Iran (Islamic Republic of)

History

Opium use has existed in Iran since the 17th century and for centuries the country was an important opium producing and distributing centre (Moharreri 1978; Spencer and Agaho 1990-91). Royal orders for the restriction of drug use are documented as far back as 400 years ago (Razzaghi *et al.* 1999). By the 1920s the size of illegal opium sales inside Iran, together with its contraband trafficking to other countries, amounted to about 100 tons a year (Kerimi 2000). It was not until the mid 20th century that opium addiction became a serious concern with an opium using population believed to be second only to China. In 1949 it was estimated that 11% of Iranian adults were drug users, that is 1.3 million opium addicts. During this period, Tehran had an estimated 500 opium dens (McCoy 1991). In 1955, Iran introduced its first laws against the cultivation and use of opium and consequently production and exports of opium dropped sharply (Spencer and Agahi 1990-91). This ban remained in place until 1969 by which time opium users numbered 350,000 and consumed an average of 240 tons of opium each year (McCoy 1991). In 1969 the government permitted limited and supervised cultivation of opium. At the same time they initiated a nationwide opium maintenance program for people 60 years and older for whom detoxification was not advisable due to various chronic diseases. By 1972, Iran's drug addicted population had grown to 400,000 of whom 105,000 were registered opium smokers. In 1975 it was reported there were 30,000 heroin users (Moharreri 1978; McCoy 1991).

From 1974 to 1977 a major detoxification program operated throughout Iran. Its emphasis was on out-patient treatment and it served around 30,000 out-patients (Spencer and Agaho 1990-91). To reduce a drug user's habit, coupons for opium tablets for two to three months were provided or methadone treatment was made available (Razzaghi *et al.* 1999). In 1978, a survey from the National Iranian Society for the rehabilitation of the Disabled showed 94% of registered addicts used opium while 50% of non-registered drug users mentioned heroin (Dalvand *et al.* 1984). Soon after the Islamic Revolution in 1979, there was an upsurge of drug use, with official sources suggesting 5% of the population was drug-addicted, possibly as many as two million people. At the same time, public health services for treatment were closed for the next few years (Razzaghi *et al.* 1999). By early 1980, a severe anti-drug campaign was introduced which involved the extensive use of the death penalty for drug trafficking (Dalvand *et al.* 1984; McCoy 1991). A survey conducted among Iranian adolescents during the early 1980s showed opium was the drug of choice followed by cannabis and heroin (Spencer 1985). Throughout the 1980s and 1990s the courts were sending drug users to mandatory treatment and rehabilitation centres or to prisons. In 1994, Iran developed out-patient treatment centres in all 28 provinces and supported the development of Narcotic Anonymous (NA) and other self-help groups. Since the late 1990s the law has allowed treatment-seeking drug users to be excepted from penal punishments (Razzaghi *et al.* 1999).

Current Situation

Iran, which borders the largest opium producing country in world, Afghanistan, has become a major bridge linking the drug production zone to the lucrative consumer

markets of the Persian Gulf, Turkey, Russia and Europe. (Narcotics 1998; Narcotics 2001; Drug Control Headquarters (DCHQ) 2001). Before the Islamic Revolution in 1979, Iran had up to 33,000 hectares of opium under cultivation but by 1993 it was estimated at 3,500 hectares (Narcotics 2001) although such a large amount is hotly disputed by Iranian authorities (Mehryar, A. personal communication 2001). Following an examination of over one million acres in traditional poppy growing areas in 1998/1999 the amount of opium cultivation is negligible, although in the more remote parts of the country it still may occur (Narcotics 2001). Currently the major trafficking routes into Iran can be found in the provinces of Khorassan, Sistan and Baluchestan, areas with harsh climatic conditions and rugged mountainous terrain. In these areas there are numerous border skirmishes with drug smugglers and in 2000 a total of 1,532-armed confrontations occurred. In the last two decades more than 3,000 law enforcement officials have been killed and 10,000 disabled. In 2000, 142 law enforcement personal and 904 drug traffickers have been killed in armed clashes (UNDCP 2000; NDCR 2001).

