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Workshop Report: Defining Mechanisms for Scaling Up HIV Control Programs among Injecting Drug Users: Challenges and Obstacles

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Introduction:

Almost three decades ago, when the world was on the verge of celebrating eradication of Smallpox, just another disease created a significant challenge for the world. A new virus called HIV, managed to make changes in priorities and policy-making of health systems in a very short time scale. This virus has become more important as its transmission is accompanied with a range of risky behaviors. Behaviors that, although in many communities are not looked at positively, but nonetheless, occur in almost all of them. Theoretically speaking, transmission of HIV may be easily controlled through some simple changes in behavior. Nevertheless, in practice, it is not such an easy task. There are various approaches towards HIV epidemic in different countries ranging from absolute denial to its acceptance as a reality and, of course, making efforts to control it through realistic methods and stopping the virus transmission cycle.

Countries must recognize the key elements in development of this epidemic by placing an emphasis on and concentrating upon the correlation between HIV epidemiology and social behaviors and conditions that hinder the access to information and services on prevention and use thereof. Having an understanding of this epidemic is the basis of *knowing the response* and provides countries with the opportunity to critically assess who the participants in HIV prevention are and who must participate therein.

HIV/AIDS prevention among populations that are exposed to the highest risk of transmission, such as injecting drug users, commercial sex workers, and those who have unprotected sexual behavior, and preventing virus transmission from such people to the general population across the country, is a challenge that those in charge of health care issues in countries such as Iran, where AIDS epidemic is on the concentration stage, are faced with. Although this epidemic may not yet be the case for the general population of this country, but considerations such as young population, existence of some observations on the increasing share of sexual relationships in the spread of the epidemic, and the considerable IDU population that is estimated to be around 200,000, makes it more necessary to scale-up harm reduction programs.

Iran started initial preparatory and implementation stages of harm reduction programs successfully and on a timely basis as it is now considered one of the leading countries in this field. However, the current challenge is the harm reduction outreach aggregated based on various vulnerable groups. For this purpose and in order to identify the mechanisms required for scaling up outreach of harm reduction programs, and following a number of consultative meetings, a two-day seminar called “Workshop on Defining Mechanisms for Scaling-up HIV Control Programs among Injecting Drug Users: Challenges and Obstacles” was held on 22 and

23 Aban 1386 (13-14 November 2007) in Tehran under the joint UN program on AIDS in cooperation with Iran Drug Control Headquarters. In consultation with Drug Control Headquarters, efforts were made to invite representatives of all stakeholders and finally, more than 40 experts in the respective field categorized by government organizations, non-government organization, private organizations and research centers from various parts of the country were invited (see list of participants in Annex 1). The seminar programs on various issues were followed up in four sections and 20 working groups. (See Annex 2 for Workshop Program).

The following issues were discussed in this seminar in the following order:

Workshop 1: A review of the current HIV/AIDS status among Injecting Drug Users and Prisoners; The Country Response
Workshop 2: A review of the programs, policies and processes
Workshop 3: Agonist Drugs Maintenance Treatment
Workshop 4: Needle and Syringe and Condom Programs in temporary centers and mobile teams

In each of these workshops, experts discussed a package of issues. The conclusions made have been derived from such issues. A list of the issues discussed appears in the Annex 3.

This report aims at analyzing conclusions of the above mentioned workshop and seeks to identify harm reduction status in Iran and find ways for its improvement. The following resources have been used in devising the present report:

- Written report on the process and the results as discussed in workshops
- Report of the IR of Iran on Monitoring the Declaration of Commitment approved by the Special Meeting of the UN General Assembly on HIV/AIDS, January 2008
- The document on "HIV/AIDS Status in IR of Iran and its Country Response" that was released in December 2006 by the Ministry of Health and Medical Education.
- Report of the World Health Organization consultants from their comprehensive visit from this country in 2006.
- Efforts have been made, as far as possible, to make use of international experiences and studies conducted in the world to enhance quality of this report. A list of the resources is available in Annex 4.

It must be noted that, in preparation of the present report, in addition to the issues discussed during the workshops pertaining to key concepts, definitions of harm reduction, outreach of

harm reduction programs and its necessity in Iran, a review of the global harm reduction challenges have also been included by making use of the resources indicated in the Annex 4. In the section dealing with a review of the current situation, since the participants did not have the required resources, some parts have been added to the report based on the resources they touched upon. These have been highlighted in the report so as to distinguish them from other issues discussed during the workshop. One of the major resources that have been used in this section is the last report of the IR of Iran on The Monitoring of Declaration of Commitment that was prepared and released by the Ministry of Health and Medical Education in 2007.

Key Concepts

- Opioid Substitution Therapy

Various types of Opioid Substitution Therapy have been widely accepted by the society as a drug dependence treatment and of the harm reductions programs. (Resource-50). This treatment includes prescribing a drug that has effects similar to illegal drugs (the term agonist in pharmacology) with less risk. Drug treatment by agonists is available only for those who are at the initial stages of drug dependence because effectiveness of Substitution Therapy for those using cocaine and amphetamine-type drugs has not been proved yet. (Resource 23).

- Methadone Maintenance Treatment

Methadone Maintenance Treatment (MMT) is a medication-based treatment for heroin users. Methadone is used as a substitute for heroin and it therefore, prevents temptations and deprivation symptoms and allows injecting drug users to quit injecting and take part in treatment programs. There are firm evidences demonstrating that Methadone Maintenance Treatment results in reduction in use of illegal use and injection of drugs and subsequently decreases possibility of HIV transmission.

- Harm Reduction

Harm Reduction has been defined in the report in detail.

- Needle and Syringe Programs

Needle and Syringe Programs are programs which provide sterile needles and syringes and other injection equipments. Additionally, usually these programs also provide condoms and training of safer injection for HIV prevention. A large body of evidence indicates that Needle

and Syringe Programs prevent HIV transmission and have no negative impacts on the society. Needle and Syringe Programs are cost-effective (Resource 2), do not encourage drug use (Resource 3) and may establish connections between injecting drug users and drug users treatment programs (Resource 4).

What is Harm Reduction?

There have been various approaches to addiction in communities namely anti-supply approach, demand reduction through initial prevention programs and treatment and the most recent approach, that has received more emphasis after emergence of HIV, is harm reduction.

There are different definitions and even different terms in this respect namely Harm Reduction, Risk Reduction and Harm Minimization (Resources-5). In defining Harm Reduction, David Ostrow says:

"*Harm reduction is anything that reduces the risk of harms for the individual that can not or will not quit his risky behavior and is ranked from changes in behavior to changes in use of drugs and sexual relationships*" (Resources-6).

The definition provided by the International Society of Harm Reduction in 2002 is as follows:

"Policies and programs that primarily seek to reduce health, social and economic consequences of psychoactive drugs for the user, the family and the society without having to limit the drug use." (Resources-7)

Although there are different definitions for Harm Reduction, but there are three basic points in this concept (Resources-8). Firstly:

- Harm Reduction is in fact a preventive measure involving three levels though some resources refer to it as a secondary prevention measure
- Is a part of the health services promotion continuum
- Policies and programs towards reducing harmful consequences of drug use while the individual continues to use drugs and is not in the opposite direction of the avoidance-oriented services (Resources-9).

In other words, in this approach, the fact that the user continues drug use for any reason is accepted. Obviously, this does not imply an approval of the continued use. Nevertheless, the user, like any other human being, is treated with respect (Resources-10).

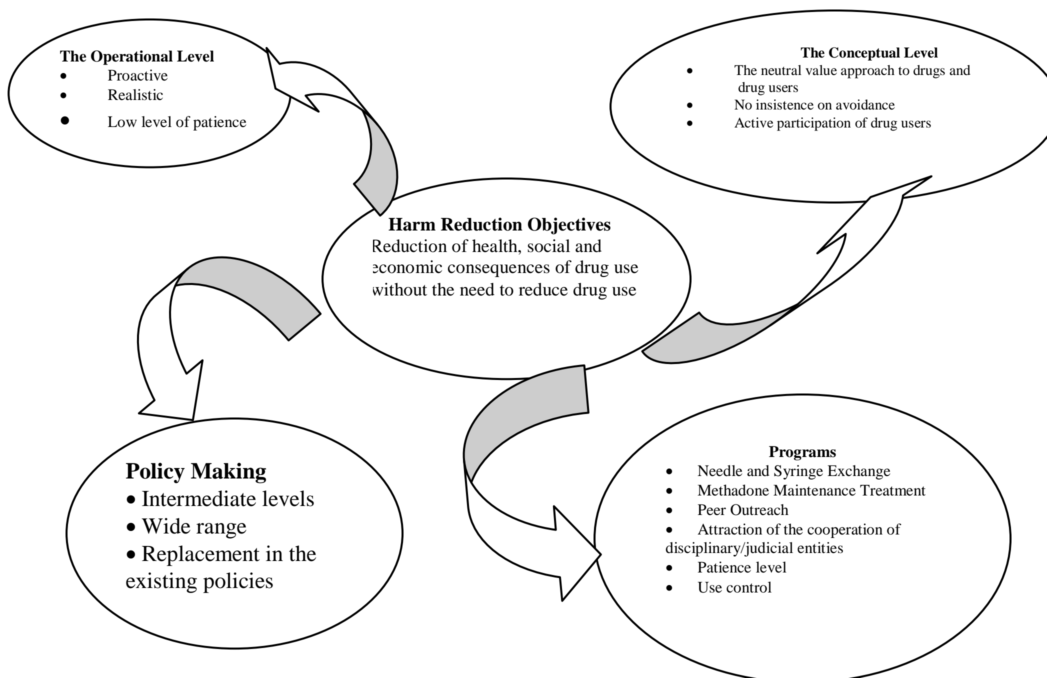
These principles demonstrate the very fact that harm reduction interventions have humanitarian outlook and, in addition to reduction of HIV/AIDS occurrence and prevalence, they need to take into consideration reduction of pain and misery of users and their families and eventually, rights of all stakeholders.

There are advocates and opponents to this approach each of whom consider the issue from their own point of view and hold reasons that are not necessarily evidence-based and most of which are based upon personal and individual observations. Thus, for harm reduction interventions to be sustainable, they need substantiated and strong evidences and scientific defense from harm reduction interventions based on evaluation and assessment of programs.

As mentioned earlier, this approach, for various reasons that shall be addressed later in this report, is an approach which, despite being recognized as a successful one, is still subject to debates for which reason, expansion of this approach to include different countries, including Iran, faces different challenges.

In any case, in relation to HIV and other blood-borne diseases, harm reduction strategies are implemented to reduce adverse health and social effects of injecting drug use. HIV prevention among Injecting Drug Users, in the best scenario, takes place by provision of the following services:

- Availability and possibility of referral to variety of types of addiction treatments including Substitution Therapy such as Methadone Maintenance Treatment. (Resources-12)
- Easy and comfortable access to sterile needle and syringe and hygienic disposal of such equipments (Resources-13 and 14)
- Community-based interventions and peer outreach programs (Resources-15).
- Basic health care such as Hepatitis B vaccination, care of abscesses and veins (Resources-2)
- Prevention of transmission through sex among users and their sexual partners such as access to condoms, treatment of sexual diseases, voluntary consultation and tests and antiretroviral treatments required for those who need them (Resources-2)
- Appropriate training and information (Resources-2)
- Access to care services at home and hospitals for the needy and social-physiological support and consultation services (Resources-2).
- The following drawing better demonstrates the concept of harm reduction services (Resources-16):



Coverage of Harm Reduction Programs, Definition and Principles

It is said that "coverage" in harm reduction, is a concept that has been coined and used more inappropriately and has been least understood than any other concept. A definition for this concept that is used much is the percentage of people that, in the process of an intervention, have been reached at least once (or there has been access to them in one year). Under this definition, coverage is a simple statistical issue. For instance, if 100 percent of injecting drug users have been accessed once, and if they have been trained once, or have received one new needle and syringe, there is full coverage. In this case, even though coverage is full, but it is obvious that HIV epidemic shall not stop by such intervention. The fact of the matter is that, whatever the concept of coverage is, it should be used as a tool for finding more support for harm reduction programs and scaling it up further (Resources-17).

