Young people and drugs
Towards a comprehensive health promotion policy
Tehran Report

Unabridged version

Asian Harm Reduction Network

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(Conducted under the working title: “Through the Eye of the Needle” - a research into the environmental factors that shape the drug careers of young people in selected cities in Asia").

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# Young people and drugs – Towards a comprehensive health promotion policy

## Contents

- **Acknowledgements** ........................................................................................................ 5
- **Executive summary** ....................................................................................................... 6
- **Figures, textboxes, graphs, quotes and case studies** .................................................. 13
- **Explanatory notes** ........................................................................................................ 15
- **Introduction** .................................................................................................................. 19
  - Rationale .......................................................................................................................... 19
  - Geographical scope and structure .................................................................................. 20
  - Stakeholders and partners .............................................................................................. 20
  - Funding agencies ............................................................................................................ 20
  - Goal a Quotes nd objectives .......................................................................................... 20
  - Key questions ................................................................................................................ 21
  - Theoretical framework .................................................................................................... 22
- **Part I: Methodology** ...................................................................................................... 27
  - **1. Research design** ...................................................................................................... 27
    - 1.1. Research sites and implementing partners .......................................................... 27
    - 1.1.1. Approach and guiding principles ....................................................................... 27
    - 1.1.2. Quality control ................................................................................................... 28
  - **1.2. Data-management** ................................................................................................ 29
    - 1.2.1. Analysis of existing data .................................................................................. 30
    - 1.2.2. Key informants .................................................................................................. 30
    - 1.2.3. Focus group discussions .................................................................................. 31
    - 1.2.4. Open interviews ............................................................................................... 33
    - 1.2.5. Case studies ....................................................................................................... 34
    - 1.2.6. Survey ................................................................................................................ 34
  - **1.3. Comparability and generalisability** ...................................................................... 36
    - 1.3.1. Comparability .................................................................................................... 36
    - 1.3.2. Generalisability ................................................................................................. 36
- **Part II: Findings** ............................................................................................................ 37
  - **Chapter 1: Setting the tone** ......................................................................................... 37
    - 1.1. The problem .......................................................................................................... 37
    - 1.2. The response: HIV/AIDS prevention among people using drugs ....................... 44
  - **Chapter 2: Profile of the sources** ............................................................................... 52
    - 2.1. Key informants and participants of the focus group discussions ......................... 52
    - 2.2. Open interviews and survey sample ...................................................................... 53
  - **Chapter 3: Drug use and health; a KAP study** ............................................................. 55
    - 3.1. Knowledge levels on HIV/AIDS and Hepatitis C ................................................. 55
    - 3.2. Attitudes towards drug use and health .................................................................. 59
    - 3.3. Unsafe practices ..................................................................................................... 62
  - **Chapter 4: Drug careers and environmental factors** .................................................. 65
    - 4.1. Characteristics of drug use .................................................................................... 65
    - 4.2. Initiation ................................................................................................................ 68
    - 4.3. Development of drug use ...................................................................................... 76
    - 4.4. Efforts to reduce drug use: treatment and relapse ................................................. 86
  - **Chapter 5: Drug related problems** ............................................................................. 97
    - 5.1. Onset of problems .................................................................................................. 97
    - 5.2. Health problems ..................................................................................................... 99
    - 5.3. Financial problems ............................................................................................... 99
    - 5.4. Judicial problems ................................................................................................. 100
    - 5.5. Stigmatisation, alienation, criminalisation ............................................................. 103
- **Part III: Conclusions and recommendations** ................................................................. 107
  - Conclusions ...................................................................................................................... 107
  - Prevailing scenarios ......................................................................................................... 108
  - Recommendations .......................................................................................................... 108
- **Annexes** ........................................................................................................................ 114
- **References** .................................................................................................................... 144
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This report describes a research project among people using drugs in Tehran conducted from November 2003 until November 2004, executed under the responsibility of the Asian Harm Reduction Network, Thailand.