According to UNDCP, 90% of the worldwide morphine and opium seizures occur in Iran. In 2000 a total of 254,271 kilograms (kg) of different types of narcotics were seized throughout the country. This included heroin (6,189 kg), morphine (20,275 kg), opium (179,053 kg), hashish (31,581 kg), Acetic (15,678 kg) and others (1,495 kg). Over the past 10 years drug seizures have increased with each passing year (NDCR 2001). It is believed that opium stocks in Afghanistan in the past two years have reached record levels so a continuation of large amounts of narcotics flowing into the country is likely. Recent studies have shown that the average revenue gained from opium cultivation in Afghanistan is 15 times higher than for wheat and as a result of poverty, political instability and waring factions the growing of opium will continue to be attractive (Narcotics 1998; Drug Control Headquarter 2000a; Narcotics 2001).

In 1998/1999 a rapid situation assessment (RSA) at ten major urban sites where 1,472 illicit drug users were interviewed was undertaken. It showed the most commonly used drugs during the last month of the interview was opium (73.3%), followed by opium residue (21.9%), heroin (39.4%) and hashish (12.6%). The life time use of heroin among drug users is high in places such as Kermanshah (70%), Khoransan (62.7% and Tehran (60%). The use of codeine containing syrups and analgesics purchased from pharmacies has also been reported (Razzaghi *et al.* 1999). Drug use is on the rise in Iran and the country is increasingly vulnerable. Iran is the most populous country in the region with 45% of its population under the age of 14 and 26% aged between 15 and 30 years old. Unemployment levels are estimated to be 14% (about 6 million people) and the per capital income has dropped sharply. In recent years there have also been increases in internal migration, urbanisation, crime and social problems: ingredients that can foster vulnerability to the risk of drug use (Razzaghi *et al.* 1999; UNDCP 2000; Iran News Daily 2001).

Drug taking practices and risk factors

The traditional practice is that opium (*thariac*), opium residue (*shire and sukhte*) and cannabis (hashish) are smoked in opium pipes. Opium is also swallowed and commonly dissolved in tea and coffee. From the 1930s to the 1950s drinking opium in tea and coffee shops was common but these practices are now heavily penalised, ensuring this is no longer the case. A small proportion of drug users have been known to dissolve opium or the opium residue (blackwater opium) for injecting (UNDCP

2001). Heroin is smoked, snorted and injected. In Iran the heroin is usually dissolved with citric acid or drops of lemon juice to form an injectable solution. When opium, or opium residue, is injected an aqueous solution is prepared by heating the substance in a cooker and then drawing it into the syringe using cotton wool as a filter. The RSA study found that most injecting is intravenous, using the veins of the arms and legs and the deep veins of the groin. Inside the prisons the injecting equipment consists of frequently used needles, hand-made needles (pomps) and droppers. The study found injecting is much higher than previously believed and that IDU was prevalent, to varying extents, in all urban sites under review. Drugs are commonly bought from street dealers and ethnographic studies show that deserted buildings, gardens or parks in the suburban areas of cities are common sites for using drugs. Opium tends to be used in the privacy of people's homes and hashish is commonly used at parties, rolled as a cigarette and smoked (Razzaghi *et al.* 1999).

During the past two decades, partly as a result of serious law enforcement policies after the revolution, the drug culture has changed. Illegal alcohol use was attacked with more fervour than drug use and government authorities were often reluctant to talk frankly about the emerging drug taking patterns and practices among some sectors of society (York 2000; Narcotics 2001). Polydrug use occurs and the RSA study showed 60% of the respondents used one drug while the rest used more than one substance. The majority (96.2%) used drugs more than once a day. The reasons given for switching to injecting was that the opium was not giving the desired high, that opium was becoming too expensive and unavailable and that heroin was cheaper and easier to get on the streets (Razzaghi *et al.* 1999). In 2000 it was reported that a gram of heroin could be bought for about US$3-4 (York 2000).