As mentioned above, there are different definitions for this concept. The World Health Organization relates this concept with effectiveness of the program and provides the following definition: Percentage of the population that needs an intervention and receives it effectively (WHO, 2001). The Joint UN Program on AIDS has defined this concept in a more specific term in Needle and Syringe Programs: "Number of sterile syringes that are given to an injecting drug user in a certain period of time divided by number of injections of this individual in the same period of time (UNAIDS 2006).

Which level of coverage for HIV epidemic control may be effective can be subject of a discussion and we face shortages of scientific data on this issue (Resources-14). Based on a analysis conducted in New York, Needle and Syringe Programs should have at least a sixty percent coverage so that transmission may be prevented (Resources-18) although Hickman and Heimer have recently stated that this objective may be achieved even by less coverage (Resources-14). The best option is to avoid stating one single figure for appropriate level of coverage in different countries because the ideal coverage in each area depends on a number of factors and to respond to it, the following items must be clarified first (Resources-14):

The endemic stage: On which level of endemic this country or region currently is (low level, concentrated, general, hyper endemic[1])?

- What are the sociological characteristics of the involved groups? For instance, gender and age pattern of users, their education, marital status, etc.)
- What is the use pattern in the country (For instance, what is the dominant drug used? What is the most used method?)
- What is the high-risk/protecting and environmental behavior pattern? (For instance, to what level are the used injecting equipments used? How accessible are the sterile injecting equipments? Are Harm Reduction Programs implemented?

The AIDS Projects Management Group has accepted access definitions of the World Health Organization and has generally stated suitable level of coverage in various harm reduction programs as follows (Resource 13):

- The Needle and Syringe Program. It appears that at least sixty percent of injecting drug users in one particular area need to have access to quality and regular Needle and Syringe Programs so as to prevent/reverse the HIV epidemic among Injecting Drug Users.

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[1] UNAIDS and WHO have categorized the HIV epidemic into three conditions: Low, Concentrated and General. To devise the objectives in these guidelines, another situation called Hyper-Endemic has also been added:

Low Prevalence Scenarios: Cases where the HIV prevalence in the community is less than 1 percent and HIV occurrence has not reached a considerable level in any of the population sub-groups.

Concentrated Scenarios: Cases where HIV prevalence in one or more population sub-groups such as men who have sexual relationship with other men, injecting drug users, commercial sex workers and their customers, is high but, the virus is not yet circulated in the general population.

General Scenarios: Cases where HIV prevalence in pregnant women referring to pregnancy health care centers is between 1% and 15%. This indicates that the HIV prevalence is high enough for the sexual relationship networks to cause spread of the epidemic.

Hyper-Endemic Scenarios: Refers to regions where there is 15 percent or more HIV prevalence among the population and the endemic progresses through multiple relationships between two sexes that are simultaneous and widely spread while use of condom is little or non-consistent.

- To substitute opioids, at least forty percent of drug users must take part in Substitution Treatment Programs on a regular.
- For anti-retroviral treatments, 100% of the HIV positive Injecting Drug Users need to receive systematic anti-retroviral treatments.

This group considers three main aspects for coverage, namely;

- Access: Access must be on regular basis and the number of people referring to services must be identified. It should also be made clear if provision of services is suitable and adequate for prevention/reversal/treatment of the epidemic.
- Range and scope of services: Can all the interventions provided bring about prevention/reversal/treatment of the epidemic?
- Quality: Are the interventions attractive and effective enough so as to materialize their objectives?

Although, the ideal level of coverage varies in different areas, but successful programs in various regions across the world have more or less identical characteristics. The "UNAIDS Best Experiences" (Resources-19) demonstrates that the following factors are common characteristics of the high-coverage programs:

- Making use of harm reduction principles to devise programs that are suitable for the respective conditions instead of imposing models that other countries have prepared. Those designing and implementing the programs must devise effective interventions for appropriate studies and measures in respect of HIV for their own region.

- Easy access is the indicator of high coverage programs.

- Involving Injecting Drug Users is a key activity: Regular interaction among Injecting Drug Users and program workers, based on mutual respect and friendship, appears to be an important element in achieving high coverage. More participation on the part of Injecting Drug Users (in a suitable structure) may lead to more sustainable programs.

- Advocacy needs must be prioritized, properly staffed and their financial resources must be provided: In order to overcome community's fears and government's concerns on harm reduction programs, there needs to be careful thoughts and fundamental work.

- Support from the whole society, its representatives in the government, religious entities and other intellectuals are required: This will be generally achieved through advocacy in various levels.

- Law enforcement plays a critical role in Harm Reduction Programs: In most countries, dealing effectively with HIV/AIDS among Injecting Drug Users means that programs are being implemented in a punitive environment. Effective programs need to be implemented in places where drug users are present and these programs need to work with drug dealers and owners of injection passages to make sure majority of Injecting Drug Users are present. The law does not necessarily need to support all activities of all effective programs. However, in order to achieve high coverage, law must allow for implementation of these programs without any obstacles.

- Provision of funds is an important issue in expansion of programs in order to achieve high coverage: Many harm reduction programs are launched by funds provided by foreign donors. Not only should foreign providers of funds be flexible as to the required sums of money at any location, but they also need to be flexible as regards certain elements of the program and the required implementing methods under certain conditions of the program.

- It is important to provide funds sustainably: It may take years before high coverage is achieved. Nevertheless, provision of funds is often limited to twelve-month contracts.

- Different conditions and grounds in which programs are implemented vary and lead to differences in the way Injecting Drug Users are dealt with and the services that may attract them more to the program. High-coverage harm reduction programs, in addition to needle exchange or methadone, provide a range of various services: In most cases, expansion of services is achieved through establishing connections and participation of other organizations. Financing the program must be flexible enough so that programs mat deal with such groups.

- A certain program may be replicated for Injecting Drug Users in other regions, cities and provinces: Successful HIV prevention programs among Injecting Drug users may be started in one location, scaled up it and then implemented in other parts of the country.

- Management issues are important: Technical assistance and training of managers, their training and retraining, (or constant training) particularly those who directly deal with Injecting Drug Users is necessary and effective supervision and ability of addressing problems, regular group meetings, and constant training opportunities are considered to be vital elements.

- They learn from experiences: Due to diverse conditions in which programs address HIV among Injecting Drug Users, a process of trial and error is required so that specific combination of program components, staff and other required characteristics for achieving high-coverage are established.

Harm Reduction and its Necessity in the Country

Currently, the HIV epidemic, as one of the most serious risks threatening human health, is a major challenge not only in the health sector, but in all economic, social and political aspects as well (Resources-20). Today, man is faced with spread of HIV in a large part of the world. Estimations indicated that by the end of 2005, around 39 million people were infected by HIV, four million and one hundred thousand of which were infected in 2005 only (Resource-20). Majority of 570,000 under 15 children that die because of AIDS per year, have been infected through mother-to-child transmission. However, the major transmission route in the whole world is sexual transmission. In the course of past twenty years, significant efforts have been exerted to control HIV and reduction of its impacts on individuals, families and communities. However, it is now very clear that, this epidemic is so dynamic and complex that, there are no fixed or definite methods to control it that may be used in all countries (Resources-21). The response to this question that, what has made AIDS to evolve from a simple infectious disease to a global disaster is an important issue that must be taken into consideration in making plans to control this disease in the society.

Currently, Injecting Drug Users make up 10 percent of total new HIV incidences in the world (Resource-21) although this figure is much higher in countries like Iran, as the statistics recently released by the *AIDS and Sexual Disease Control Department at the Ministry of Health* indicates that more than 60 percent of the total population that live with HIV in Iran, are Injecting Drug Users. Since 1990’s, it has become evident that HIV incidence among Injecting Drug Users may be prevented by effective, safe and cost-effective methods (Resources-21). Today, and under the current circumstances, there is no more time for any debate on whether harm reductions programs are effective or not (Resources-21) and based on joint recommendations of the World Health Organization, UNODC and the Joint UN Program for AIDS Control, time should no longer be wasted for pilot programs the effectiveness of which has already been proven (Resources-23).

It must be noted that, thanks to the efforts exerted based on state policies, not only there are no obstacles against scaling up harm reduction programs, but Article 6 of the *General Policies*

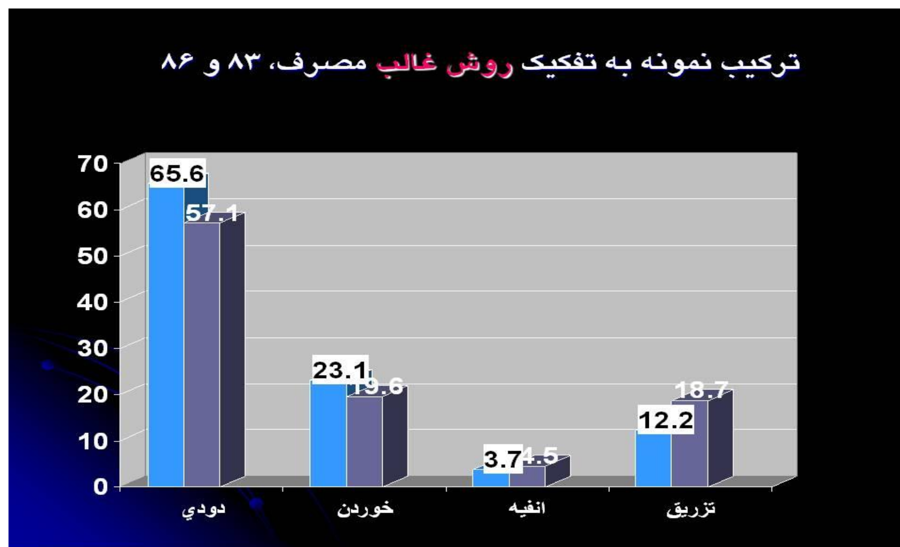
against Narcotics that has been approved by the State Expediency Council and then notified to the three Powers for execution, stipulates the following:

"Establishment and scaling up of public facilities for diagnosis, treatment, rehabilitation and adoption of comprehensive and far-reaching scientific measures aimed at:

- Treatment and rehabilitation of users
- Harm reduction
- Prevention of the change in use pattern from low-risk drugs to high-risk ones.

Therefore, there is suitable political environment in the country. Nevertheless, it appears that, to create suitable outreach, there are still challenges ahead. This seminar has been held to touch upon such challenges.

Of course, it must be noted that, such a situation, namely inadequate outreach of programs is observed in most of the countries with risk of HIV among Injecting Drug Users. This means considerable number of countries has already started harm reduction interventions but have moved slower and with some delays (Resources-22). This makes it more important to pay adequate attention to the concept of outreach and scaling it up. In particular, outcomes of the latest quick assessment conducted on conditions of addiction in Iran in 2007 reveals that 18.7% of drug users use injection as their main method of drug use which indicates a considerable rise if compared to 2004 when only 12.2% of drug users used it as their main drug use method (the following below):



As for the appropriate time for scaling up harm reduction intervention, the recommendation released by the World Health Organization consultants in 2005 stating that "*Realistically speaking, it may take Iran 5 years to scale up HIV prevention strategies so that they reach a suitable level. Afterwards, it may take another 5 to 10 years before HIV epidemic starts to decline. All-inclusive activities must be conducted in this respect and, in allocation of resources priority must be given to activities for which there are apparent evidences indicating their safety and cost-effectiveness*" (Resources-26).