Particularly at the site level, the project was confronted with many setbacks and constraints, and the research would have been a complete failure if it hadn’t been for the sheer tenacity, energy, enthusiasm and commitment of all those involved.

Not willing to take the risk of missing anyone, AHRN would like to thank everyone very much for their contributions.

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Executive summary

Background

Late 2003, the Asian Harm Reduction Network (AHRN) embarked upon a multi-site research to gain insight in drug careers –or pathways– of young people and the impact that environmental factors have on these careers as well as on drug use related problems. In addition, data was collected with regards to knowledge, attitudes and practices, related to drug use and HIV/AIDS. The research was simultaneously conducted in New Delhi (India), Greater-Jakarta, (Indonesia), Tehran (Iran), and Lahore, Peshawar, Quetta, Rawalpindi and Karachi (Pakistan). This report is the unabridged synthesis of Tehran research reports that were written by the site research managers, located in Tehran.

Insight in the factors that are at play in the onset and development of drug careers are extremely useful for the development of targeted approaches as well as for the formulation of broad policies in the field of drug use and HIV/AIDS prevention.

Methods

The research was conducted by locally hired research teams that largely consisted of (recovering) people using drugs (PUD). Key methodological principles were: involvement of all stakeholders, non-judgmental approach, informed consent and confidentiality. Data were gathered through: analysis of existing data; interviews with key informants (n=16); focus group discussions with parents and family members, PUD, service providers, policy makers, law enforcement officers, etc, (n=7); open interviews with PUD (n=47) and a large-scale survey with PUD (n=281). The interviews with key informants and focus group discussions were conducted to come to tentative conclusions on the issues at hand. Through the open interviews and survey with PUD, these conclusions were verified, and elaborated upon, resulting in detailed information on how youth drug careers develop and what related problems are associated with it.

Findings and conclusions

Characteristics of PUD

- Large proportions of young PUD (16%) have migrated to their city of current residence before they turned 19.
- Large proportions of PID (43%) usually spend the night in ‘open areas’, such as the street or a park.
- Only 10% of PUD have not finished primary school.
- In terms of source of income, a mixed picture arises: PUD appear to be involved in all kinds of work, including street-based work, steady work, and illegal activities. In addition, dependency on family members is quite common.
- Injecting drug use seems to lower one’s chances to hold a steady job significantly.

Drug use and health, a KAP study

- Mass media can reach a large group of people, whereas school, parents and other family members fail to spread information on health issues such as HIV/AIDS and Hepatitis C.
- Drug use and drug use related issues are commonly discussed with fellow PUD. GOs and NGOs that specifically target people at risk have an important role to play in spreading of knowledge and raising awareness in regards to HIV/AIDS and Hepatitis C.
- Knowledge levels among PUD (regardless whether they were injecting) in regards to HIV/AIDS transmission, cure and prevention are low. Knowledge on Hepatitis C is extremely low.
- Most respondents describe the effects of most drugs in a largely positive manner.
- Amongst young PUD, the image of a drug does not significantly differ between those who have used that particular drug and those who haven’t.
Most non-PID are aware of health risks related to injecting and this is a major factor in the decision not to inject. Very few non-PID would readily start injecting if they were offered to do so.

There are reports of antipathy amongst non-PID towards PID.

Many PID appear to be unaware of the health risks that are associated with injecting. HIV/AIDS is mentioned by few PID as a drug use related health risk.

The addictive nature of injecting is widely recognised amongst PID, yet PID remain optimistic about the possibility to be able to abstain.

Sharing injecting equipment and other unsafe injecting practices are quite common (about 40% "often or always" and near 90% answer differently than "never").

Being injected by a fellow PUD with a used needle is quite common when one first starts injecting.

Desperation, as a result of withdrawal symptoms, is the main reason for not using clean injecting equipment.

The cost and effort involved in buying new injecting equipment every time are important factors in sharing needles. Needles for individual use are often used many times.

Applied cleaning practices are not effective in preventing the spread of blood borne diseases.

For many PID, the ritual that accompanies injecting is an important part of its attraction.