Pharmacies are the most common places to buy needles and syringes (Razzaghi *et al.* 1999) and can be purchased without a prescription. Needles and syringes (particularly those for injecting insulin) are easily accessible at a relatively cheap price. Locally produced needles and syringes cost about 160 Rials (US$0.9 cents). The average daily wage for a manual labourer is about 32000 Rials (about US$4.00) (A. Mehryar personal communication 2001). In 1998 an RSA showed that of the respondents injecting drugs (N= 323) nearly half reported sharing their syringes and needles. Seventy per cent of those recruited from the streets were sharing needles. Among all the respondents injecting, up to 88% claimed to use some sort of cleaning technique: the methods included wiping with fingers or cloth, using saliva, plain water and hot water. Overwhelmingly the techniques were inappropriate to protect users from viruses such as HIV/AIDS (Razzaghi *et al.* 1999). Inside the prisons sharing is extremely common and the head of the Welfare Organisation reports that the cost of a syringe, which has been used perhaps more than 30-40 times, is 2,000 to 3,000 tommans (around US$2.50) (Iran News Daily 2000).

Prevalence and profile

In 2000, there were over 269,259 drug offenders including 121,742 drug smugglers, 144,478 drug addicts and 2,939 foreign national arrested for drug law violations. Seventy-five per cent of those arrested were for opium related crimes; among these 3% were women. In 2000 there was an 18% growth in the total number of drug related detainees (compared to 1999). The highest rate of arrests of the 28 provinces occurred in Tehran (29%) (DCHQ 2001). Over the past 20 years up to 1,700,000 people have been imprisoned due to drug charges (State Welfare Organisation 2000).

Estimates of the number of drug users come from various sources. Mandatory drug screening occurs before marriage, government jobs and obtaining driving licences. In 1998, 1.3% of all people tested for drug use under the category of marriage and government jobs (n = 768,525) were found to be positive for opium use. Many who are screened by this method are aware of the implications of a positive test so the chances of under estimation are high (Razzaghi *et al.* 1999).

The government of Iran estimates the number of drug addicts at over 1.2 million with an additional 600,000 drug users. However, National AIDS experts have estimated there are up to 3.3 million drug addicts (defined as repeated and continuing drug use over a nine month period) (Wodak 1997; Narcotics 2001). Estimates suggest 200,000 people inject drugs daily with an additional 300,000 injecting weekly or fortnightly (Wodak 1997). In 2001 the estimated number of IDUs in the country ranged from 200,000 to 300,000 and this figure is rising as result of shifting drug trafficking patterns and the increased availability of heroin (Iran News 2001; MAP 2001). In some cities along major drug trafficking routes it has been estimated that 10% of the population are drug users (Moore 2001). In Tehran, with a population of 12 million, it is estimated there are about 240,000 drug users but this figure is considered far too low. Estimates as to the quantity of drugs consumed in Iran are difficult to gather but in 2000 experts in drug control suggested it was likely that 730 tons of opium was consumed annually although others have suggested it is much greater (Hamshahri 2000).

The RSA study of 1998/1999 showed that most drug users were aged between 20 and 40 years (68%) and of these 20% were aged between 25-29 years. Most are male (93.4%) although many experts believe drug use among women is rising dramatically and is under-estimated. Over half are married (56.7%) and most live with their families (94%). The respondents who were in prison were distinctly younger and their unemployment rate was higher. Most respondents (80%) are employed, mainly as labourers. The average cost of a drug habit for a user is about half of his average monthly earnings of about RI 400,000. Similar characteristics have also been found in another study among users at an out-patient treatment facility (Razzaghi *et al.* 1999;Ahmadi and Ghanizadeh 2000; Moore 2001).

