



Review

Drug use treatment and harm reduction programs in Iran: A unique model of health in the most populated Persian Gulf country



Zahra Alam-mehrjerdi ^{a,*}, Mohammad Abdollahi ^b, Peter Higgs ^c, Kate Dolan ^a

^a Program of International Research and Training, National Drug and Alcohol Research Centre, Faculty of Public Health and Community Medicine, University of New South Wales, Sydney, Australia

^b Faculty of Pharmacy, and Pharmaceutical Sciences Research Center, Tehran University of Medical Sciences, Tehran, Iran

^c National Drug Research Institute, Faculty of Health Sciences, Curtin University, Melbourne, Australia

ARTICLE INFO

Article history:

Received 18 July 2014

Received in revised form 27 April 2015

Accepted 20 June 2015

Keywords:

Drug

HIV

Harm reduction

Asia

Persian Gulf

ABSTRACT

Because of the proximity of Persian Iran to Afghanistan, the main opium producer in the world, drug use especially opium use has a long history in Iran. Opium and its residues are the traditional drugs while heroin, heroin *Kerack*, norgesic, temgesic, and methamphetamine use and injection have emerged more recently. In recent decades, heroin smoking and injection have presented challenges to the Persian health policy makers to accept and develop the internationally-approved programs of drug use treatment and harm reduction. The current paper summarizes the overall picture of main drugs used and the history of establishing the nationwide movement of drug use treatment and harm reduction programs after the 1979 revolution until the end of 2014. The paper concludes that Persian Iran has a well-developed healthcare system in the provision of drug use treatment and harm reduction programs in the south-west of Asia especially the Persian Gulf region. These therapeutic and harm reduction-related programs are required to be strengthened by opium supply reduction and eradicating drug production in Afghanistan. The provision of prevention programs, drug education via mass-media, employment and inexpensive leisure activities are required in Iran. In addition, conducting household surveys of the prevalence of drug use and evaluating the clinical effectiveness and treatment outcomes of the provided drug treatment and harm reduction programs are required. National and regional collaborations are rigorously suggested to manage supply reduction along the borders and implement demand reduction inside the borders.

© 2015 Elsevier B.V. All rights reserved.

Contents

1. Introduction	79
2. Drug use problem	79
3. Drug treatment system	79
3.1. Compulsory drug treatment	79
3.2. The first drug use treatment programs	79
3.2.1. Medical detoxification with clonidine or naltrexone	79
3.2.2. Other medical methods of detoxification	80
3.3. Recent drug use treatment programs	80
3.3.1. Methadone, buprenorphine and naltrexone maintenance treatment programs	80
3.3.2. Harm reduction programs	80
3.3.3. Drug treatment and harm reduction programs in prisons	80
3.3.4. Women-specific drug treatment and harm reduction programs	80
3.4. Other drug treatment modalities	81
3.4.1. Opium tincture	81

* Corresponding author. Tel.: +61 2 8936 1008; fax: +61 2 9385 0222.

E-mail address: z.alammehrjerdi@unsw.edu.au (Z. Alam-mehrjerdi).

3.4.2. Methamphetamine use treatment	81
3.5. Non-governmental organizations (NGOs)	81
3.6. The national addiction telephone line	81
3.7. Refugees and drug treatment	81
3.8. Research and international collaborations	81
4. Conclusion	81
References	82

1. Introduction

Iran also called Persia is a vast Persian-speaking country with Indo-European roots and Aryan race in the south-west of Asia. It is situated between the Caspian Sea in the north and the Persian Gulf and the Sea of Oman in the south. The population of Iran is approximately 78 million.

Iran is the most populated Persian Gulf country with the longest borders. The country has also long borders with Iraq, Turkey, some Central Asian countries, Pakistan and Afghanistan.

2. Drug use problem

Drug use is a serious health concern in Persian Iran. Iran borders Afghanistan, a major producer of opium globally. It is across this border that opium and heroin are massively smuggled to Iran. In addition, opium and heroin production in Afghanistan has resulted in the indirect role of Iran as a drug transit country to Europe and other parts of the world (United Nations Office on Drugs and Crime, 2013a).

There is a paucity of household surveys of the prevalence of drug use in Iran. The total number of regular and recreational substance users is estimated to be between 4 and 7 million people (Jafari et al., 2008). Studies show that 1,200,000–2,000,000 people are dependent on illicit drugs (Alam mehrjerdi et al., 2014). Opium, opium residues, low purity heroin, impure Persian methamphetamine, hashish, alcohol and prescription opioids are used by drug users while cocaine, inhalants and ecstasy are not common. The main route of drug administration is smoking (Alam mehrjerdi et al., 2013, 2014; Mokri, 2002).

