

THE BECKLEY FOUNDATION  
DRUG POLICY PROGRAMME



# THE RISE OF HARM REDUCTION IN THE ISLAMIC REPUBLIC OF IRAN

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The Beckley Foundation Drug Policy Programme (BFDPP) is a new initiative dedicated to providing a rigorous independent review of the effectiveness of national and international drug policies. The aim of this programme of research and analysis is to assemble and disseminate material that supports the rational consideration of complex drug policy issues, and leads to more effective management of the widespread use of psychoactive substances in the future.

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## SUMMARY

A tough anti-drugs campaign was launched in Iran following the revolution that established the Islamic Republic in 1979. Individuals caught in possession of drugs received fines, imprisonment and corporal punishment. The death penalty was prescribed for serious drug offences. Despite these measures, drug use and drug trafficking have continued to increase, and Iran has become the principal transit country for drugs from Afghanistan. In 2002, Iran accounted for a quarter of world opiate seizures. At this time, it was officially estimated that there were between 200,000 and 300,000 drug injectors in the country, and this is widely regarded as an underestimate. The costs of Iran's drug problem include: high levels of dependency and addiction; strains on the capacity of the criminal justice system; increases in drug related deaths; and high rates of HIV/AIDS infection among injecting drug users. There is growing recognition in Iran of the limits of enforcement, and the importance of the medical and social dimensions of drug misuse. This has resulted in improvements in drug treatment and expansion of harm reduction services.

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## IRAN'S DRUG PROBLEM

### *A long history of drug use*

For centuries, Iran was a major global centre of opium production and distribution. In the 1920s, it supplied around 100 tons of opium a year to internal and external markets (Kerimi N 2000). It has been estimated that by 1949 more than one in ten adults in Iran (11 per cent) were using drugs; there were 1.3 million regular opium users; and the capital city, Tehran, contained 500 opium dens (McCoy A 1991). In 1969 there were, reportedly, 350,000 opium users, consuming a total of 240 tons of opium a year. By the early 1970s, it was

estimated that there were 400,000 drug addicts, a quarter of them registered opium smokers. In 1975, there were also 30,000 identified heroin users (Moharreri M R 1978; McCoy A 1991). Drug use has been widespread in Iran for hundreds of years. But there have been recent changes in the nature of, and response to, the country's drug problems.

The 1979 Islamic Revolution installed the theocratic state of Ayatollah Khomeini. According to an assessment made by the United Nations in 1999, there was a significant increase in the use of heroin in the years that followed. Official Government sources claimed that five per cent of the Iranian population was drug addicted shortly after the revolution, some two million people (Razzaghi E *et al* 1999). This figure is much higher than

those that were being recorded less than a decade earlier, raising questions about definitions of drug addiction and the collection, compilation and interpretation of the data. What is beyond dispute is that during the revolutionary period controls on the opium poppy became temporarily ineffectual. This combined with the new regime's focus on alcohol to fuel a steep escalation in drug use (York G 2000; Narcotics Control Strategy Report 2001).

## Changing problems

### *From producer to transit country*

Since the Islamic Revolution, there has been a *fall* in opium cultivation within Iran's borders.

In 1979, around 33,000 hectares of land were under opium cultivation in Iran. By 1993, this had fallen to 3,500 hectares (Narcotics Control Strategy Report 2001). The Iranian authorities have claimed that even this comparatively low figure is an over-estimate (Mehryar A, personal communication, 2001). A 1998/1999 survey of one million acres of land in traditional poppy growing areas concluded that opium cultivation was negligible (Narcotics Control Strategy Report 2001).<sup>1</sup>