A Review of the Current Situation and Iran's Response

A. HIV Epidemic in Iran

For the first time in 1986, a person infected with HIV was identified in Iran. Subsequently and by 1995, there were very few HIV positive persons but the number was increasing. 1995 may be considered the first serious HIV experience in Iran which signaled serious warnings in this country. Iran, which had been successful in controlling the first impulse of the epidemic since 1986, and had practically brought safety coefficient of blood and blood products up to the international standards, had to establish a new approach. In 1995, this country experienced a number of HIV epidemic cases in a number of prisons. From 1995 to 2004, the identified cases per year had an increasing trend and afterwards, although still with an increasing trend, it had a slower pace since then (Resources-27). In explaining possible causes of this trend, there are various issues addressed. It would be useful to study the Report on Declaration of Commitment.

The first HIV transmission cases through drug injection were identified in 1992 and by 1995, 5 new cases of HIV transmission through injection were identified per year. However, by emergence of the epidemic among Injecting Drug Users, identified transmission cases through injection in 1995 soared up to 30 times as much as the number of cases in the preceding year and, for the first time, injection was recognized as the transmission route with highest prevalence. Subsequently, number of recorded transmission cases through injection has so far constantly increased and has remained to be the most dominant transmission route (Resources-29).

Based on the recent statistics released before 22 March 2008, a total of 17,270 HIV infection cases have been indentified in the country (Resources-28) out of which 68.1 percent are infections caused by drug injection, 7.7 percent due to sexual transmission, 0.6 percent mother-to-child transmission cases and 1.4 percent due to receiving blood products. The

transmission route of 22.2 percent of cases has not been identified (Resources-28). Although share of sexual transmission in the identified cases has stayed relatively stable in the course of past years and has been reported to be some 5 to 8 percent, however, its absolute figure has constantly increased as it has gone up from 50 persons in 2000 to 1517 by the end of winter 2008 (Resources-28). In addition, share of unidentified transmission routes in the identified cases has also gone up in the course of recent years from 8.2 percent in 1988 to 23.7 percent in 2006 and subsequently to 22.2 percent by the end of winter 2008. (Resources-28) (Resources-2). In this respect, there is a consumption based on which at least a part of the increase in cases with unidentified transmission routes has been due to sexual transmission but has remained unidentified because of fear of stigma (Resource-29) and it is partly due to addition of cases in identified observations to the recordation system of identified cases in which, due to the observation method, the transmission route remains unknown. From the total number of cases identified, by 21 March 2009, 1369 persons are on the AIDS stage and 2539 persons have lost their lives. In addition, based on the statistics released on 22 March 2009, most of the identified infected persons were aged between 25 and 34 (41.0%) and then 35 to 44 (31.9%) (Resources-28) and only 6.1% of them were female (Resources-28).

B- HIV Epidemic among Women

As mentioned above, women constituted some 6% percent of the total number of identified cases of HIV positive persons. Perhaps one reason for this may be the major role that injecting drug use plays in the spread of the epidemic in the country and the little number of female Injecting Drug Users. Nevertheless, there are other reasons that need to be taken into consideration such as cases of female drug users referring to drug dependence treatment centers is less than the real number due to the existing stigma caused by addiction and other restrictions or limitations. Another problem is the facts that the existing centers established based on harm reduction programs do not have suitable facilities/environment for women so that they may adequately meet their special needs. Perhaps for this reason the concerned organizations have decided to launch special temporary centers for women on a pilot basis.

Another noteworthy point is that the monitoring and patience-finding mechanism of the country is of such nature that men are identified more than women and majority of monitoring centers and bases have been launched in prisons and or centers to which Injecting Drug Users refer where men make up the majority (Resources-24). Here, one should not disregard women, both women drug users and wives of drug users and their role as a Bridge Group. This is the group that may act as the mediator for transmission of the concentrated epidemic in certain population groups to the general population.

Based on results of the Quick Assessment of Addiction Conditions conducted in 2007, while almost seven percent of the drug users in the country (6.0%) were women in 2004, this figure was reported to be 5.2% in 2007 (Resources-31). Even if results of the Quick Assessment are taken into consideration, it shall be observed that, based on the least estimation, there are almost 42,000 female drug users and up to almost 89,000 such users based on the highest estimations countrywide. In the meantime, a look at the document on status of HIV/AIDS in IR of Iran and the Country Response that was released in 2006 will reveal that addiction among women calls for special attention. The said document mentions that: "*In our country, although women so far make up a small portion of the total HIV infected population, but there are worrying signals indicating spread of this epidemic among women. In the 2000-2004 periods, the proportion of infected women in the total HIV infected population across the country reached 5.82 percent from 4.99 percent. Also, share of female infected persons in some provinces that have been the pioneers of this epidemic among Injecting Drug Users, have constantly risen from 2000 to 2004*."

Based on data and evidences included in the IR of Iran report on Monitoring the Declaration of Commitment as approved by UN General Assembly special meeting on HIV/ADIS, drug injection has been the dominating pattern in Iran in the course of past years. This correlation of HIV epidemic and drug abuse in Iran has led to selection of harm reduction approach as one of the main policies of the Ministry of Health and Medical Education for controlling this epidemic and its incorporation in first and second anti HIV/AIDS strategic programs as one of its main approaches.

C – Voluntary Consulting and Testing (VCT)

Voluntary Consulting and Testing (VCT) is recognized as one of fundamental approaches for HIV prevention in high-risk populations and is recommended for scaling up such services (Resources-23). For this reason, it has been considered as one of the fundamental strategies of the HIV/AIDS control and prevention strategic program. Temporary centers are one of the centers that may play a significant role in scaling up these services. A small number of such temporary centers offer voluntary consulting and testing services mostly in an incomplete manner because a major part of these services are conducted without testing. In the field of referral, the existing problem is the lengthy referral route from temporary centers to the behavior consultation centers and then blood transfusion centers. A large number of drug users do not take the tests.

In the latest Report on Declaration of Commitment, two indicators deal with this issue namely HIV testing in the general public that has been indicated in the report for which no information

is available and the other is HIV testing in the population exposed to the highest risk the brief result of which is that this figure for Injecting Drug Users in 2007 is 22.9% (702 persons out of 3060 persons) and 20.4% (57 persons out of 280 persons) for female commercial sex workers in Tehran in 2007. There are no data on men who have sexual relationship with other men (Resources-33).

D- Epidemiology Status of Drug Use

A number of countrywide studies have been conducted to estimate number of drug users and other use patters each with a different methodology that have sometimes had their own faults. Some studies were referred to as evidences of such differences, namely:

A) The study conducted by late Dr. Shahmohammadi in which the total number of users has been estimated to be 3,700,000 across the country. The participants in the workshop believed that this survey has been conducted by questionnaires and at emergency medical service centers only.

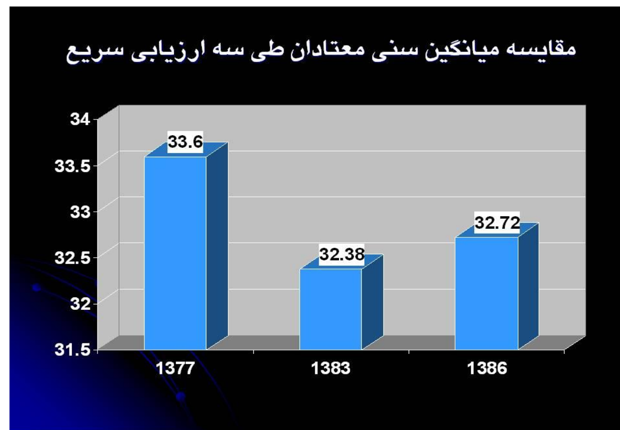
B) Another survey is a Quick Assessment Survey of 2004 conducted by Dariush Institute. In this survey, the number of drug users in the country has been estimated to be 1.500.000 (1,200,000 – 1,700,000).

A similar survey was also conducted in 2007 to estimate number of the addicted in the country, determine population profile of the addicted across the country and determine the correlations between some variants (next report) by the Snowball Sampling Method (applicable to the "hidden" population) and the Capture-Recapture/Multiplication Estimation Method. The results of this survey show that the number of drug users in the country has been estimated to be one million and two hundred thousand (800,000 to 1,700,000) or 1.71% of the total population (1.14% to 2.42%) of which 94.8% are men and the rest are women (Resources-30).

E- Addiction Status and Injecting Drug Use Pattern in the Country

In the field of changes in the addiction pattern across the country, it appears that the addiction age has fallen. Start of the first use has also changed from light to heavy drugs. In addition, the first use through injection has increased. Also, based on the statistics on people referring to rehabilitation centers in Tehran city in June 2006 and early 2007, 18.20% and 43% of the people referring to such centers, respectively, used crack.

It must be noted that, based on preliminary results of Drug Abuse Quick Assessment Plan in 2007, the average Injecting Drug User age has decreased from 33.6 in 1994 to 32,72 in 2007. (The diagram below)



The fact of the matter is that not only is it difficult to obtain a true figure, but to reach an estimated figure of drug users across the globe is no easy task because such behavior is considered a hidden one. Notwithstanding the real figure of drug users, another point which is important from HIV/AIDS point of view is the use pattern.

Assessments conducted in the course of recent years in the country indicate that, during the said years, heroin use, compared to opium, has increased and the share of Injecting Drug Use has also gone up during the said years. (Resources-31). The survey conducted by Rahimi Movaghar, et. al., the average increase in incidence of drug use in 1978-1998, has been 8% and average increase in incidence of Injecting Drug Use in the ten years preceding the survey has been 33% per year. (Resources-32). Number of Injecting Drug Users in Quick Assessment of drug abuse in 1999 and 2001 has been estimated as 130,000 and 200,000, respectively. Based on calculations of the data presented in the Quick Assessment in 2007 this figure has been indicated as 225,000. Assuming that number of drug users remains stable (a point the Quick Assessment results of these years have indicated), it may be observed that the relative ratio of Injecting Drug Users in the total drug users has been increasing during the said years.

As regards shared injection, the most up-to-date data available is the UNGASS 2008 report. Under Indicator 19 of this report that deals with Safe Injection among Injecting Drug Users and its definition, percentage of Injecting Drug Users that have reported use of sterile injection equipment in their last injection has been mentioned. This has been reported to be 74.5%

across the country in 2007 (1516 persons out of 2036) (Resources-33). Tables 1 and 2 demonstrate a more detailed picture of the latest available data in this field (Resource-33):

Table 1: Use of less risky injection in the last injection among Injecting Drug Users in Iran

Age* / *Gender	***Younger than 25***					***25 and older***				
	N1[a]	N2[°]	N3[◊]	Ratio of Sterile Injection	Ration of Safer Injection β	N1[a]	N2[°]	N3[◊]	Ratio of Sterile Injection	Ration of Safer Injection β
Male	218	57	283	0.77%	97.0%	1264	336	1698	74.4%	94.2%
Female	7	4	11	63.6%	100%	27	13	44	61.4%	85.1%

N1[a]: Number of Injecting Drug Users that have had an injection in the preceding month and have used a sterile syringe.

N2[°]: Number of Injecting Drug Users that have had an injection in the preceding month and have used a syringe that had been previously used by themselves.

N3[◊]: Total number of Injecting Drug Users that have had an injection in the course of the last month.

β: Includes injection by sterile syringes and injection by a syringe that has been previously used by the user himself.

Table 2: Use of less risky injection in the last injection among Injecting Drug Users in Tehran

Age / Gender	Younger than 25					25 and older				
	N1[α]	**N2[°]**	**N3[◊]**	**Ratio of Sterile Injection**	**Ration of Safer Injection β**	**N1[α]**	**N2[°]**	**N3[◊]**	**Ratio of Sterile Injection**	Ration of Safer Injection β
Male	**24**	**8**	**33**	**72.7%**	**96.7%**	**236**	**34**	**283**	**83.4%**	95.4%
Female	0	0	0	Can not be calculated	Can not be calculated	1	0	1	100%	100%

N1[α]: Number of Injecting Drug Users that have had an injection in the preceding month and have used a sterile syringe.
N2[°]: Number of Injecting Drug Users that have had an injection in the preceding month and have used a syringe that had been previously used by themselves.
N3[◊]: Total number of Injecting Drug Users that have had an injection in the course of the last month.
β: Includes injection by sterile syringes and injection by a syringe that has been previously used by the user himself.