Half the sexually active PUD often or always had unprotected sex. The most often mentioned reason is "don't like it (using a condom)." Other main reasons include (presumed) monogamy and lack of availability of condoms.

Characteristics of drug use

Despite current supply reduction efforts, all kinds of traditional drugs are widely available. Consequently, harm reduction and demand reduction strategies remain important.

In terms of which drugs were being currently used1, opium use is the most significant, then heroine and marijuana / hash.

The type of drug used appears highly dependent on local circumstances with availability being the main factor:

→ Heroin and opium are the main.
→ The category "other" consists largely of "alcohol," which the research team had decided to not include.

Logically, life-time use (LTP) is markedly higher than current use (LQP). LTP percentages total more than 200, confirming that careers are rather flexible and fluid; switches from one drug to the other or experimenting with certain drugs for a short time are quite common. Many people have used a wide range of drugs throughout their lifetime, thus displaying a 'willingness to try anything'.

Opium in Tehran (n=175) is generally smoked (75%), while 37% have eaten it and 6% mention injecting.

Most active users can also be called intensive users, particularly those who use opiates.

Initiation

half of people start using drugs before they reach the age of 19, and sizable proportions start before they turn 16 years old.

More than 50% mention opium-based drugs as their drug of initiation and near one-third started their drug career with cannabis-based drugs (32%). High perceived availability of a certain drug (as presented in Table 29) goes hand in hand with high initiation rates for using those drugs.

Opiate use (largely heroin and opium) is extremely common (LTP=89%) and 71% of the opiate users started their drug career with an opiate. About two thirds are PID and almost a quarter of them initiated through injecting (heroin).

1 The terms "drug of choice" or "preferred drug" are avoided here, because they imply that the drug used is the drug that the person likes best. Oftentimes, the drug used is a result of complicated decision-making processes that take into account factors such as availability, price, risk of getting caught, effects of the drug, and perceived health risks, among others.
Although most PUD are living with their parents at the time of initiation and their relationship was not considered bad, the parents usually don’t find out about drug use until much later (if at all).

Those parents that do know commonly react with anger – not the reaction that is desired by the PUD.

Curiosity, peer pressure and acceptance among friends are the most important factors that drive initiation. Having friends who use drugs is an important factor during the initiation stage. Mostly, the drug is given for free by friends and taking drugs is done with some good friends during initiation, as well as afterwards.

Initiation tends to be unplanned, free of cost and not connected to any specific problems at the time. Generally, it is viewed as an enjoyable experience, with some people feeling regret as time passes.

PUD tend to turn to fellow PUD if they feel the urge to talk about their drug use or drug use related problems. Parents, other family members, non using friends, or (N)GOs play a minor role in this regard. Many PUD, have no one to turn to.

Reactions from the non-PUD in one’s environment tend to follow a similar line: generally, they do not know for quite some time and, once they find out, their response can be characterized as anger or urged to stop. Some people are indifferent and few offer the positive support that would have been desired by the PUD.

Teachers and the school system are commonly viewed as being focused on knowledge and job skills only, rather than adopting an approach that fosters development of strong personalities or social skills.

Development of drug use

Drug careers of young people tend to be dynamic and changeable. Shifts from one drug to the other as well as from one mode of intake to the other occur regularly and sometimes very quickly.

More than 40% of the respondents switched to injecting after having used other modes of intake for more than five years.

In crucial switches, factors related to the (perceived) effect of the drug are considered very important. For example, the strength (quicker high) of the new drug scores very high, as well as factors such as relaxation/sleep, suppression of feelings, bored with previous high and to enhance confidence. Expectedly, since injecting creates a quicker high, the strength of the new high is of little importance in switches away from injecting.

Social factors appear quite important, with peer pressure being a major one. Possibly related to this, curiosity also scores high. Factors such as fashionable and to be different also are rated highly. Enhance performance at work/school (work, for most respondents) appears significant. Attraction to drug culture is relatively important.