But as Iran's importance as a producer of opium has declined, its significance as a transit country has increased. This is because it shares a border with Afghanistan, now the largest producer of opium in the world. It, therefore, links West Asian producers with markets in the Persian Gulf, Russia, Turkey and Europe. Drugs are flooding through the country. In the year 2000, 254,271 kilograms of controlled drugs were seized inside Iran, including 6,189 kg of heroin, 20,275 kg of morphine, 179,053 kg of opium and 31,581 kg of hashish (UNDCP 2001). According to the World Drug Report 2004, 65 per cent of *all* opiate seizures were in Asia in 2002, compared to 28 per cent in Europe and 6 per cent in the Americas. In 2002, Iran accounted for a staggering 25 per cent of the world total - with Afghanistan's other neighbour, Pakistan, accounting for 16 per cent (UNODC 2004).<sup>2</sup>

### *More harmful patterns of drug use*

It is widely accepted that levels of harmful drug use are increasing due to changing patterns of drug trafficking, and, particularly, the increase in the availability of heroin. It has been estimated that 10 per cent of the populations of key cities on the main trafficking routes are drug users.<sup>3</sup>

A Rapid Situation Assessment (RSA) of ten urban sites conducted in 1998/1999 (Razzaghi E 1999) reported that the drug that had been most commonly used in the previous month was opium (73.3 per cent of respondents). But, in addition, over one third (39.4 per cent) of respondents had used heroin. In some areas of Iran, life time prevalence rates for heroin use were extremely high: 70 per cent in Kermanshah, 62.7 per cent in Khoransan and 60 per cent in Tehran.

Traditionally, opium, opium residue and cannabis were smoked in opium pipes, or dissolved in tea or coffee and ingested.<sup>4</sup> But modes of drug administration are changing too.

In particular, an increase in heroin dependency has been accompanied by a rise in injecting drug use. The RSA 1998/1999 found that injecting drug use in Iran was significantly higher than previously believed. The main reasons that Iranian drug users gave for switching to injecting were that opium no longer gave them the desired high and had become too expensive. In 2000, a gram of heroin could, reportedly, be purchased on the streets of Iran for as little as three to four US dollars (York G 2000).<sup>5</sup>

The Iranian Government estimated in 2001 that the number of drug addicts in the country was 1.2 million. But national HIV/AIDS experts have claimed that in reality the figure is nearer to 3.3 million addicts, using a rather different definition of addiction as repeated and continuing drug use over a nine month period (Narcotics Control Strategy Report 2001). Estimates of the numbers of injecting drug users in Iran ranged from 200,000 to 300,000 (Iran News 2001; MAP 2001). The latest World Drug Report from the UNODC states that 'Iran could be home to as many as 200,000 injecting drug users' (UNODC 2004).

### *Drug-related harm*

The first Beckley Report concluded that the ultimate goal of drug policy should be to reduce drug-related harm. It shifted the evaluative emphasis 'from effectiveness in reducing the *use* and *production* of illicit drugs to effectiveness in reducing the *harm* associated with drug use and drug policy' (Roberts M et al 2004).

All else being equal, an increase in the availability of drugs will result in a rise in drug-related harm. But other factors supervene on this relationship. These include methods by which drugs are administered and the availability (or otherwise) of services such as needle exchanges.

<sup>1</sup> Although it was acknowledged that cultivation could be continuing in remote areas of the country that were not properly surveyed.

<sup>2</sup> There is a useful discussion of per capita seizures in the UNDCP report: 'A calculation of [overall] seizures in unit equivalents on a per capita basis provides a somewhat different picture. The largest seizures are still found in the Americas (12 units per inhabitant in 2002) and in Europe (10 units), but Africa comes next (3 units) below the global average of 4 units, followed by Oceania (3 units). Given the large population in Asia, per capita seizures in this region are relatively small (2 units per inhabitant). However, in the countries around Afghanistan (Pakistan, Iran, Central Asia) per capita seizures of 13 units in 2002 were even higher than in the Americas or in Europe' (UNODC 2004, p. 40).

<sup>3</sup> In Tehran with a population of 12 million, it has been estimated that there are about 240,000 drug users. It is widely felt by experts that this figure is far too low.

<sup>4</sup> Between the 1930s and 1950s it was a common practice to drink opium in tea and coffee shops. But this is now subject to tough legal penalties.

<sup>5</sup> The switch from opium to heroin use in these circumstances is a further example of the substitution effect that has been discussed in detail in previous Beckley briefings and reports.