F. Sexual Behaviors: within the Framework of Family and beyond it; with the same and the opposite sex; Commercial Sex Work and drug Use; Use of Preventive Methods

It has been observed in the surveys so far conducted that, sexual behaviors with various sex partners and without observing prevention principles such as use of condoms in sexual relationships is prevalent (Resource-24). Results of some surveys indicate that more that 60 percent of drug users have experienced sex before the age of twenty, more than on third of married drug users have sex outside the family, and 70 percent of single drug users have reported sexual intercourses more than 20% of which has been with commercial sex workers (Resources-33). Many Injecting Drug Users have experienced sexual intercourse with commercial sex workers and having more than one sex partner is widespread among them

(Resources-35,36). In the Quick Assessment of 2004, 59.9% of drug users have had a sexual intercourse during the preceding year and 43.2% of them have had sexual intercourse with a person other than their spouse (26% of them have had a sexual intercourse with a woman other than their wife and non-commercial sex workers, 24% have experienced a sexual intercourse with a female commercial sex worker and more than 13% have experience a man-with-man sexual intercourse). From these, only 16.5% often used condoms and 47.6% never used condoms. The survey conducted by Zamani, et al. shows that from 156 persons that, during the month preceding the survey had both an injection and a sexual intercourse only 19.8 percent did not have a shared injection and had used a condom in their last sexual intercourse. The latest available data in this field that has been indicated in the report on Declaration of Commitment reflects that generally almost 33% of Injecting Drug Users in Iran have used condoms. Tables 3 and 4 present a more detailed picture of what we know (Resource-33):

Table 3: Use of Condom in the last sexual intercourse among Injecting Drug Users in Iran

Age / Gender	Younger than 25			25 and older		
	N1[a]	**N2[°]**	**Ratio**	**N1[a]**	**N2[°]**	N3[◇]
Male	**203**	**70**	**34.5%**	**1346**	**439**	32.6%
Female	7	2	28.6%	26	8	30.8%

N1[a]: Number of Injecting Drug Users that have had an injection in the preceding month and have had sexual intercourse in the preceding year.

N2[°]: Number of Injecting Drug Users that have had an injection in the preceding month and have had sexual intercourse in the preceding year and have used a condom in their last intercourse.

Table 4: Use of condom in the last sexual intercourse among Injecting Drug Users in Tehran

Age / Gender	Younger than 25			25 and older		
	N1[a]	**N2[°]**	**Ratio**	**N1[a]**	**N2[°]**	N3[◊]
Male	**22**	**10**	**45.5%**	**189**	**72**	38.1%
Female	0	0	Can not be calculated	1	1	100%

N1[a]: Number of Injecting Drug Users that have had an injection in the preceding month and have had sexual intercourse in the preceding year.
N2[°]: Number of Injecting Drug Users that have had an injection in the preceding month and have had sexual intercourse in the preceding year and have used a condom in their last intercourse.

High-risk sexual behaviors have been proved to be another driver behavior for the epidemic in communities. As mentioned earlier, due to both its young population as well as considerable prevalence of drug use among the youth and the fall in the addiction age, the Iranian society is also exposed to higher risks of HIV epidemic. High-risk sexual behaviors among Injecting Drug Users were earlier discussed in detail. There have been alarming statistics in the general population as well, such that the report submitted by Iran to the UN on monitoring the Declaration of Commitment indicates that, based on a survey conducted in seven provinces in the third and fourth quarters of 2005, 15.9 percent of single men (117 out of 1114) and 4.5 percent of single women (53 out of 1188) have experienced sexual intercourses before the age of 19. It can not be determined, on a countrywide basis, what percent of these intercourses have been high-risk. However, references have been made to two surveys. One of these surveys was conducted in 2004 among the youth of a Tehran neighborhood. Based on this survey, from 422 persons that had experienced sex in the preceding year, 110 persons (21.1%) have had more than one sex partners (Resources-37). Another survey conducted in 2006 among male university students of a university in Tehran (Resources-38) revealed that 12.3% (14 out of 114) male under-nineteen students, 39% (116 out of 295) male students aged 20-24 and 28.6% (4 out of 14) students older than 25, have had sexual intercourse with

more than one partner. As for the use of condom by commercial sex workers, a survey conducted in 2007 in Tehran indicates that 55% (154 out of 280) of them used condoms in their last intercourse.

G. Epidemiology Status in Prisons

In the very early stages of the epidemic, HIV targeted prisons and, in many countries, HIV prevalence among prisoners is considerably higher than the general public. Prevalence of Hepatitis C is even more than HIV. While majority of HIV positive prisoners or those on the AIDS stage have been infected outside the prison, the risk of infection in prisons, particularly through unsterile injection equipments or unprotected sex, is high. Surveys conducted across the world indicate that many prisoners have maintained drug use including injecting drug use in prisons. HIV outbreak has occurred in some prisons which reflect how HIV may quickly spread in prisons unless an effective measure is taken to prevent the transmission. Importance of launching and implementation of HIV prevention interventions in prisons, including drug treatment programs, were recognized as preliminary stages of start of the epidemic (Resources-23).

Participants' point of view on the current status in prisons may be summarized as follows:

The report released by the Watch Center reflects 2.5 – 3.5 percent of prisoners are HIV positive though in some the Watch Center reports, individuals known to be with HIV have been excluded from the sampling and thus estimation lower than the actual figure has been obtained.

On high-risk sexual behavior in prisons and the impact of Methadone Maintenance Treatment on such behaviors, participants stated that:

In connection with sexual and injecting behaviors in prisons it appears that, taking into account special circumstances of prisons, there is a considerable degree of such behaviors in prisons a fact which is duly confirmed by prison authorities as well. Sexual behavior is highly related to drugs and methadone reduces such behavior through reducing violence. As a result, the need for money also reduces. In addition, injections in prisons have reduced in the course of recent years and, of course, some prisoners believe it is due to use of Crack[1]. Needle and Syringe services offered in prisons are very limited and need to be scaled up.

[1] Possibly highly pure heroin

Currently, Methadone Maintenance Treatment has been significantly promoted in prisons, and Iran is one of those countries with highest number of inmates covered by Methadone Maintenance Treatment. Nevertheless, an alternative strategy, including the Needle and Syringe Services, is not implemented in prisons across the country but there are only some prisons where it is implemented on a limited scale and on trial basis. It must be noted that this has not been experienced much in the world as it has been implemented only in 2002 in prisons of some countries such as Germany, Spain, Switzerland, Moldavia, Belarus and Kirgizstan (Resources-39-40). Among the said countries, only Spain has implemented this program in all prisons and the same has recently started in Australia. This is while Methadone Maintenance Treatment was first implemented on a pilot basis in prisons in 2003 (Resources-39).

H. Policymaking and the Law

Another issue the participants had been asked to comment on was policymaking and the existing laws some of which were addressed earlier. Viewpoints of participants may be summarized as follows:

Article 15 of the Anti Drug Law stipulates that the addicted, except for those who refer to treatment centers for the purpose of treatment, are criminals. This article of law practically managed to help launching of addiction treatment centers in 1995 as a result of which drug users referred to such centers with less fear. The term "self-introducing (voluntary referral)" was an appropriate term that was then coined for a group of drug users seeking treatment. Also, in the new Drugs Control Draft Act, the term "harm reduction" has been used wherever the issue of addiction is addressed. Of course, the definition for harm reduction may vary depending on the management systems a fact that may be considered a potential threat. Another issue raised was that although the Second Strategic Program for AIDS Prevention and Control has been drafted, but it has not been approved yet. Finally, there are no strategic programs pertaining to addiction in the country and plans are prepared on an annual basis. As regards provision of human resources, reference was made to Resolution Number 308 of the National Security High Council that explicitly states that all departments/bodies engaged in the field of addiction must have the required organizational chart but, apart from the Disciplinary Forces (the Police), other government organizations and bodies have not used this Resolution to optimize their human resources for which reason the human resources chart pertaining to addiction at administrative level in the Ministry of Health and Medical Education is either poor or does not exist at all. Thus, in order to respond to a challenge, mere policymaking will not suffice and there needs to be an appropriate executive force as well. On environmental levels, responding to this problem has a much more serious nature.

I. Iran Drug Control Headquarters' Approach towards Harm Reduction

Iran Drug Control Headquarters has had effective interventions in controlling HIV epidemic in various fields ranging from making state policies to provision of harm reduction funds through its Treatment, Rehabilitation and Vocational Training Bureau. The General Drug Control Polices that have been duly approved by the State Expediency Council and then notified to the three Powers for their execution is among measures taken by the Iran Drug Control Headquarters to adopt state policies in the field of addiction to support harm reduction programs. Article 6 of the said Policies stipulates:

"Establishment and expansion of public facilities for diagnosis, treatment, and rehabilitation and adoption of comprehensive and all-inclusive scientific measures aimed at:

- Treatment and rehabilitation of drug users
- Harm reduction
- Prevention of changes in drug use pattern from low-risk to high-risk (Resources-42)

In the new Drug Control Draft Act, wherever the issue of addiction has been addressed, the term Harm Reduction has also be included.

As for provision of funds in the field of Harm Reduction activities, this Headquarters provided IRR 104,000,000,000 and 134,000,000,000 in 2006 and 2007 respectively, for executive organizations and bodies that are the main responsible bodies for harm reduction policies in order to scale up these programs (Resources-26). The budget allocated to treatment and harm reduction in the country has increased from IRR 8.5 trillion in 2005 to IRR 20 trillion in 2007. It is predicted that the budget for treatment and harm reduction shall reach IRR 40 trillion in 2008. The table below demonstrates a more detailed picture of allocation of budget to harm reduction interventions:

Table 5: Funds Allocated to Maintenance Treatment and Temporary Centers for 2005 – 2007 (in trillion Rials)

Program	2005	2006	2007
Methadone Maintenance Treatment	**100**	**37500**	47000
Temporary Centers	**1200**	**6000**	10000
Total	1300	43500	57000

It must be noted that, based on IR of Iran's report on monitoring the Declaration of Commitment as approved by the Special Meeting of the United Nations General Assembly on HIV/AIDS in 2006, the total national budget spent on HIV epidemic was IRR 275,636,676. Thus, if we take IRR 104,000,000,000, almost 35% of the total HIV-related costs have been incurred for harm reduction and on the expense of Iran Drug Control Headquarters.

Disconnecting the relationship between drug users and distribution systems and dealers, constitutes the general approach of Iran Drug Control Headquarters. In the new Drug Control Draft Act, medical insurance of drug users and harm reduction has been taken into consideration and Drug Courts are also discussed as one of the current tools in the world (as an approach to treatment of addiction). In the new amendment of the Drug Control Act, more authority has been entrusted to the Disciplinary Forces to directly refer drug users that are arrested to treatment centers.

In recent years, thanks to the measures taken by the Headquarters, there has been a change in the Disciplinary Force's approach to cooperate with harm reduction programs. Making use of experiences of other countries, provided by United Nation's agencies, has been one of the approaches of the Drug Control Headquarters. This has been an important element and useful to scale up and diversify harm reduction programs.

The following are among future programs of Iran Drug Control Headquarters and member organizations and bodies:

- To design and scale up Harm Reduction Mobile Centers
- Prepare and install automatic vending machines for syringes, condoms and hygienic products.
- Scale up Harm Reduction programs and services in rural areas in view of high statistics of drug use, particularly Cracks, in such areas.
- Industrial plantation of *Shaghayegh Alfira* and provision of the required raw materials for production of opium syrup, nultrexone, and, bopronorphine and reducing prices of these medicines.
- Monitoring and assessment of Harm Reduction Programs
- Launching (Information and Communication) Network in the country on Harm Reduction
- Supporting Non-Government/Private Organizations engaged in this field.