Parallel to increasing use and/or switches towards injecting, a process of alienation from mainstream develops: non-PUD slide to the background as fellow-PUD gradually become all important and ever present.

Factors related to price and availability appear rather important with easier availability of the new drug rated very much a factor. Lack of availability is associated with a switch towards a more effective mode of intake - usually injecting - to counteract the lack of availability or higher price.³ Health related factors seem only of importance in the switches away from injecting.

Poly-drug use is quite common and takes many different forms.

Overall, one third of respondents have experienced one or more cases of overdose, 33%. In terms of overdose in one’s immediate environment, the rate was 65%. In other words, most PUD know of overdose cases around them and about one third have experienced overdoses themselves.

Roughly half of the respondents indicate that they somewhat or totally intended to overdose.

The PUD often has to deal with the overdose her/himself. In other cases, drug using friends are commonly the people who look after the person who experiences an overdose.

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³ Indeed, 85% of those who rated this factor highly switched towards injecting
Parents and non-drug-using friends appear to be of little significance in this respect. Very few are looked after by professionals and carers often do not know what to do in case of overdose.

- Overdose seems to act as a warning signal to many PUD, yet rarely leads to initiation of treatment or change of drug or mode of intake.

**Efforts to reduce drug use: treatment, relapse and abstinence**

- Most PUD wish to quit, yet find themselves unable to do so. Meanwhile, they tend to be optimistic about their ability to stop using.
- Most PUD go through periods during which they try to reduce their intake or abstain.
- PUD identify their parents (and to a lesser extent non-PUD friends and partners) as the people who should be involved in such efforts.
- In efforts to reduce one’s intake, PUD largely avoid those situations and people that they associate with drug use.
- Use of drug-related services - and particularly treatment services - is low. Most PUD are never treated for their drug use. However, those that do enroll in treatment tend to do so repeatedly.
- Parents are the main driving force behind enrolling into treatment with peers playing an important role in some cases. Some PUD go into treatment when they are ‘not ready’ for it.
- A main reason for going into treatment is boredom or being fed up with drug use (or its related problems), often leading to a willingness to abstain.
- Demand for residential treatment exceeds supply. Expense is a major constraint to going into treatment. A further obstacle is lack of knowledge of available services. There are insufficient low-threshold hold, client-centred treatment facilities, that specifically target female PUD or PUD from the lower socio-economic classes.
- There seems to be some stigma attached to going into treatment, with some PUD not informing anyone unless they have to.
- Drug related services -particularly those run by NGOs- are generally evaluated positively.
- There is insufficient collaboration, mutual referral and coordination between service providers.
- During treatment, there is insufficient emphasis on social and social-economic aspects of drug dependency.
- Within the sites, there are big differences in policies and rules inside treatment facilities. There are reports of physical punishment.
- Drug use related services -particularly those run by NGOs- are generally evaluated positively.
- Relapse is extremely common, regardless the kind of treatment that preceded it. Out 119 respondents who had gone into treatment, 89% had relapsed.
- Exposure to PUD friends and the urge to use are two major relapse factors. Drugs are widely available and easily accessed.
- Parents and schools do often not know for quite some time that a PUD has relapsed.

**Drug use related problems**

- Many PUD experience few problems during the first stages of their drug use. Relationship problems (within the family, as well as with friends and at school or work) tend to be the first signal that drug use might have a problematic side to it.
- More concrete drug related problems tend to develop when dependency starts to become apparent, particularly, because of the financial and health consequences of increased use.
- The large majority of PUD, if not all, suffer from drug use related health problems after time, yet often symptoms are ignored or not taken seriously at first. Self-medication is common.
- PUD, and particularly PID, spend large proportions of their total expenses on drugs.
- Overall, more than half of the respondents had been in contact with the police due to their drug use and the most common offences were possession and use of drugs.
- Drug use -including injecting drug use- appears quite common in a number of prisons. In such prisons, unsafe injecting practices are rampant. Yet, the large majority of those respondents that went to prison said their drug use decreased or stopped completely while imprisoned.
Access to condoms in prison is problematic.
When one’s drug use becomes central in one’s lifestyle, many PUD experience stigmatisation, alienation and discrimination from different sources, including parents, non-PUD friends, potential employers / care givers, and community.
With increasing dependency, PUD tend to remain in contact with PUD only. Self-stigmatization and self-marginalization reinforce stigmatization and alienation experienced from mainstream society.
Drug use (often regardless the type of drug or mode of intake) is illegal and, as a result, PUD tend to be criminalised.