These points are well-illustrated in the case of Iran. A rise in prevalence of drug use and changes in patterns of drug use have been associated with a range of drug-related harms.

### *Crime and nuisance*

The RSA 1998/1999 survey told a familiar story about the public nuisance associated with drug supply and use in Iran (Razzaghi E *et al* 1999). It concluded that drugs were commonly bought from street dealers, and that deserted buildings, gardens or parks in the suburban areas of cities were common sites for drug consumption and injecting (by contrast, opium and hashish are typically smoked in private settings).

As in other countries, the enforcement of drug laws, against a backdrop of increased trafficking and use, is placing massive pressures on the criminal justice system.

In 2000, the system processed over 269,259 drug offenders, an 18 per cent increase in the total number of detainees compared with the previous year. Over 80,000 prisoners were incarcerated for drug-related crimes (DCHQ 2001). Nearly three quarters (72.7 per cent) of injecting drug users in the RSA 1998/1999 study had a history of imprisonment, which compares to 36.3 per cent of non-injectors (Razzaghi E *et al* 1999).

The policing of the drugs trade in this region of Asia has resulted in a staggering level of injuries and deaths. The major trafficking routes into Iran are in the provinces of Khorassan, Sistan and Baluchestan. These are all rugged and forbidding mountainous areas with harsh climates. They are the scene of border skirmishes between law enforcement officers and drug smugglers. There were 1,532 armed confrontations in 2000, with 142 law enforcement officers and 904 drug traffickers killed. In the decade prior to this, more than 3,000 law enforcement officials were killed policing the drugs trade, and a further 10,000 disabled (UNDCP 2000; NDCR 2001).

### *Welfare, families and children*

It has been calculated that the average cost of a drug habit in Iran is around half of average monthly earnings of 400,000 Rials (approximately \$45 US dollars). The expenditure of such a high proportion of average income on drugs will inevitably impact on the health and welfare of users and families.

The RSA 1998/1999 study found that the majority of drug users were male (93.4 per cent), and over half were married (56.7 per cent). Almost all of them were living with their families (94 per cent).<sup>6</sup> Most respondents (80 per cent) were employed mainly as unskilled labourers on comparatively modest salaries (Razzaghi E *et al* 1999; Razzaghi E 2001).

Iran is the most populace country in this region, with a high proportion of young people within its population. Nearly half of Iranians are under the age of 14 (45 per cent) and a further

quarter are aged between 15 and 30 years old. There has been a sharp fall in per capita incomes. Unemployment levels have been estimated at 14 per cent, which is around six million individuals (Razzaghi E *et al* 1999; Ahmadi J and Ghanizadeh A 2000; Moore M 2001). There has been a rise in internal migration, urbanisation, crime and social problems, providing a breeding ground for the development and spread of drug problems (Razzaghi *et al.* 1999; UNDCP 2000; Iran News Daily 2001).

### *Drug related deaths and drug-related health problems*

The RSA 1998/1999 study found that most drug injecting is intravenous, using the veins of the arms, legs and groin. This will often result in physical damage and infection (Razzaghi E *et al* 1999).

Of the 323 respondents to this survey who were injecting drugs, nearly half reported sharing syringes and needles. Eighty eight per cent reported using some sort of cleaning technique, most of which were grossly inadequate, with methods including wiping with fingers or a cloth and using saliva, plain water or hot water.

There is a high rate of HIV/AIDS infection among injecting drug users in Iran. In July 2001, the Iranian National Committee on AIDS reported that the cumulative total of officially recorded HIV infections was 2,458. Of this total, 1,841 (74.8 per cent) were drug users (MAP 2001). The evidence suggests that the majority of people who have become infected with HIV in Iran are injecting drug users, and this is due to the widespread sharing of needles and syringes. The recorded figures for HIV/AIDS will significantly underestimate the numbers of people actually infected. The Iranian Ministry of Health estimates that there were as many as 60,000 people infected with HIV/AIDS in 1999 (Prevention Department 2000).