J. Harm Reduction Programs Outreach

Although harm reduction programs have been evaluated as successful in their various approaches, but it does not imply that these programs may be able to stop the epidemic cycle no matter the scale in which they are implemented. In a part of the Workshop, level of programs' outreach was addresses as follows:

Based on the statistics released by the Iran Drug Control Headquarters, by mid September 2007, number of people covered by the Methadone Maintenance Treatment was as follows:

The Concerned Organization	Government		Private but Under Supervision	
	MMT Centers	**Number of People Covered**	**Number of centers**	Number of People Covered
Ministry of Health	**134**	**29000**	**355**	20000
The Welfare Organization	**41**	**3425**	**369**	19500
Total	175	33425	7243	39500

These statistics need to be carefully studied because there is the possibility of overlap in the statistics presented, particularly in cases where centers obtain permits from both the Ministry of Health and the Welfare Organization. On the other hand, many of those that are included in the Methadone Maintenance Treatment are principally the patients that have received treatment for a period less than six months which, under the Health Ministry's Protocol, are not considered as Maintenance Treatment and need to be clearly defined.

Number of Temporary Centers and Mobile Teams are indicated in the Table below:

	Temporary Centers	Mobile Teams	Covered individuals
Ministry of Health	**58**	**86**	10000
The Welfare Organization	**76**	**140**	14000
Total	134	226	24000

The Declaration of Commitment Report, under prevention programs indicator among populations exposed to highest risks, on the issue of important concepts of harm reduction programs' outreach in the country it has been stated that: "In accordance with the information received from the Iran Drug Control Headquarters, total number of 2,940,000 sterile syringes were distributed among Injecting drug Users in the first and second quarters of 1386 (April-September 2007)".

It is worth mentioning that, Methadone Maintenance Treatment is one of the main pillars of harm reduction programs for Injecting Drug Users. By late September 2007, 57,000 Injecting Drugs Users received Methadone Maintenance Treatment by Universities of Medical Sciences, The Welfare Organization, The Prisons and Correctional Centers' Department, and the private sector. According to the previous report issued in 2004, the said number was only 4300 which now indicate an increase of 13 times as much (Resources-33). Based on this report, total coverage of prevention programs in high-risk populations has been estimated to be 17.6% (Resources-33) which, although has increased, but still is far from the desired level.

Harm reduction programs' outreach may also be calculated by a different method such that, based on the results of Quick Assessment conducted in 2007, there were one million and two hundred thousand drug users in the country 18.7% of which i.e. almost 225,000 are injecting drug users. Thus, even assuming that all 57,000 persons that are under the Methadone Maintenance Treatment are Injecting Drug Users, and considering an average of 3 injections per day for each center, there will be 5,500 persons covered under Needle and Syringe Programs per day on average. Then by adding the said 57,000 to 5,500 and dividing it by 225,000 a figure equivalent to 28% for harm reduction programs outreach for 2007 shall be obtained which is still far from the effective level of epidemic control among Injecting Drug Users that is estimated to be minimum 60 percent. In the meantime, as indicated later, outreach calculation is much more complicated than this simple method and needs much larger data. It must be noted that, harm reductions programs' outreach is more likely to be much less among women than men since, as mentioned earlier, the respective centers are more suitable for provision of services to men than women and that they have not been designed to provide services to women by taking into consideration their special needs of women. Perhaps for this reason, and in order to increase access to this group, special temporary centers for women are being established.

A Review of the Harm Reduction Global Challenges

It appears that no country or geographical region has remained immune from HIV and many countries that, due to their religious and cultural norms, were assumed to be HIV immune, now are confronted by rapid increase of this threat (Resources-43). The following table demonstrates this situation in countries that are mainly Moslem. Of course, there are also challenges against harm reduction programs in many other countries as well.

Iran has been among the leading countries in the region and Moslem countries in the field of harm reduction. There are a large number of committed and informed people to help the country to control this epidemic and there are also considerable grounds for addiction-related researches in Iran as well. On harm reduction programs in Iran WHO experts said in 2005: "*There are many signals indicating that Iran has had an excellent start in controlling the epidemic since:*

- *Even all lower levels of the government authorities have also realized the importance and serious nature of the problem;*
- *Iran is fully committed to harm reduction programs, evidence-based policy making and planning;*
- *Iran has started implementation and scaling up of harm reduction programs (Resources-26)*;"

Nevertheless, harm reduction programs in Iran have not been free of challenges as according to the same experts: "Iran is confronted by significant obstacles in achieving HIV and AIDS control. The present level of implementation of HIV prevention policies in all aspects cover only a fraction of what they need to cover. Rapid strengthening of HIV prevention strategies among Injecting Drug Users so that they reach a level of effective performance that will break the transmission cycle in this as well as other groups, must be Iran' main priority in the next decade. In addition to scaling up the current addiction treatment activities, particularly replacement treatment, due attention needs to be paid to rapid scaling up of Needle and Syringe Programs as well as training of mobile teams in temporary centers. Also, needs of groups of opium users that are on the verge of starting injections must also be met (by provision of services that are suitable to their needs). Capacity making is required for a large number of experts and other personnel on national, provincial and local levels. Additionally, the responses to HIV in Iran must be taken into consideration and promoted from quality control point of view. Surveillance and monitoring HIV/AIDS prevalence among Injecting Drug Users, statistics and estimation of number of drug users and Injecting Drug Users and accurate data

on implementation of HIV/AIDS prevention strategies are not satisfactory on national and provincial levels (Resources-26)”.

Table 1: HIV/AIDS prevalence and AIDS-related mortality in countries with 50 percent or greater Muslim population, 2001–2003[1]

	Country	Estimated number of adults and children living with HIV/AIDS		Estimated number of deaths due to AIDS	
		Year		Year	
		2001	2003	2001	2003
1	Afghanistan	*	*	*	*
2	Albania	*	*	*	*
3	Algeria	*	<10 000	*	<500
4	Azerbaijan	<10 000	<10 000	<500	*
5	Bahrain	<10 000	<10 000	*	<500
6	Bangladesh	10 000 – <100 000		500 – <1 000	
7	Brunei Darussalam		<10 000		<500
8	Burkina Faso	100 000 – <500 000	100 000 – <500 000	10 000 – <50 000	10 000 – <50 000
9	Chad	100 000 – <500 000	100 000 – <500 000	10 000 – <50 000	10 000 – <50 000
10	Cocos (Keeling Island)	*	*	*	*
11	Comoros	*	*	*	*
12	Djibouti	*	<10 000	*	500 – <1 000
13	Egypt	<10 000	10 000 – <100 000	*	500 – <1 000
14	Eritrea	10 000 – <100 000	10 000 – <100 000	<500	1 000 – <10 000
15	Ethiopia	>=2 M	1 M – <2 M	>=100 000	>=100 000
16	Gambia	<10 000	<10 000	<500	500 – <1 000
17	Gaza Strip	*	*	*	*
18	Guinea	*	100 000 – <500 000	*	1 000 – <10 000
19	Guinea-Bissau	10 000 – <100 000	*	1 000 – <10 000	
20	Indonesia	100 000 – <500 000	100 000 – <500 000	1 000 – <10 000	1 000 – <10 000
21	Iran (Islamic Republic of)	10 000 – <100 000	10 000 – <100 000	<500	500 – <1 000
22	Iraq	<10 000	<10 000	*	*
23	Jordan	<10 000	<10 000	*	<500
24	Kazakhstan	<10 000	10 000 – <100 000	<500	<500
25	Kuwait				
26	Kyrgyzstan	<10 000	<10 000	<500	<500
27	Lebanon		<10 000		<500
28	Libyan Arab Jamahiriya	<10 000	10 000 – <100 000	*	*
29	Malaysia	10 000 – <100 000	10 000 – <100 000	1 000 – <10 000	1 000 – <10 000
30	Maldives	<10 000	*	*	*
31	Mali	100 000 – <500 000	100 000 – <500 000	10 000 – <50 000	10 000 – <50 000
32	Mauritania	*	<10 000	*	<500
33	Mayotte	*	*	*	*
34	Morocco	10 000 – <100 000	10 000 – <100 000	*	*
35	Niger	*	10 000 – <100 000	*	1 000 – <10 000
36	Nigeria	>=2 M	>=2 M	>=100 000	>=100 000
37	Oman	<10 000	<10 000	*	<500
38	Pakistan	10 000 – <100 000	10 000 – <100 000	1 000 – <10 000	1 000 – <10 000
39	Qatar	*	*	*	*
40	Saudi Arabia	*	*	*	*
41	Senegal	10 000 – <100 000	10 000 – <100 000	1 000 – <10 000	1 000 – <10 000
42	Sierra Leone	100 000 – <500 000	*	10 000 – <50 000	*
43	Somalia	10 000 – <100 000	*	*	*
44	Sudan	100 000 – <500 000	100 000 – <500 000	10 000 – <50 000	10 000 – <50 000
45	Syrian Arab Republic	*	<10 000	*	<500
46	Tajikistan	<10 000	<10 000	*	<500
47	Togo	100 000 – <500 000	100 000 – <500 000	10 000 – <50 000	10 000 – <50 000
48	Tunisia	*	<10 000	*	<500
49	Turkey	*		*	*
50	Turkmenistan	<10 000	<10 000	<500	*
51	United Arab Emirates	*	*	*	*
52	United Republic of Tanzania	1 M – <2 M	1 M – <2 M	>=100 000	>=100 000
53	Uzbekistan	<10 000	10 000 – <100 000	<500	<500
54	West Bank	*	*	*	*
55	Western Sahara	*	*	*	*
56	Yemen	*	*	*	*

In addition to what was stated above, surveys indicated that the following challenges existed particularly in countries with cultural and religious patterns similar to that of Iran:

- Gender Inequality: Lack of balance in strength of men and women that manifests itself in the relationship between these two genders and in economic and social fields as well, makes it difficult to make equal use of the services provided. In most of such countries women are less educated than men and it is easier to exploit them (Resources-51).

- Discrimination and stigma: Social stigma always accompanies those living with HIV in all societies. Those with high-risk drug use and sexual high-risk behaviors should expect more stigma in Moslem countries, due to their cultural and religious structures. For this reason, those exposed to lower risks are more likely to apply for suitable services (Resources-43).

- Negligence/misinformation: Misconceptions on this disease and its transmission routes lead to this very belief that HIV is transmitted through immoral sexual contacts and the society is less informed on other transmission methods. (Resources-51).

- Another challenge facing harm reduction programs is of a different type and shall lead to serious approaches in scientific areas if the philosophy of harm reduction is not correctly understood. This challenge is a philosophic challenge between the harm reduction model and the medical model. The harm reduction model is used for more access to Injecting Drug Users. However, HIV prevention is sometimes looked upon by a fully medical approach. It is here where sometimes these two approaches challenge each other in the following ways:

- Structural Philosophy: In the harm reduction model, decisions are made within the society through observing it in a process and in an all-inclusive manner. But, decisions in a medical model are made based on instructions and by due observation of the relevant hierarchy.

- The implementing structure: The harm reduction model is new, undergoes changes and is constantly disputed while the medical model was launched in early twentieth century and is accepted by the majority of the society.

- The Theory on Studying Causes of Drug Use: Three elements namely Drug, Set and Settings are taken into consideration in the harm reduction model. However, the medical model considers drug use from the disease/medicine point of view which makes the user claim that physicians are unable to diagnose his problem (Resources-45).

- The Service Recipient Role: In the harm reduction model, the drug user, as a recipient of services understands the choices he is provided with, makes a decision, gradually demonstrates small changes in his behaviors and thus reduces harm. However, in the medical model, he accepts the treatment provided whatever it may be, and follows its instructions (Resources-45).

- System Design: The harm reduction model seeks to find where the target group is and makes efforts to take the required interventions there (Resources-46) while in the medical model, it is the patient who has to refer to the required place to receive services.