In 2000, drug users constituted more than half of the prison population and the number of inmates incarcerated for drug related crimes was 80,415 (DCHQ 2001). Eighty per cent of prison authorities acknowledged that drug use took place inside prisons although not at a great rate (Razzaghi *et al.* 1999). Among the IDUs participating in the RSA study, 72.7% had a history of imprisonment compared to 36.3% among the non IDUs. The mean age of initiation into drugs among IDUs was 20 years and the mean age for starting IDU was 26 years. As a general rule, IDUs in Iran do not seem to be as young as IDUs in other countries. Just fewer than 50% of IDUs were found to have a history of drug use in the family, only slightly more than that found among non-IDUs (Razzaghi 2001).

Deaths as a result of drug use have been on the rise in recent years. In 1996 it was 717 people, and in 1997 it was 788 (DCHQ 1998). By 2000, this figure had risen to 1000 people throughout the country (State Welfare Organisation 2000).

The first AIDS case was identified in 1986. The cumulative total to late 1997 was 1,297 cases of HIV infection and 192 cases of AIDS (Wodak 1997). The Iranian

National Committee on AIDS has reported a cumulative total of 1,953 HIV/AIDS cases by April 2000 (Prevention Department 2000). As of July 2001 there were 2,458 reported HIV infections and 357 AIDS cases (MAP 2001). However, in 1999 it was estimated 25,000 people in Iran were HIV positive (Khah 1999) while in the same year the Ministry of Health estimated there were 60,000 people infected with HIV or AIDS (Prevention Department 2000). In 2001 of those people infected with HIV, 1,841 were identified as drug users with IDU the source of transmission (74.8%) (MAP 2001). Many of those people who had HIV were identified in prisons or had been to prison. HIV infections were detected among IDUs in two prisons in 1996; at this time 29% of injectors were found to be HIV infected. By 2001, HIV infection was found in IDUs in 10 prisons and at one prison the prevalence reached 63%. At the treatment centres the prevalence of HIV among IDUs was found to be 12% (MAP 2001). Identified cases of HIV/AIDS in low risk groups is as low as 1/160,000 but among IDUs it is reported to be as high as 1/81 (Prevention Department 2000). This prevalence rate among IDUs is high and as this group remain underground caution is required in accepting this figure (Mehryar A., personal communication 2001).

Government response to illicit drug problems

The Anti-Narcotics Law of 1988 covers all aspects of drug control including cultivation, production, consumption, sales and distribution. In 1997 this law was amended in order to be more responsive to the internal drug problem. The age of criminal responsibility is 16 years (UNDCP 2000). The possession of smuggling of opium and cannabis of up to 50 grams can result in a fine of 4 million rials and up to 50 lashes. The penalties become harsher according to the amount that is found on the person. The death penalty may be commuted to life imprisonment and 74 lashes if the quantity does not exceed 20 kg and the perpetrator did not succeed in smuggling/distributing/selling (DCHQ 1997). The execution of drug offenders is usually limited to drug lords, organised drug criminals and armed drug traffickers (DCHQ 2001). Anyone who deals in, puts on sale or carries heroin or morphine is sentenced to various punishments, for example for more than five centigrams to one gram the fine is two to six million rials in cash plus 30 to 70 lashes (DCHQ 1997).

Drug addiction is considered a crime but the authorities are ready to consider drug use as a medical problem. Drug users who are undergoing treatment are not meant to be persecuted, nor are the specialists offering treatment. The costs of diagnoses, treatment, medicines and rehabilitation are to be paid by the addicts according to the approved tariffs but the government will finance the costs for those unable to pay (DCHQ1997). It is up to the judge to distinguish whether the person is an addict or a trafficker; a positive test to opium shows the person was an addict while possession was interpreted as being a trafficker (Razzaghi *et al.* 1999).