Recommendations

The appropriate government and non-government agencies are urged to further develop and implement the following recommendations, in collaboration with PUD and people that have inside knowledge and experience with the complicated issues of drug use and HIV/AIDS prevention.

General policy directions

Policy makers are urged to focus and tailor drug policy more towards young people, and in particular teenagers, and identify and make use of the positive aspects of the prevailing youth culture to develop primary and secondary prevention interventions; review policies and programmes away from the current focus on the penalisation of drug use towards the development of a more comprehensive set of services, including social, financial and legal support, as well as social and economic rehabilitation; and consider the implementation (or expansion) of harm reduction interventions in closed settings.

In the fields of health and education, effectively use of the mass media and educational institutions to reach the general population with information regarding HIV/AIDS and Hepatitis C transmission and prevention; target primary prevention of drug use at urban as well as rural settings and at a very young age group; probably 14-15 years old is the time at which the most impact can be generated; sensitize and raise awareness amongst teachers and school administrations in order to improve primary and secondary prevention of drug use among children towards the development of an early detection, case management and referral system rather than punishment and expulsion; review educational system and curriculum in a manner that emphasizes development of individual strength as well as social skills; improve health information and awareness regarding the adverse health effects of drug use and access to health services to PUD; and improve information and awareness on risks related to unprotected sex and ensure availability and access to condoms.

In terms of legislation, take into account the effects that (current or planned) legislation or law enforcement might have on the availability (and price) of a certain drug, particularly if changes in availability are likely to adversely affect health behaviour; consider measures that would break the link between drug dependency and related high expenditures (e.g. provision of needles and syringes, de-criminalization of certain drugs, and pharmacotherapy); and endeavour to significantly reduce bribery and improve the effectiveness and credibility of law enforcement agencies.

Community building, programming at the site level

Mobilize and involve parents and other family members as early as possible in primary and secondary prevention, including during and after treatment, follow up and after care; and include parents and communities in education and awareness campaigns, such as information and contacts on what to do when a young person uses drugs, drug use related risks and available options. Develop and conduct community-building activities towards early detection of drug use and a positive response towards it.

Strengthen outreach work and drop-in-centres in the areas with high concentrations of street-based populations in order to reach street-based PUD and, in particular, PID. Implement community building activities, including awareness raising and education that counter the exclusion of PUD from mainstream society. Re-strategize and scale up awareness and
education programmes with a focus on reducing stigma and discrimination through existing NGOs and GOs working in this field, at the local level with community members by including key leaders (religious and political).

Service delivery

Primarily, programme managers are urged to review all the conclusions and recommendations offered in this report together with the target group and adjust current directions and activities accordingly.

In general terms, the following directions are suggested: Urgently develop, improve, and/or scale up (tools available for) primary and secondary prevention interventions that stress the adverse effects of using opiates and injecting as compared with other drugs and modes of intake; effectively target the period between the onset of drug use and switching to injecting (if at all) for secondary prevention and harm reduction interventions; develop preventive interventions that take into account the period of social factors which appear to contribute significantly in the decision to switch towards injecting; develop and scale up free and easily accessible needle and syringe exchange programmes; provide information on safe injecting; develop and conduct activities that focus on imparting practical skills on safe injecting and safe sex; and develop, improve, and/or scale up harm reduction services that stress the adverse effects of using heroin and of injecting as compared with other drugs and modes of intake.