The situation is particularly grave inside Iran's prisons. Injecting equipment consists of frequently used and shared needles and even hand made needles and droppers. A newspaper report in 2000 claimed that in Iran's prisons a syringe that had already been used 30 to 40 times could cost the user as much as 2,000 to 3,000 tomans, which is roughly US \$2.50 (Iran News Daily 2000). In 2001, infection was identified among injecting drug users in ten Iranian prisons, with a 63 per cent rate of HIV infection amongst drug users in one institution (reported in UNODC 2004, p. 50).

Drug-related deaths are also on the increase in Iran. In 1996, the official figure was 717 deaths, a year later this had risen to 788, and by 2000 the figure had reached 1,000 (DCHQ 1998; State Welfare Organisation 2000).

<sup>6</sup> Some experts on the drug situation in Iraq believe that there is a hidden problem of drug use among women, and that this is both chronically underestimated and rising rapidly.

## CHANGING APPROACHES TO THE DRUG PROBLEM

Iran has been struggling to control and regulate drugs for centuries – with Royal Orders to restrict drug use documented as far back as 400 years (Razzaghi E et al 1999).

As recently as the 1950s, drinking opium in tea and coffee shops was a common, and officially tolerated, cultural practice in Iran. In 1955 Iran introduced its first laws in modern times to prohibit the cultivation and use of opium. Fifteen years later, in 1969, with opium users estimated to number 350,000, the law was relaxed to permit limited use and cultivation (McCoy A 1991). The Government initiated a nationwide opium maintenance programme aimed at people over the age of 60 suffering from chronic illnesses, for whom it was felt that detoxification was not advisable (ibid). From 1974 to 1977 a detoxification program operated throughout Iran, serving around 30,000 out-patients (Spencer C and Agaho C 1990-91). Drug users were provided with coupons for opium tablets for two to three months, and in some cases methadone treatment, to help them cope with the detoxification process.

Following the 1979 Revolution, however, a tough anti-drug campaign was launched.

### *An enforcement driven approach*

Despite evidence that levels of drug use were surging upwards after the 1979 Islamic Revolution, public health services delivering drug treatment were initially closed, being replaced by compulsory ‘rehabilitation’ camps. The laws against drug use or dealing were strictly enforced, with severe punishment the norm. Iran’s drug laws combine fines, imprisonment, corporal and capital punishment. The death penalty is prescribed for serious drug offences. If the quantity of drugs does not exceed 20 kg and the perpetrator does not succeed in smuggling, distributing or selling them, the courts have the option of commuting a death sentence to life imprisonment and 74 lashes – still an extremely severe penalty.

Throughout the 1980s and 1990s, the courts sent thousands of drug users to mandatory treatment and rehabilitation centres or prisons. In 2000, of over 269,259 drug offenders processed through the system, 144,478 were considered drug addicts, rather than dealers or smugglers (DCHQ 2001). In a twenty-year period, a total of 1,700,000 people have been imprisoned for drug offences (State Welfare Organisation 2000).

Another aspect of this enforcement driven approach has been the widespread use of mandatory drug screening in Iran. People are routinely screened before marriage, to obtain driving licenses and after applying for government jobs (Razzaghi E et al 1999).<sup>7</sup>

<sup>7</sup> In 1998, 1.3 per cent of all people tested for drug use under the categories of marriage and government jobs (n = 768,525) were found to be positive for opium. This is likely to be an under-estimation as some drug users adapt their behaviour before screening to avoid a positive test.

### *The limits of enforcement*

These uncompromising law enforcement measures have failed to stop the drug traffickers or reverse the increase in drug use and availability within Iran. Here, as elsewhere, a growing recognition of the limits of law enforcement as a means of reducing prevalence and drug-related harm has resulted in a greater interest in demand-side and harm reduction initiatives – a return to the sort of policies that were being pursued prior to the 1979 Revolution.