Discussions and Conclusions

An overview of what was discussed in the workshops and the panels makes it clear that failure to scale up harm reduction programs and increase their outreach across the country shall expose this country to risk of a widespread epidemic. WHO experts' report on Iran indicates the same. In a part of their report they stated:

"Rapid strengthening of HIV prevention strategies among Injecting Drug Users so that they may reach a level of effective performance that will break the transmission cycle in this group and other groups must be Iran's main priority of in the next decade. In addition to scaling up the current addiction treatment activities, particularly replacement treatment, due attention needs to be paid to rapid scaling up of Needle and Syringe Programs and training of mobile teams in temporary centers as well as those groups of opium users that are willing to start injections…(Resources-26)"

From viewpoint of participants in the workshop, the challenges of scaling up harm reduction programs across the country may be classified in a number of categories that are mentioned below without prioritization:

- Budget
- Monitoring and Assessment
- Inter-sector communication
- Services provided for those living with HIV
- Opioid Maintenance Treatment Services
- Needle and Syringe and Condom Programs
- Other cases

A. Budget and Financial and Administrative Regulations

As for current regulations, it must be stated that one of the challenges that establishment of temporary centers are confronted by is that usually such centers require a longer time to set up the main reason of which are the existing administrative and financial formalities. Moreover, such centers currently do not hold the required permit for provision of services and offer the respective services on the basis of financial contracts. There are two fundamental problems there. Firstly, financial contracts are normally concluded on an annual basis and undergo lengthy processes in governmental departments and systems before they are concluded. In view of this lengthy administrative process, conclusion or official extension of contracts normally takes months. Such uncertainty and non-payment of the respective expenses, particularly if the second problem that shall be described later also occurs, shall confuse the institutions that run temporary centers and shall practically disrupt provision of services or shall reduce their quality.

The second problem is that, under the regulations currently in force, The Ministry of Health and Medical Education is required to hold tenders for contracts the subject of which costs more than IRR 250,000,000 (in 2007) and although such tender formalities are skipped through the Tender Avoidance Commission, but still this does not occur on all cases and centers are transferred through publication of tenders which result in transfer of centers in one-year intervals which, in turn, leads to instability of centers and service providing teams.

In the meantime, nature of transfer of such services is not compatible with tenders because principally lower prices imply limited services that seriously harm effectiveness of harm reduction programs - a point which is already sometimes observed where some centers impose limits on provision of needles and syringes. Currently it appears that this is caused more by little knowledge and training of those involved in temporary centers.

Another noteworthy point is that the amended protocol and instructions have long been devised but have not been notified yet. In the meantime, there are no specific guidelines for Methadone Maintenance Treatment in temporary centers and measures are taken in accordance with guidelines of drug abuse treatment private centers while these two structures are completely different and require different mechanisms. Additionally, there are no fixed and confirmed instructions/guidelines for provision of services particularly Needle and Syringe services.

As for the budget, it must be noted that, in a process such as harm reduction which is not profitable for the private sector in the general sense of the word, financial support is among

the most fundamental facilitators of progress of the program and the challenges related to it have an impact on all aspects of the program. The state budgeting is structured on the basis of annual budgets in accordance to which the government usually presents an annual budget for the upcoming year during the third quarter of the current year. It is then approved in mid February and early March once Parliament's concerned specialized commission duly studies and incorporates all the required amendments therein. Finally, it is duly approved by the Guardian Council after which it becomes binding for the government. This is while organizations in charge of harm reduction programs usually do not receive their budgets on a regular basis as such programs are new and have not been institutionalized in the organizational tasks and functions. Because of this structure, in some cases, executive organizations propose their budgets for the upcoming year while they have not yet received their budget for the current year.

In addition, even after approval and notification, these budgets may be consumed within the concerned organization at the discretion of the director of the provincial organizations and executive units for purposes other than what they have been approved or intended.

Importance of the above points and problems that they pose against harm reduction programs becomes even more apparent particularly bearing in mind that one of the fundamental principles of provision of harm reduction services is absence of any disruption in provision of such services.

Another challenge for harm reduction programs in the country is that the budget allocation process is not proportionate and suitable for each program and sometimes it is not clear for policymakers what achievements this level of annual expenditure will have for the country. Obviously, in such situations there is less financial support.

For this reason, and for more accurate, better and more optimized consumption of funds, and for the purpose of devising and determining budgets for centers, it has been recommended that the following steps should be included in the agenda for the concerned authorities:

- Review the efficiency costs and planning for more cost-effective interventions
- Improvement of communications between administrative and field organizations
- Making use of all stakeholders in the country planning
- Incorporating provincial and local differences in budget allocation
- Assessment of state expenses on addiction and AIDS for provision of the required feedback in planning of the budgets of future years

As mentioned earlier, another problem facing harm reduction programs is that the allocated budgets confront numerous difficulties on their route from the center to the outside one of which is the lengthy process of budget allocation and notification to the provincial organizations. It has been recommended that these measures should be taken in order to reduce the time span between budget allocation and notification.

Reviewing and finding the way to shorten the budget allocation process in the current situation, sometimes takes more than a year. In this connection, providing the required clarifications for editors and financial and administrative authorities in each province and organization, is another task that needs to be carried out as soon as possible so that we may not observe differences of practices/trends because it has been observed that, in some universities and welfare organizations, harm reduction services are granted through tenders based on lower costs and without taking into consideration background and capabilities that, in the long run leave an adverse effect on quality of services. Additionally, the same process is not observed in conclusion of contracts and payments. For instance, sometimes the institute party to the contract is required to pay the social security organization's share while this is not relevant in view of the combination of human resources in the centers and that payments are not made for human resources based on the Labor Department's regulations.

The relationship between concerned government organizations and entities with non-government organizations and private institutes active in this field is another issue that sometimes turns into a challenge between these groups. It is advisable to take measures so that all departments get informed of the manner in which communication is established with private institutes and non-government organizations active in this field. Iran Drug Control Headquarters plays a fundamental role in this respect.

B. Monitoring and Assessment

Monitoring and assessment of harm reduction processes are essential for consistent and endurable harm reduction programs. A review of the above challenges indicates that still there are no dynamic and effective monitoring and assessment mechanisms in the country although preliminary steps have been taken. It is recommended that appropriate grounds be prepared for monitoring and assessment in the country to align individual isolated programs in one single harm reduction program[1], activities be standardized and monitoring and assessment

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[1] Currently, harm reduction programs are implemented by different organizations mainly the State Welfare Organization and the Ministry of Health and Medical Education, and of course, sometimes other entities or organizations such as the Disciplinary Forces, the Red Crescent Society, Municipalities and etc. carry out such activities as well. Accordingly, while there are various authorities in charge with policies that are not much similar, it would not be possible to conduct suitable and proportionate

indicators be devised so that appropriate data suitable for the program objectives and values may be achieved.

Another measure that is recommended in this field is that required measures must be taken to activate the surrounding levels in the process and attract their participation and involve them. These may include involving surrounding levels in devising the monitoring and assessment programs as well as strengthening and empowerment of the environment for self-assessment, action research and use of the results thereof to improve programs. Another objective that must be taken into consideration in this connection is to make use of monitoring and assessment results for the purpose of optimization of processes. To achieve this, feedbacks on monitoring and assessment needs to be provided to all the levels and stakeholders on a timely basis. In the meantime, the country needs to be ready for conducting countrywide studies such as behavior surveillance system to respond to challenges related to the surveillance system.

C. Communication between and within sectors

Coordination and alignment of activities carried out in a given field are essential elements for their success. This also applies to harm reduction programs as well. However, although in some cases higher-level policymaking measures are aligned but unfortunately this alignment is not at the desired level in provinces. This problem may cause crisis for harm reduction programs and have adverse effects on their efficiency. The Provincial Secretariat for Drug Control Headquarters' Coordinating Council is the coordinating body in provinces that can not necessarily be a successful one at all times. On the coordination between sectors, representatives of Drug Control Headquarter stated that the said Headquarter is exerting every effort so that the required coordination is established among all concerned organizations. However, in some cases, the required coordination does not necessarily exist on provincial levels. On the other hand, the Provincial Secretariats for Drug Control Headquarters' Coordinating Councils do not have a specific program to establish such coordination among sectors. For this reason, in order to achieve further coordination, the Headquarter has released an Instructions stating that from 13 October 2007, no organization is allowed to, directly and without the prior coordination with the Anti Drug Control Headquarter, notify any instructions/guidelines on harm reduction and treatment.

HIV epidemic can not be considered as a problem of the health systems for which reason the respective interventions can not be limited to health systems and a wide range of interventions

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monitoring and, particularly, assessment activities. It would be advisable to align all similar activities in the same field so that their budgets may be traced and then proceed to assess the results gained by such services.

are required to control the epidemic. Accordingly, revising the communications between sectors has an important role in facilitating the future processes and implementation of the existing processes.

The problem raised in connection with the cooperation between sectors is that in some cities like Tehran, there are government or public bodies such as the Municipality, The Disciplinary Forces, Imam Khomeini Relief Fund and Vocational Training Centers that initially did not exist as potential authorities of harm reduction programs. In such cases, in view of lack of a devised and pre-defined structure, communications and cooperation between centers have been on temporary basis and these entities have been vague and in some cases with adverse effects as well.

To resolve problems pertaining to the cooperation between sectors, it has been recommended that specific practices must be defined to increase the level of coordination between those in charge of harm reduction programs in the country. Additionally, in view of the fact that establishing an understanding on administrative level does not necessarily imply expansion of these understandings to surrounding levels and provinces, it has been recommended that a countrywide letter of understanding be prepared between Ministry of Health, The Welfare Organization, The Prisons Department and the Disciplinary Forces aimed at clarifying terms of references and programs of each organization pertaining to new plans and then notified to provinces that must, of course, hold strong sanctions. This letter of understanding must pay particular attention to facilitating harm reduction services on the society level and prisoners at the times of their entry and exit so that no disruption is caused in provision of services.

The coordination within sectors, on concerned organizations' level, needs to be promoted. For instance, Health Deputy Departments in Universities are in charge of supervising and establishment of temporary centers while these centers need to obtain their permit for provision of Methadone Maintenance Treatment services from the Treatment Deputy Ministry and should of course receive their medicine from the Food and Medicine Deputy Ministries. This triangle makes three Deputies supervise temporary centers each of which uses its own policy that is sometimes completely different from that of other two. To solve this problem, it has been recommended that Terms of Reference of various deputies (in universities) be prepared based on functions of each Deputy in harm reduction programs and then notified to concerned universities.

Another aspect of the communication between sectors is the relationship between service providing institutes which currently have no relationship with each other or even if there is one, it is based on individual connections. To resolve this problem, it has been suggested to

establish a nationwide harm reduction network among non-government organizations and private institutes active in this field.

There is defined in the implementing mechanism a committee named Harm Reduction State Committee. It has been suggested to define functions of this Committee and establish a specific mechanism pertaining thereto with other state subcommittees for the AIDS control program.

It is worth mentioning that, particularly in view of the transmission pattern in the country, there needs to be a full coordination between AIDS and Addiction programs and together with devising a state strategic program in the field of HIV/AIDS, a strategic program for addiction needs to be devised as well.

D. Services for Those Living with HIV

Generally speaking, these people need three categories of support namely economic support, social-psychological support and medical support. Main services offered to people living with HIV are offered in Behavior Consultation Centers. These centers do not take structured steps in the field of economic support and in countrywide programs these types of support have been assigned to other organizations such as the Welfare Organizations, Imam Khomeini Relief Fund and the Red Crescent. To what extent these individuals are supported and if the supports are provided adequately and proportionately is a subject that needs further studies.

In the field of social-psychological and medical supports, it is expected that Behavior Consultation Centers shall have an important role here. Assuming this role requires certain human resources and specific terms of reference. This is while shortage of trained human resources is among challenges facing these centers. Additionally, due to lack of appropriate organizational chart in Behavior Consultation Centers and absence of adequate budget for running these centers as well as shortage of training workshops, these functions are not carried out well.