More specifically, the following recommendations are offered: maintain contact with PUD to gauge and exploit periods of readiness and willingness to reduce intake or abstain; develop mechanisms to recognise increased motivation to reduce one’s intake and link such with referral to treatment interventions; improve health information and awareness on the adverse health effects of drug use and drug use related harm in general to PUD; develop and improve IEC – possibly in the form of a manual – and awareness raising on overdose response among PUD and parents. IEC/ABC materials on drugs should be non-judgmental and enable young people making well informed choices. While an emphasis may be on primary prevention, secondary prevention and harm reduction should be incorporated; focus on HIV/AIDS prevention information and awareness, including drug use related harms, within those services that target PUD and specifically PID; use peer education to reach more PUD and to facilitate the development of tailored materials; regularly assess knowledge levels pertaining to health risks involved in drug use and drug related practices and develop and/or revise awareness techniques and materials accordingly; improve awareness and knowledge levels amongst PUD in regards to the addictive properties of drugs, the actual workings thereof, as well as the (different) potential related risks; and consider the provision of services available to PUD that test the quality and safety of drugs before intake.

Treatment services

Policy makers and programme developers are urged to consider the following: Improve and/or develop a holistic or integrated approach, including social rehabilitation, follow up, and after-care for all exiting clients; scale up residential treatment services; ensure that drug treatment is low threshold, voluntary and accessible to all income groups. Improve awareness of the availability of treatment services and work towards removal of the stigma that is attached to going into treatment and to the people that have gone through treatment; monitor and evaluate treatment services; and strengthen coordination, collaboration and mutual referral between (GO and NGO) services providers.

Consider adopting more “open” treatment policies and programmes and recognise the fact that relapse is part of the healing process and develop responses that take into consideration possible high relapse rates; review treatment intake procedures to ensure that people that go into treatment are psychologically ready to do so; include early detection of self-destructive or suicidal behaviour in counselling and treatment services; develop treatment interventions that take into consideration that a prolonged stay away from situations and people associated with drug use might well be crucial for success; and involve parents and other family members in guided efforts towards reduction of intake or abstinence, including during and after treatment.
Research

Registration and standardization of drug use and HIV/AIDS related data need to be improved and organisational capacity and networks that gather, process and analyse data on drug use and drug use related harms should be (further) developed. Thorough monitoring and evaluation of relevant primary, secondary and tertiary prevention projects, programmes and policies as well as further research into drug use related areas at regional, national and local levels are required to develop evidence-based policies and programmes.
Figures, textboxes, graphs, quotes and case studies.

Figures
Figure 1: The KAP-trap ........................................................................................................ 231
Figure 2: Life skills approach .............................................................................................. 242
Figure 3: A comprehensive model ..................................................................................... 242
Figure 4: Drug careers, factors and consequences .............................................................. 252

Textbox 1: Scope of drug use and HIV/AIDS ........................................................................... 421
Textbox 2: Government responses ......................................................................................... 514
Textbox 3: Legislation ............................................................................................................. 45
Textbox 4: The Gateway Theory revisited .............................................................................. 7068

Graphs
Graph 2: Most important source of knowledge on HIV/AIDS and Hepatitis C (n=1302) .... 5654
Graph 3: Last quarterly prevalence (LQP) of selected drugs ............................................... 6664
Graph 4: Age at initiation (Q30) ............................................................................................. 6866
Graph 7: Period until switch towards injecting ...................................................................... 7879