The last six or seven years, in particular, have seen the focus of drug policy in Iran move from anti-trafficking activities to responding to the social and health aspects of domestic consumption, particularly the rise of addictive patterns of heroin use. This is not to say that the legal framework has been liberalized – the Anti-Narcotics law was actually strengthened in 1997. Under the new law, possession of up to 50 grams of cannabis or opium can result in a fine of four million rials (around US \$450) and up to 50 lashes. Punishment for someone who deals in, puts on sale or carries heroin or morphine varies depending on the circumstances – for possession of between five centigrams and one gram the fine is two to six million rials (US \$225 to \$675), plus 30 to 70 lashes (DCHQ 1997; DCHQ 2001).

There are signs, however, that the extreme punishments available under the law are being implemented with less enthusiasm – the death penalty is now only used for major traffickers, and most instances of possession do not result in imprisonment.

A further complication is that the judge has discretion to decide whether somebody is a drug addict or a trafficker. A defendant who tests positive for a drug is generally considered an addict, whereas anyone in possession of a drug can potentially be dealt with as a trafficker (Razzaghi *et al.* 1999).

### *Increasing treatment services*

Drug addiction is still considered a crime in Iran, but there is a widespread recognition that it is also a medical problem. Since the mid 1990s, the law has allowed drug users who access treatment to be exempted from penal punishments.

The first developments under this new policy of expanding treatment were of three types.

**A small number of government supported Therapeutic Communities.** These residential centres provided abstinence-based group work programmes to heroin addicts, most of whom had been referred from the courts. Up until 1999, an estimated 25,000 to 30,000 drug addicts had been referred to these residential centres, with 90 per cent of admissions following a court order, and an average stay of between two and six months. However, there were serious problems with the standards of treatment offered in these residential centres, which have been described as having an infrastructure like an overcrowded prison. (Razzaghi *et al.* 1999).

**The development of ‘Narcotics Anonymous’ support groups.** These were encouraged in community centers in major urban areas and were popular with the authorities because they followed the 12-step philosophy that emphasized abstinence from all drugs.

**The relaunch of the outpatient clinics that had been closed down in the 1970s.** At first these clinics offered only short detoxification programmes using clonidine, a substance that had been seen as inappropriate for this purpose in European clinics for many years. However, the number of outpatient centres grew rapidly. By the year 2000, there were 100 such clinics, with a capacity to treat 100,000 addicts per year, as compared to 65 in 1999 and 40 in 1998.

By the end of the 1990s, however, there were growing concerns about the effectiveness of these treatment methods. At this point, the Iranian authorities, still at that time diplomatically isolated from many governments, encouraged their medical and welfare professionals to interact with drug treatment experts from other countries in the search for effective models of drug treatment. This interaction has led to a much more sophisticated development of treatment and harm reduction services in the last five years.

### *HIV Prevention*

Together with concerns about the impact of drug addiction on community cohesion, the fear of a drug injecting related HIV epidemic has driven much of the policy attention to drug problems in Iran in recent years. A study conducted in 1999 found that awareness of the risks of HIV/AIDS infection amongst drug injectors was worryingly low. The RSA 1998/1999 found that 20 per cent of respondents had not even heard of HIV/AIDS. Between 20 and 30 per cent of those who had heard of the disease were unaware that it could be transmitted by sharing injecting equipment (Razzaghi *et al* 1999). At that time, there had been little work on HIV/AIDS prevention for drug users – and, specifically, drug injectors – in Iran. In 1999, it was reported that there were no printed materials on HIV/AIDS available to drug users at all (*ibid*).

Many of the service developments over the last five years have been specifically designed to address this problem of the high risk of HIV/AIDS infection, and low levels of awareness of the risks amongst drug users. Developments in three areas are of particular significance: substitution treatment, outreach services and prisons.

### *Substitution Treatment*

Responding to concerns about the effectiveness of short-term detoxification using clonidine, the first long-term substitution programme was initiated in 1999 in the Southern city of Marvdasht. Managed by a non-Governmental organization (Persepolis), this clinic offered buprenorphine tablets to more than 3000 clients between 1999 and 2001. It appears that this project has been successful in retaining patients in treatment and gaining local community support. This has resulted in greater support for substitution treatment in Iran.