The State Welfare Organisation, affiliated to the Ministry of Health is in charge of treatment and rehabilitation of drug users. Up until recently there were 12 treatment and rehabilitation centres in the country with one centre for women. Until 1998/1999 an estimated 25,000 to 30,000 people were referred to these centres and 90% of these admissions were a result of court orders. The average duration of stay is two to six months. The centres were described as having the infrastructure of an overcrowded prison. These centres have now been closed and the new approach is the introduction of outpatient treatment centres (Razzaghi *et al.* 1999). In 2000, the number of out-patients centres in provincial capitals was100 compared to 65 centres in 1999 and 40

in 1998. During 2000 it was anticipated that the treatment centres could offer services to over 100,000 volunteer addicts per annum. Treatment is generally modelled on medical detoxification using clonidine, phenthiazines or other tranquillisers. The duration of treatment varies between three and six months and includes individual counselling, group therapy and family therapy. In addition the therapeutic community program model is currently being endorsed and preparations are under way for the establishment of nine such centres to offer these services. Duration of treatment may be from three months to two years. There has also been the development of self-referring and Narcotic Anonymous centres with an estimated 5,000 members throughout the country (Razzaghi *et al.* 1999; DCHQ 2001;Moore 2001). Relapse rates are believed to be between 60% and 80% depending on the site and duration of follow up but hard data is lacking (Razzaghi *et al.* 1999).

Government response to drug use and HIV

The majority of people who have become HIV infected are IDUs: this is due to widespread sharing of contaminated needles and syringes. In the 1998 RSA, up to 20% of the respondents had not heard of HIV/AIDS and over 20% to 30% of the respondents who had heard of AIDS did not know it could be transmitted through the sharing of injecting equipment. It appears there are scant HIV prevention programs in place among drug users or drug injectors in Iran and what is available is unlikely to be specific and/or explicit about the ways to avoid becoming HIV infected. It has been reported that there are no printed materials on HIV/AIDS for drug users (Razzaghi *et al.* 1999) and drug users are a hidden population and difficult to gain access to. Efforts to distribute needles and syringes to imprisoned drug users has met with strong objections (Mehryar A. personal communication 2001).

In recent times however, harm reduction pilot programs have been introduced in the three provinces most affected by injecting drug use (Kermanshah, Shiraz and Tehran) and the Ministry of Health has initiated these. The programs occur at outpatient clinics and also incorporate services for HIV infected patients (counselling, clinical management, antiretrovirals, laboratory tests and social support). There are no fees for such services. For IDUs there is counselling, methadone treatment and needle exchange. The clinic in Kermanshah attends to 700 clients per month and of these 150 are on methadone and about 50 use the needle exchange service. This pilot program presented its findings to the cabinet and the president in mid 2001 and has been warmly received. As a result of the findings the program is to continue and be expanded. Plans are now under way to extend the harm reduction program to 15 more clinics in 2002 (MAP 2001). Information on how long a client is maintained on methadone treatment is unavailable.

National AIDS Policy

Although a policy does exist, and HIV infections are highest among IDUs, the coordination of activities between the NAP and the National Drug Control Headquarters is generally lacking. Brochures have been prepared for schools and families on the issues of HIV/AIDS but none have specifically been produced for drug users. The main focus of the policy appears to be to control the nation's blood supply and the prevention of HIV transmission through medical injections (Mehryar A. personal communication 2001). Specific mention and/or activities aimed at drug users has been omitted.

Non government responses to drug use and HIV

In recent years a number of treatment facilities have been established by the private sector and are openly advertising in the press. The qualifications of the people running these clinics, and the outcomes of their activities, still remains largely untested (Mehryar A. personal communication 2001). There are three leading NGOs in the country involved in drug prevention, treatment, counselling, support for families and public awareness raising: the Drug Control Community, Aftab Society and POD International. NGOs dealing in drug prevention, treatment and rehabilitation are new to Iran and it is likely it will take some time before they can build up the capacity to effectively deliver the broad based services needed (Razzaghi *et al.* 1999). There are no known NGOs involved in harm reduction activities.

Estimated number of drug users	1.8 million to 3.3 million
Estimated number of IDUs	200,000 to 300,000
Drugs used	opium, opium residue, heroin, hashish, codeine
Drugs injected	blackwater opium, heroin
Estimated number of HIV infections among IDUs	1,841 IDUs infected with HIV, or 74.8% of all HIV infections are IDUs

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