Quotes
Quotes 1: Knowledge levels on HIV/AIDS and Hepatitis ....................................................... 57
Quotes 2: Attitudes towards injecting amongst PID ................................................................. 60
Quotes 3: Initiation and peer pressure ..................................................................................... 71
Quotes 4: Initiation: level of planning, enjoyment and regret ................................................. 73
Quotes 5: Parents’ reaction to initial use .................................................................................. 74
Quotes 6: Friends’ and partners’ reaction to initial use (non-PUD) ........................................... 75
Quotes 7: Drug use at school in Jakarta and at the work place in Tehran ............................... 76
Quotes 8: Development of drug use (part 1) ........................................................................... 77
Quotes 9: Development of drug use (part 2) ........................................................................... 79
Quotes 10: Crucial switches; crucial factors ............................................................................ 81
Quotes 11: Crucial switches; some comments ........................................................................ 82
Quotes 12: Crucial switches; how about the parents? .............................................................. 82
Quotes 13: Overdose ............................................................................................................... 85
Quotes 14: Abstinence .............................................................................................................. 87
Quotes 15: Reasons for going into treatment .......................................................................... 89
Quotes 16: Who was behind it? ............................................................................................... 90
Quotes 17: Constraints to access or complete available services .......................................... 91
Quotes 18: The services .......................................................................................................... 92
Quotes 19: Contributing factors of relapse .......................................................................... 94
Quotes 20: Relapse and the immediate environment ............................................................. 96
Quotes 21: Onset of problems ................................................................................................. 98
Quotes 22: Health problems .................................................................................................. 99
Quotes 23: Judicial problems and law enforcement ............................................................... 101
Quotes 24: Drug use in prison ............................................................................................... 102
Quotes 25: Stigmatisation, alienation, criminalisation ......................................................... 104

Case studies
Case Study 1: Initiation ........................................................................................................ 6967
Case Study 2: Some switches ............................................................................................... 7977
Case Study 3: Two clients; methadone programme at DIC .............................................. 9593
Case Study 4: Drug use in prison ....................................................................................... 10199
Young people and drugs – Towards a comprehensive health promotion policy
Explanatory notes

This report is the unabridged research reports that were written by the site research managers (SRM) located in Tehran.

The Introduction is followed by three main parts: I: Methodology, II: Findings, and III: Conclusions and recommendations. The findings are described in six chapters: In Chapter 1, the research sites are described in terms of drug use and HIV/AIDS: the issues and current action. Chapter 2 provides an overview of the sources for this research. In Chapter 3, the findings of a KAP study with regards to drug use and health are presented. Chapter 4 focuses on drug careers and the role that key factors in one's immediate environment play in those drug careers, including availability, price, parents, peers, partners, school, work, law enforcement, and services. Finally, in Chapter 5, drug use related problems are examined.

The survey produced a wealth of quantitative data, resulting in close to one hundred tables. Only those tables that are considered of particular relevance are incorporated in the core text. The others are annexed in the back of this document. To improve readability, percentages are generally presented without decimals. Throughout the digital version of this document, tables and other references (such as quotes, case studies, graphs, figures, and Email addresses) can be accessed by putting the cursor on the reference and pressing Ctrl + left-click. At the bottom of each annexed table there are such hyperlinks back to the main text (Back to main text). Other annexes include the research tools (interview guides, questionnaires, protocols, etc), most of which are separate documents that can also be accessed by following the hyperlinks.

Quotes from the open interviews and focus group discussions are generally presented by topic in boxes, between inverted commas. In the case that the quote is from a person other than a person using drugs, this is mentioned behind the quote between brackets.

The PDF version as well as the abridged version of this report will soon be available on AHRN's website at http://www.ahrn.net.

AHRN is ultimately responsible for the content of this report, including the findings, conclusions and recommendations. Great effort has gone into insuring that the findings are accurate, truthful, complete and representative, and that the conclusions and recommendations follow from these findings. Readers are encouraged to provide feedback on any perceived incorrect information in this report to the Principal Investigator at gdekort@ahrn.net.

Throughout this document, United Nations spelling was used, which can be seen as a mixture of British and American English.
Definitions

Drugs

Psychoactive substances, including opiates, Amphetamine Type Stimulants (ATS) cannabis, and others. In addition, certain legal substances, in particular those that are injected (Diazepam, buprenorphine, etc), as well as glue (sniffing) are included in this research. Although caffeine, tobacco, and other substances in common non-medical use are also drugs in the sense of being taken primarily for their psychoactive effects, they are not the focus of this research. Alcohol was not an explicit part of this research. It was covered to the extent it played an essential role in one’s drug career.