In 2000, the first methadone pilot project opened within a government psychiatric hospital, eventually serving 140 patients. In 2002, with the support of the United Nations Office on Drugs and Crime’s (UNODC’s) office in Tehran, a major new outpatient drop-in centre was opened in the capital offering maintenance treatment to large numbers of addicts on an outpatient basis, alongside other services.

The Iranian Ministry of Health has expressed satisfaction with the results from these early projects, and has promoted their expansion. The Ministry of Health is currently drafting national guidelines on the appropriate standards for delivery of methadone maintenance treatment, the dissemination of which it is hoped will lead to a rapid expansion of the numbers receiving this treatment. To date, however, there has been limited progress in developing new clinics.

There are now a small number of clinics across Iran offering some form of substitution therapy, but with a total of only 2500 patients per year, the vast majority of whom are receiving detoxification only.

### *Outreach*

Following a similar timetable, the Persepolis project introduced the idea of community-based drop-in centres (DIC) to the authorities in 2000. These were designed to provide a means of outreach to drug injectors (who were largely found amongst the urban poor), to provide them with reliable information and education around drug use and the risks of HIV infection, as well as access to clean needles, condoms, and general healthcare.

The need for these services was highlighted when an early survey of 900 street drug users showed a 25% HIV prevalence rate. The DICs have been the focus of HIV prevention efforts amongst drug users, and many have introduced needle and syringe exchange programmes as part of a package of prevention and education measures. The Ministry of Health states that there are currently more than 60 ‘triangular clinics’ across Iran (centres that deal with public health issues, including addiction), but it is unclear how many of these have initiated needle exchange programmes.

As in most countries, the involvement of state-funded public health services in the distribution of clean equipment for the injection of illegal drugs has been controversial in Iran. However, with consistent support from international agencies, Iranian public health officials and NGOs, the Iranian government has concluded that the importance of minimizing the transmission of HIV and other infections justifies such measures. This official approval for needle exchange programmes was most clearly and recently expressed in an official order of the head of the Iranian judiciary (see Box).

### *Prisons*

Iran has a history of widespread incarceration of drug offenders. A significant proportion of the prison population is comprised of drug users. The concentration of drug users in crowded and unsanitary conditions presents a challenge for drug treatment and public health services. Other countries have

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## ISLAMIC REPUBLIC OF IRAN Judicial Branch

### Executive Order to All Judicial Authorities Nationwide

Among the legal obligations of the Ministry of Health and Medical Education is the implementation of programs necessary for the prevention of transmission of communicable diseases aimed at harm reduction and maintenance of public health and well-being of society based on guidelines required to fulfill its mission. One of interventions has been done by the Ministry of Health and Medical Education includes provision of needles, syringes and other material used individually by drug addicts and AIDS patients as well as methadone maintenance treatment programs as means of combating HIV and Hepatitis infections among drug addicts. According to the Ministry some judicial authorities have considered such an intervention as ally to crime subject to punitive action, thus unintentionally impeding the implementation of health and treatment programs aimed at prevention and combating the transmission of dangerous contagious diseases.

Thus, this is to remind judges at all courts of justice and prosecutors' offices throughout the country that since a major element of accompaniment in crime needs to be verification of malicious intent, the said interventions are clearly void of such malicious intent but rather motivated by the will to fulfill the mission of protecting society from the spread of deadly contagious diseases such as AIDS and hepatitis. Therefore all judicial authorities must consider the lack of malicious intent in the interventions of the Ministry of Health and Medical Education as well as those of other centers and organizations which are active in this field and not accuse the service providers with unfair characterization of accompaniment in the criminal abuse of narcotics and not impede the implementation of such needed and fruitful programs.

*Seyed Mahmood Hashemi Sharoudi*  
*Head of the Judiciary*  
*Jan 24th 2005*

experienced the initiation or acceleration of HIV, Hepatitis or TB epidemics through drug-related transmission in prisons, and all the conditions exist for this to be a very real threat in Iran.

