitation services.
- 6) There are currently no HIV prevention programs in place in Iran although drug injecting appears to be on the rise. HIV infection is already a problem in some prison settings. HIV prevention programs including the sexual health

component need to be undertaken immediately, while taking into consideration the legal context of Iran.

- 7) Several types of targeted intervention activities in the fields of drug abuse prevention, drug treatment or rehabilitation and prevention of health consequences appear essential.
- 8) Initial demonstration programs in prevention, drug treatment or rehabilitation and prevention of health consequences need to be properly monitored and evaluated so that good practice programs could then later be replicated all over the country
- 9) There is strong obvious need to build up systems and capacities of monitoring and evaluation of all programs, which should be incorporated from the beginning of the pilot programs.
- 10) There is an urgent need to decentralize prevention, treatment and rehabilitation programs. The primary and private health care systems and NGOs or voluntary organizations in Iran may be appropriate bodies to render services.
- 11) Collaboration may be sought with WHO and UNAIDS in the area of prevention of HIV among drug users/ injecting drug users and sexual health of drug users which are important areas of concern

The objective of this Rapid Situation Assessment (RAS) study was to survey the use of multiple substances in diverse segments of the Lebanese population. METHODS: A multi-method and multi-sample survey was conducted to collect quantitative and qualitative data from the academic sector (high school and university students), substance users in treatment or under arrest (prison, detention), and non-institutionalized "street" users. Cannabis represented the most commonly used illicit drug in both high school and university students, and tranquilizers were the most frequently misused medicinal substance. Heroin was responsible for 50% of the treatment admissions, followed by cocaine (20%), and alcohol (20%); heroin was also the most common substance of arrest. Rapid Situation Assessment (RSA) of drug abuse in Iran. E Razzaghi, A Rahimi, M Hosseini, A Chatterjee. Prevention Department, State Welfare Organization, Ministry of Health, IR of €}, 1999. Antimicrobial susceptibility of Helicobacter pylori strains isolated from patients in Shiraz, Southern Iran. S Farshad, A Alborzi, A Japoni, R Ranjbar, KH Asl, P Badiee, MA Shahidi, World Journal of Gastroenterology: WJG 16 (45), 5746, 2010.