Another service that must be available for those exposed to highest risks and Injecting Drug Users are Voluntary Consulting and Testing. As described in beginning of the report, on average one hundred consultation and tests are conducted on an annual basis in Behavior Consultation Centers. There can be several reasons for such little number of services. Firstly, in temporary centers, that are the first level of contact of health systems with Injecting Drug Users, there is a shortage of trained human resources for provision of pre-test consultation services. Another problem is that in cases where temporary centers have to refer the patients

to Behavior Consultation centers, practically many of those who had initially been referred to these centers quit the process because of lengthy processes and lack of availability of these centers in some regions and also the fact that these centers refer these people back to the Blood Transfusion Organization. Taking into consideration the fact that, temporary centers and Behavior Consultation centers do not have a constructive mutual relationship and practically have no available forces for subsequent follow-ups, this problem gets much worse and therefore, the number of cases of Voluntary Consulting and Testing does not increase as required. This lengthy route and the problem may be promoted by providing the required trained human resources in temporary centers and use of counterpart forces as well as conducting quick tape tests in temporary centers.

In the field of tape tests, it must be taken into account that the fact of the matter is that many patients that refer for tests, do not carry out their tests and even a large percentage of those who do refer, do not follow up the process to receive the test results. A survey reveals that 39% of those whose HIV tests has been negative and 30% of those whose test result has been positive, never referred back to receive their test results (Resources-47). Of course, this does not imply that these tests are taken without pre-test consultation and without taking into account level of outbreak in the population because if the pre-test consultations do not take place, announcing the positive test result may have devastating consequences. Also, in cases where HIV prevalence is low in the target population, the value of projected positive value shall decrease. A survey has revealed that if the outbreak is ten percent, this value shall be 98% and if the outbreak is 0.1%, then this value shall drop to 33% (Resources-48). Thus, taking into account a number of considerations, as it is the case in other countries (Resources-49), these tests may be taken in temporary centers by trained staff. As a result, more people living with HIV shall be identified.

E. Opioid Maintenance Treatment Services

Opioid Maintenance Treatment in Iran is limited mainly to Methadone Maintenance Treatment and, Boprnorphine Maintenance Treatment is not a favorite one for reasons that shall be described later.

Although Methadone Maintenance Treatment was launched back in 1960s and has been provided in different countries since then, but by prevalence of HIV epidemic among Injecting Drug Users has been of particular importance and is being used as one of the fundamental tools for controlling the epidemic among the said population.

Methadone Maintenance Treatment has a history of less than 5-6 years and there are several problems for service providers and users.

Currently service providing units follow two models. First are the centers that have obtained their permits from Universities of the Ministry of Health and Medical Education. Second are centers that have received their permits as Addiction Quitting Centers from The Welfare Organization but have had to obtain from the Ministry of Health a permit for provision of agonist medicine. Practically, there are three problems in such a situation. First of all, instructions for provision of services that have been devised by the Ministry of Health and the Welfare Organization are not necessarily similar and in some cases they are even contradictory. Secondly, statistically speaking, there is still this challenge that there may be overlaps of individuals and a person referring to a center that has received its permit from the Welfare Organization and the Ministry of Health may be counted twice. This problem shall continue to be considered a serious matter until such a time when the Unique Identification Code system is not implemented. Absence of this system also makes it possible for profit-seeking individuals to receive services from several centers and may lead to a practical increase in illegal sales of Methadone. The third problem is that these two groups provide completely different services as well. For instance, in centers that are under the supervision of the Welfare Organization, patients receive more social support such as medical subsidies while there are no such alternatives for patients referring to centers that are supervised by the University. Such discrepancy in services offered practically leads to confusion of patients and makes possible misuse more likely.

Another point appearing in the current instructions as well as statistical forms requested from centers is that there are no clear lines differentiating detoxification by Methadone, Methadone Maintenance Treatment and Low Threshold Methadone Treatment[1] and this lack of clear distinction leads to consideration of the current data as unreliable.

A different problem is the response to this question that weather the Injecting Drug Users or Opium Dependants may receive Methadone Maintenance Treatment or not? Although there are no documented data available, but observations indicate that a considerable percentage of those receiving Methadone Maintenance Treatment are not the target groups of this program i.e. Injecting Drug Users. This may have various reasons including poor performance of

[1] Low Threshold Treatment is a type of service that has been designed to increase maximum access and requires minimum standards. Normally the average of fewer doses is prescribed and is suitable for temporary centers and the homeless. Usually, in this model of treatment, strict rules of Maintenance Treatment Centers such as dealing with absences, exclusion of individuals and regular tests does not exist and thus the Home Dose does is not prescribed. JOURNAL FOR DRUG ADDICTION AND ALCOHOLISM 23th year: 2000 no 3 (selection of the articles in English) *"GUIDELINES ON HARM REDUCTION"*

centers, high demands for Methadone Maintenance Treatment, absence of suitable treatment methods for Opium users and other non-heroin drugs.

Paying attention to recommendations of the World Health Organization's experts demonstrates that there needs to be a suitable mechanism for Opium users and as described earlier tools such as opium syrup may be considered for non-injecting persons.

To resolve these problems it is recommended that a specific regulation for establishment and supervising Opioid Maintenance Treatment services - not for Methadone only - be prepared and launched by the Ministry of Health and the Welfare Organization with identical supervisory forms.

There are some simple, but in the meantime important problems in the field of required Methadone. One problem is that different types of Methadone in 5, 20 and 40 milligram pills and Methadone syrup are available and the effect as observed in the patients is that these compositions do not have identical effective materials. For instance, there are fewer treatment centers that do not have to alter doses at times of altering from pills to syrups or vice versa. This problem manifests itself more together with the fact that treatment centers practically have no alternative for making a choice for deciding the type of medicine they need and have no option but to use the types that are available with the Food and Medicine Deputy Ministry. Such alteration, even if the effective ingredients of various medicine types are identical and proportionate, leaves a psychological impact on the person and adversely affects the medicine's effect.

Also, the experience with distribution of essential medicine such as Insulin shows that, if an appropriate mechanism for correct estimation of the required medicine is not used, it is always possible that the medicine is not distributed appropriately and in practice, it becomes rare in one province and too much in another one.

Another problem that is seen in such centers is that, unfortunately, due to shortage of relevant trained resources, the non-drug treatments are gradually losing their importance. The fact of the matter is that, although currently there is a specific training course and lesson plan for physicians working in maintenance treatment centers, but no official and obligatory training course for the psychologists engaged in such centers has been prepared yet.

Additionally, due to lack of adequate supervision/training in a number of private centers, no suitable pattern for provision of Methadone is implemented and the Home Dose is prescribed without taking into account the notified guidelines/instructions. In some cases it has been

observed that the center provides Methadone to the patient in blister form and then receive the empty container back from him/her. It goes without saying what impact this method may have on flow of Methadone outside the treatment system and practically it is possible that Methadone may be sold by patients in view of the difference of price that is almost 100 times more in the market. One suitable solution may be outsourcing the supervision or devising a single supervisory protocol for all organizations and or, alternatively, formation of supervisory teams comprised of various organizations in view of double permits of centers.

One other issue is the Methadone Maintenance Treatment in temporary centers the guidelines for which, as indicated earlier, is similar to that of the private centers while, in view of the relatively high differences in target groups, this trend should not be the same because, taking into consideration their target society, services offered in temporary centers should be free or with little costs and, if required, they should be with low threshold and without taking a urine test.

In the principles of provision of Methadone Maintenance Treatment it has been strongly emphasized in various resources (Resources-23) that these services should not be disrupted. Such disruptions repeatedly occur at the times of entry and exit of drug users to and from prisons or jails. Additionally, due to lack of an integrated system for provision of Methadone Maintenance Treatment services across the country and absence of clear guidelines as well as lack of Unique Identification Codes for this group of people that receive services there are disruptions for such people at times of travel or emergency trips.

Bopronorphene Maintenance Treatment is also a more expensive treatment than Methadone. However, in view of its little differences, particularly less likelihood of intoxication and its misuse as it is a relative agonist, makes it possible to prescribe a Home Dose more freely and thus is a suitable option for a number patients and requires more attention.

Detoxification is not without problems though it has an older history than that of Maintenance Treatment. To optimize the status of detoxification, it has been recommended that grounds be made for increasing diversity of various treatments and different detoxification and rehabilitation fields such as special attention to detoxification programs for certain groups in terms of their gender, age and HIV status and the current protocols and guidelines be adjusted in such a manner that it would be possible to have access to various treatments.

In order to achieve valid data, strengthening assessment and evaluation of current detoxification programs must be placed on the agenda. Of course, it must be taken into

account that detoxification is the first and perhaps the easiest step in prevention-oriented treatments.

In the field of provision of medical services to drug users, the situation that those involved in the treatment are usually confronted by is patients that can not afford the respective costs. For this group of patients, except for the cases in which the Welfare Organization bears a little portion of the costs, there are no other options and insurance companies refrain from provision of any type of services for detoxification or consultation services.

In addition, in order to make maximum use of the existing capacities, harm reduction programs in medical systems need be enhanced. For instance, currently a considerable portion of the treatment-oriented community centers are empty because they have fully prevention-based approaches. It is suggested that, by making use of more modern approaches such as TC Methadone, better use must be made of this capacity.

This should also happen in self-assisting groups and at least a part of them should incorporate harm reduction approaches in their programs. The NA Methadone Friendly model is a good experience.

Provision of Methadone Maintenance Treatment services in prisons and continuing them outside prisons was raised as one of main challenges in scaling up harm reduction programs. In this connection, the following suggestions were made to overcome the existing obstacles and challenges:

- Reviewing the drug use status and high-risk behaviors in prisons for better planning
- Consultation to create the organization chart in order to overcome human resources problem in prisons and care centers after leaving prisons
- Provision of the Treatment Card, implementation of MMT in the quarantine system and jails and coordination with prisons that provide MMT
- Remove obstacles in provision of services after being discharged from prisons
- Detailed planning for devising special guidelines for provision of services, letter of understanding between the Welfare Organization and the University of Medical Sciences and establishment of referral system in cities and villages
- Planning for building adequate capacity for covering prisoners after they are discharged from prisoners in cities and villages

F. Needle and Syringe and Condom Programs

For a group of users who are not willing to or can not quit drug use through injection, Needle and Syringe Programs can be of great help. These services are available in large cities and centers of provinces but there are still few cities in which this service is provided and it is offered in almost none of the villages in the country though there are drug users in villages where this issue needs to receive particular attention. In practice, all challenges that Methadone Maintenance Treatment centers and Behavior Consultation Centers provide, are demonstrated here.

The importance of these centers stems from the fact that only a part of the harm reduction service cycle deals with a drug user that continues to use drugs. Such an opportunity may be used for timely and up-to-date study of drug user's community, new drug use patterns, new addictive materials, and identification of sub-cultures that are increasingly modernized on a daily basis and activities of the addiction system.

Condom training and promotion programs are an issue that receives little attention in the temporary centers and unfortunately, because of cultural problems, it does not receive adequate attention. Another important challenge that confronts Needle and Syringe Programs is provision of Methadone Maintenance Treatment services in temporary centers. This is not a problem on its own. However, when these centers are duty bound to provide services with the same number of human resources it is obvious that more share shall be given to Methadone Maintenance Treatment and other programs become less important.

G. Harm Reduction Services in Villages:

Based on the 2006 census data, the general population of the country has been announced to be 70,495,782 of which 22,235,818 i.e. 31.5% live in villages. Due to various reasons, there are no reliable and documented data on drug use status and pattern in villages. However, what is evident is the fact that this will not be a reason for depriving such important population for harm reduction services. It appears that, considering the existing large network in the country, integration of treatment and harm reduction programs in basic health care services is one of the quickest routes for increasing outreach of such services in the country.