As a result, there is support from the Iranian prison authorities for the development of treatment and infection prevention services for drug users. A programme to introduce harm reduction services into Iran's prisons was initiated in 2003. To date, 40 prisons have developed triangular clinics, that offer services that tackle drug addiction, HIV and sexually transmitted infections. Recent figures suggest that around 1500 prisoners are receiving methadone substitution therapy. The introduction of needle exchange services into prisons is also being considered but, at the time of writing, no pilot project has been commenced.

## CONCLUSION

Developments in Iran illustrate that regional drug problems and policy responses are shaped by a complex mix of different factors, which change over time, and some of which are outside the control of national governments.

Above all, the situation in Iran has been shaped by its geographical proximity to Afghanistan. The INCB Report 2004 states that 'opium production in Afghanistan and its impact on

peace and security remain the central elements of the drug situation in West Asia ... In other countries in the region, drug trafficking and abuse are rapidly increasing, undermining social and economic stability' (INCB 2005). Against this background, the UNODC comments that 'more than half of the world's opiate users are found in Asia (7.8 million), primarily in countries surrounding Afghanistan and Myanmar. The highest prevalence rates have been reported from Iran, Kyrgyzstan and Lao PDR' (INCB 2004).<sup>8</sup>

The high rate of opiate misuse in Iran, then, reflects the huge volume of controlled drugs passing through the country on transit from Afghanistan to consumer countries. But Iranian drug problems also need to be placed in context. High unemployment, falls in income and processes of urbanisation and social dislocation within its borders provide a breeding ground for substance misuse problems, and serve to undermine traditional cultural controls on drug use, underlining the significance of the wider economic, social and policy environment.

<sup>8</sup> Pointedly, the INCB has highlights the potential impact of a destabilised Iraq on drug problems in West Asia. The Board comments that 'the drug situation in Iraq may deteriorate further because of the disintegration of the drug control structure in the country, given its geographical location and the current political and economic instability in the country. The complex interlinkage of terrorism, organised crime, corruption and drug trafficking poses an unprecedented threat, raising concerns that the overall situation will worsen' (INCB 2005). This is likely to have repercussions throughout the region.

Governments do have a significant degree of control over drug policy responses, within the parameters set out in the UN drug control treaties. From this perspective, it is striking that the Islamic Republic of Iran has followed broadly the same course as secular governments elsewhere in the world, despite the cultural differences. There is increasing recognition in Iran of the limits of law enforcement and of the importance of supporting drug treatment services that can address the demand side. There is also a greater interest in harm reduction interventions that can limit the damage that drugs cause to users, families and communities (notably substitute prescribing and needle exchange). As in other parts of the world, the urgent need to do something about the spread of HIV/AIDS is helping to overcome ideological barriers to harm reduction work.<sup>9</sup>

Significant challenges remain for the Iranian authorities. The levels of drug addiction, and the growing proportion of injectors, represent a real threat to the health and social well-being of the population; harsh enforcement and punishment continues to put a great strain on the enforcement agencies and judicial system; and the treatment and harm reduction services that have developed are not yet providing sufficiently wide coverage of the target groups of problem drug users. It is encouraging, however, that in Iran these challenges are being confronted directly, and at a time when significant reductions in drug problems are a realistic objective.

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<sup>9</sup> The increasing focus on the demand side has been welcomed by the INCB. In its 2004 report, the Board writes: 'the Islamic Republic of Iran remains a major transit country for drugs originating in Afghanistan and continues to be committed to combating the illicit drug transit traffic and drug trafficking in general. It also has increasingly recognised the dangers posed by domestic consumption. In addition to intensified efforts made in the area of drug law enforcement, demand reduction activities have recently been initiated, including the assessment of drug abuse trends and the establishment of a national institute for drug abuse research and training', it continues: 'the Board welcomes these initiatives and stresses the need to continue to enhance activities in the field of demand reduction, with particular emphasis on strengthening cooperation with non-governmental organisations' (INCB 2005).