Iran is a traditional opium user in the south-west of Asia. The first reports of opium use date back to the 17th century. Eating or smoking opium has a relative cultural acceptance in some Persian communities (Malekinejad and Vazirian, 2012). Using opium and its residues colloquially named “Shireh” and “Sukhteh” are culturally accepted among some people (Jafari et al., 2009). Studies show that inexpensive opium availability, curiosity, pleasure seeking, self-treatment of physical and emotional problems, opiate dependence, family problems, conformity with cultural norms, social acceptance, peer pressure and unemployment are the main reasons of opium use (Jafari et al., 2009; Naranjiha et al., 2008).

Heroin was introduced in Persian Iran in the 1960s (Mokri, 2002) and is highly stigmatized (Malekinejad and Vazirian, 2012). Compared with opium, heroin use and injection are new health problems. 9–16% of drug users inject heroin (Razzaghi et al., 1999). Studies show that in the 1990s, low opium availability and low price of heroin facilitated heroin injection in the country for the first time (Nassirimanesh et al., 2005). Since 2000, heroin injection has emerged as a new health concern among some drug users and is associated with the transmission of blood-borne viral infections (Afkhami, 2009). Studies show that sharing injection equipment is common and approximately 65% of all HIV-cases are caused by sharing syringes and needles (Razzaghi et al., 2006).

The reports of the Persian Drug Control Headquarters show that in 2000, smoking a new synthetic form of heroin which is

colloquially named “Kerack” became common among opium and heroin users (Akhgari et al., 2012). Heroin *Kerack* (not to be mistaken with Crack Cocaine) was first imported from Afghanistan in 2000 (Alam mehrjerdi, 2013). A report showed that in 2000, Taliban leader Mullah Mohammed Omar shortly eradicated heroin production in Afghanistan. The result was a 99% reduction in the area of opium poppy cultivation, roughly three quarters of the world’s supply of heroin at the time (Farrell and Thorne, 2005). After a short period of time, because of low heroin supply, heroin *Kerack* production was initiated in Iran and facilitated a new trend of drug injection (Malekinejad, 2011; Razani et al., 2007). Recently, heroin *Kerack* is not used. Inexpensive low purity heroin is back to the illicit drug market (Alam mehrjerdi et al., 2014).

In 2005, two illicit opioids, called norgesic and temgesic were introduced to drug injectors. Studies show that norgesic and temgesic ampoules are sporadically used in Iran (Shekarchizadeh et al., 2012; Shokuhi et al., 2008). From 2007 to 2009, a research study of 62 drug users in a hospital in eastern Iran found that norgesic and temgesic use were among the most common reasons associated with the hospitalization of drug users (Tavanaee Sani and Khaleghinia, 2012).

According to the reports of the Persian Drug Control Headquarters, in 2005, methamphetamine was first imported from South-East Asia to Iran (Alam mehrjerdi, 2013). But after a short period of time, methamphetamine production was initiated in clandestine laboratories. Methamphetamine is inexpensive and methamphetamine use has become common among opiate users and injectors as a new health concern (Alam mehrjerdi, 2013; Alam mehrjerdi et al., 2013).

3. Drug treatment system

3.1. Compulsory drug treatment

After the 1979 revolution, methadone treatment centers were shut down and replaced by compulsory residential rehabilitation centers. According to a report, this trend continued through the 1980s and 1990s and drug use was a criminal activity (Nassirimanesh et al., 2005). In the 1990s, the Persian healthcare system accepted that to consider opiate use as a criminal activity was not effective because of common opium use and heroin injection. To encounter drug use problem, a drug treatment and harm-reduction committee was established with the participation of senior scholars (Razzaghi et al., 2006). In 1994, the Persian healthcare system initiated utilizing the internationally-approved drug use treatment and harm reduction programs. In 1997, the government officially approved drug use as a health concern (Nassirimanesh et al., 2005).

3.2. The first drug use treatment programs

3.2.1. Medical detoxification with clonidine or naltrexone

According to a report (Nassirimanesh et al., 2005) in 1994, short-term medical detoxification became common for drug treatment and the Persian Welfare Organization established outpatient medical detoxification centers in all provinces. At those

Download English Version:

<https://daneshyari.com/en/article/315857>

Download Persian Version:

<https://daneshyari.com/article/315857>

[Daneshyari.com](https://daneshyari.com)