The Last Word

The Last Word may be seen in the report released by the WHO expert stating that:

"To appropriately and effectively respond to this epidemic (in Iran), funds, much more than what currently is available, is required. Initially, this may seem to be a considerable cost, but the costs of inappropriate responses will be much more."

Annex 1.

Iran Drug Control Headquarter		
1	Dr. Saeed Safatian	Director General, Treatment, Rehabilitation and Vocational Training Department of Iran Drug Control Headquarter
2	Dr. Fariborz Ahmadi	Head Treatment Department of Iran Drug Control Headquarter
3	Dr. Hooman Narendjiha	Director General, Cultural and Prevention Affairs Bureau, Iran Drug Control Headquarter
4	Dr. Ali Mohammadi	Director General, Security Central Bureau of Iran Drug Control Headquarter
5	Mr. Rahim Nazari	Head of Public Relations and Consultant of the Secretary General of Iran Drug Control Headquarter
Ministry Of Health		
1	Dr. Mohammad Mehdi Gooya	Director General, Diseases Control Center, Ministry of Health and Medical Education
2	Dr. Abbas Sedaghat	Head, AIDS and Sexual Diseases Bureau, Ministry of Health and Medical Education
3	Dr. Kiyanoosh Kamali (Ms.)	Expert, Diseases Control Center, Ministry of Health and Medical Education
4	Dr. Maryam Sargolzaee Moghadam (Ms)	Expert, Diseases Control Center, Ministry of Health and Medical Education
5	Dr. Mohammad Bagher Saberi Zafarghandi	Director General, Drug Abuse Prevention and Treatment Bureau, Ministry of Health and Medical Education
6	Dr. Ali Asghar Noroozi	Expert, Drug Abuse Prevention and Treatment Bureau, Ministry of Health and Medical Education
7	Dr. Soodabe Namazi	Expert, Drug Abuse Prevention and Treatment Bureau, Ministry of Health and Medical Education
8	Dr. Ali Beyrami	Expert, Medicine Affairs, Food and Medicine Deputy, Ministry of Health and Medical Education
9	Dr. Navid Safavi	Head, Controlled Drugs and Materials, Ministry of Health and Medical Education
10	Dr. Narges Mohammad Rezaee (Ms.)	Expert, Diseases Control Center, Ministry of Health and Medical Education
UN		
1	Dr. Golareh Mostashari (Ms)	UNODC
2	Dr. Mahshid Dadj (Ms)	UNODC
3	Dr. Hamid Reza Setayesh	UNAIDS Country Program Officer in Iran

4	Dr. Ali Feyzzadeh	UNAIDS Monitoring and Assessment Consultant in Iran
		The Ministry of Welfare
1	Dr. Parviz Afshar	Consultant to the Minister of Welfare and Social Security of IR of Iran
		The Welfare Organization
1	Dr. Farid Barati Sadeh	Director General, Prevention and Addiction Affairs Bureau, The Welfare Organization
2	Dr. Madjid Reza Zadeh	Expert, Prevention and Addiction Affairs Bureau, The Welfare Organization
3	Ms. Parisa Fazeli	Expert, Prevention and Addiction Affairs Bureau, The Welfare Organization
4	Dr. Mehrdad Ehterami	Expert, Prevention and Addiction Affairs Bureau, The Welfare Organization
5	Dr. Robert Farnam	Expert, Prevention and Addiction Affairs Bureau, The Welfare Organization
6	Dr. Kambiz Mahzari	Expert, Prevention and Addiction Affairs Bureau, The Welfare Organization
7	Dr. Zahra Erfani (Ms.)	Expert, Prevention and Addiction Deputy Office, The Welfare Organization of Tehran Province
8	Dr. Shabnam Mir Beygi (Ms)	Expert, Prevention and Addiction Deputy Office, The Welfare Organization
		The Prisons Department
1	Dr. Marziye Farniya (Ms)	Director General, Health and Treatment Bureau, IR of Iran Prisons and Correctional Department
2	Dr. Ramin Alasvand	Expert, Health and Treatment Affairs, IR of Iran Prisons and Correctional department
3	Dr. Mehrzad Tashakorian	Expert, Health and Treatment Affairs, IR of Iran Prisons and Correctional Department
		Universities
1	Dr. Parvin Afsar Kazerooni (Ms)	Head of Diseases Group, Shiraz University of Medical Sciences
2	Dr. Mehrdad Eftekhar	Assistant Professor, Iran University of Medical Sciences
3	Dr. Behnam Farhoodi	Assistant Professor, Islamic Azad University of Medical Sciences
4	Dr. Ehsan Taghiyan	Mashhad University of Medical Sciences
5	Mr. Ali Asadi	Iran University of Medical Sciences
6	Dr. Mahdiyeh Dalili	Kerman University of Medical Sciences
7	Dr. Shahin Bafteh Chi	Guilan University of Medical Sciences
8	Dr. Kambiz Nemaati	AIDS Expert, Health Deputy, Shahid Beheshti Unviersity
		Scientific Research Centers

1	Dr. Omran Mohammad Razaghi	Head, Iranian National Center for AIDS Studies
2	Dr. Setareh Mohseni far (Ms)	Expert, Demand Reduction Center, Iranian National Center for AIDS Studies
3	Dr. Azarakhsh Mokri (Ms)	Head Clinical Psychology and Treatment Bureau, Iranian National Center for AIDS Studies
4	Dr. Mohammad Reza Haddadi	Expert, Demand Reduction, Iranian National Center for AIDS Studies
5	Dr. Minoo Mohraz (Ms)	Head, Iranian Society for Protection of Patients of Infectious Diseases
6	Dr. Parastoo Kheyrandish (Ms)	
7	Dr. Hengameh Namdaritabar (Ms)	Demand Reduction Expert
	NGOs	
1	Dr. Ramin Radfar	Executive Director, Health and Culture Institute
2	Ms. Leyla Arshad	Khane Khorshid Temporary Center
3	Dr. Mohammad Reza Seyyed Ghasemi – Dr. Fatemeh Bahram Abadyan (Ms)	Payamavarne Hamyari Temporary Centers
4	Mr. Habib Sangari Bahrami	Director, Simaye Sabz Rahaee Temporary Center
5	Ms. Afshin Khosh Raftar	Director, Ahang Rahee Temporary Center
6	Dr. Farhad Hadjebi	Director, Azadi Temporary Center
7	Dr. Ali Malekzadeh	Manager, Behavior Disease Consulting Clinic, Gharb Mosalasi Clinic
8	Dr. Hadi Shirzad	Director, Research Bureau, IR of Iran Disciplinary Forces
9	Mr. Ali Kavoosi	Managing Director, Hamdelan Khamoosh Institute
10	Mr. Foroohar Tashvighi	Director, Tavalode Dobareh Institute
11	Mr. Alireza Yeganagi	Manager, Tavalode Dobareh Harm Reduction Programs
12	Mr. Babak Deylami	Manager, Public Relations Tavalode Dobareh Society
13	Mr. Amirreza Moradi	Managing Director Zangi Mosbat Iranian Institute
14	Dr. Abbas Azizi	Director, Treatment Bureau, Tavalode Dobareh Society

Annex 2.

Day One		
Time	Subject	Facilitator
8:30-8:50	Introduction and Welcome Note	Mr. Roberto Arbitrio
8:50-9:10	Harm Reduction Programs of the Iran Drug Control Headquarters	Dr. Saeed Safatyan
9:10-9:30	HIV/AIDS and Drug Abuse: The Epidemic Trend; Country Response	Dr. Omran Mohamamd Razaghi
Workshop One		
9:30-10:30	A review of the Current HIV/AIDS Status among Injecting Drug Users and Prisoners; The Country Response	Group Work
10:30-11:00	Break	
11:00-12:30	Working Group Presentation and Panel Discussion	Dr. M. Mehrdad Ehterami, Dr. Omran Mohamamd Razaghi, Dr. Saeed Safatyan, Dr. Minoo Mehraz, Dr. Hooman Narenjiha
12:30-13:30	Review of programs, policies and processes	Group Work
13:30-14:30	Lunch Break	Panel Members: Dr. Farideh Barati Sade, Dr. Mohammad Bagher Saberi Zafarghandi, Dr. Saeed Safatyan
14:30-16:00	Workshop Presentation and Panel Discussion	
Day Two		
8:30-8:45	Conclusion of the previous day	
Workshop Three		
8:45-10:00	Existing Challenges in Implementation of Methadone Programs / Solutions	Group Work
10:00-10-30	Break	
10-30-12:15	Workshop Presentation and Panel Discussion	Panel Members: Dr. Farideh Barati Sade, Dr. Mohammad

		Bagher Saberi Zafarghandi, Dr. Saeed Safatyan
Workshop Four		
12:15-13:30	Existing Challenges in Implementation of Needle and Syringe and Condom Program in Temporary Centers and Mobile Centers / Solutions	Group Work
13:30-14:30	Lunch Break	
14:30-16:00	Workshop Presentation and Panel Discussion	Panel Members: Dr. Mehrdad Ehterami, Dr. Abbas Sedaghat, Dr. Saeed Safatyan, Dr. Hooman Narenjiha
16:00-16:30	Conclusion and Closing	

Annex 3. Subject Discussed in each Workshop

Workshop One: A review of the Current HIV/AIDS Status among Injecting Drug Users and Prisoners; The Country Response
The Current Status
HIV Epidemic Status among Injecting and Non-Injecting Drug Users
Homosexuality and Heterosexuality / In and Out of the Family
Drug Use Trend and its Impacts on the Epidemic
Status of High-Risk behaviors such as Drug Use and Unprotected Sexual Behaviors among those detained in Prisons and Correctional Centers such as Camps
HIV Epidemic among Female Drug Users
The Country Response
Existing Programs of the Government
Non-Government Organizations
Connection Within and Between Sectors

Workshop Two: A Review of Programs, Policies and Processes	
Challenges	**Solutions**
Allocation of Budgets to Centers; Time of Allocation and Notification; Financial Relations between Universities and the Welfare Organization and the Centers	A review of solutions in the three sectors relating to the Ministry of Health, The Welfare Organization and the Prisons Department on three levels of countrywide, provincial and local
What are problems pertaining to the workforce engaged in Temporary Centers including their training, wages and benefits?	A review of solutions in the three sectors relating to the Ministry of Health, The Welfare Organization and the Prisons Department on three levels of country, provincial and local
Challenges pertaining to assessment and evaluation of the current activities	Solutions proposed for each problem for each program including Needle, Syringe and Condom and the Methadone program in two sectors of the society and prisons
What are Temporary Centers and Needle, Syringe and Condom Programs	Solutions proposed for overcoming these obstacles
Current challenges pertaining to those infected with Hepatitis and AIDS	Solutions proposed for overcoming these obstacles

Workshop Three: Maintenance Treatment Centers	
Challenges	**Solutions**
Is Methadone/Bopronorphine Maintenance Treatment sufficient for all patients? Or for Injecting ones only?	
What are the problems relating to implementation of above services with the Universities of Medical Sciences and Provincial Welfare Organizations? What about obtaining permits, conditions of granting permits, training courses, patience admission ceilings, etc.	Solutions proposed for overcoming each of these problems
What are the problems with procuring Methadone pharmaceutical compositions, including dose and effective materials?	Solutions proposed for overcoming each of these problems
Problem pertaining to detoxification.	Solutions proposed for overcoming each of these problems

Workshop Four: **Needle and Syringe and Condom Program in Temporary Centers and Mobile Centers /**	
Challenges	**Solutions**
What are the problems pertaining to procurement of consumer tools and disposing of collected equipments?	Solutions proposed for overcoming each of these problems
Scaling up activities of temporary centres and their obstacles	Solutions proposed for overcoming each of these problems
VCT and Testing in Temporary Centres	Solutions proposed for overcoming each of these problems
The connection between temporary centres and Methadone Maintenance Treatment and Triangle Clinics	