Person/people using drugs (PUD) and person/people injecting drugs (PID)

The term ‘people using drugs’ (abbreviated ‘PUD’ for both the singular and plural forms), is used rather than ‘drug users’ (DU). Similarly, ‘people injecting drugs’ (abbreviated ‘PID’) is introduced, instead of ‘injecting drug users’ (IDU). These terms are preferred, because of the emphasis on the ‘people aspect’ and further avoid the confusion that is caused by the fact that ‘DU’ and ‘IDU’ tend to be used for the phenomenon (drug use) as well as for the people (drug users). In addition, IDU is also known to mean ‘intravenous drug use’, implying that non-intravenous injecting is not included in the definition.

Environmental factors of drug use

Environmental factors facilitating or impeding drug use; principally those factors that do NOT fall within the realm of the personality of (potential) PUD. In other words, these factors are beyond the control of individuals, yet susceptible to interventions, other than psychological therapy. In the context of this research, the immediate environment of PUD, rather than broad national policies are the focus.

Young people

People aged 15-24 years, as defined by the United Nations. The research primarily targets young people, yet this age group was broadened when the local context called for inclusion of children and/or young adults.

Demand Reduction

International drug control conventions use this term in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies contrast with approaches which aim at reducing supply of drugs, though in practice demand and supply reduction can be complementary. The success of demand reduction is conventionally measured by a reduction in the prevalence of use, i.e. by more abstinence, and hence is separate and distinct from harm reduction.

Demand reduction is a broad term used for a range of policies and programmes which seek a reduction of desire and of preparedness to obtain and use illegal drugs. Demand for drugs may be reduced through prevention and education programmes to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programmes (e.g. methadone); treatment programmes mainly aimed at facilitating abstinence, reduction in frequency or amount of use; court diversion programmes offering education or treatment as alternatives to imprisonment; broad social policies to

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3 UNESCAP, 2000, Youth Participation, A Manual on Youth Participation and Compilation of Best Practices
4 The next two definitions are derived from: UNODC, 2000, Demand Reduction, A Glossary of Terms, Sales No. E.00.XI.9, ISBN: 92-1-148129-5
mitigate factors contributing to drug use such as unemployment, homelessness and truancy.

Harm Reduction

In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. In practice, harm and demand reduction are often complementary.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRN</td>
<td>Asian Harm Reduction Network</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>ATS</td>
<td>Amphetamine type stimulant</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop-in-centre</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion(s)</td>
</tr>
<tr>
<td>GO</td>
<td>Governmental organization</td>
</tr>
<tr>
<td>HDR</td>
<td>Human Development Report</td>
</tr>
<tr>
<td>INGO</td>
<td>International non-governmental organization</td>
</tr>
<tr>
<td>INCAS</td>
<td>Iranian National Centre for Addiction Studies</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge Attitudes Practices</td>
</tr>
<tr>
<td>MOHME</td>
<td>Ministry of Health and Medical Education</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NS(E)P</td>
<td>Needle and syringe (exchange) programme</td>
</tr>
<tr>
<td>PID</td>
<td>Person / people injecting drugs; either currently or in the past</td>
</tr>
<tr>
<td>PUD</td>
<td>Person / people using drugs; either currently or in the past</td>
</tr>
<tr>
<td>PLHA</td>
<td>Person / people living with HIV/AIDS</td>
</tr>
<tr>
<td>RAR</td>
<td>Rapid Assessment and Response</td>
</tr>
<tr>
<td>SAPTO</td>
<td>Substance Abuse Prevention and Treatment Office</td>
</tr>
<tr>
<td>SRC</td>
<td>Site research committee(s)</td>
</tr>
<tr>
<td>SRM</td>
<td>Site research manager(s)</td>
</tr>
<tr>
<td>TUMS</td>
<td>Tehran University of Medical Sciences</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNESCAP</td>
<td>United Nations Economic Social Commission Asia-Pacific</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Testing and Counselling</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>
**Introduction**

In late 2003, the Asian Harm Reduction Network (AHRN) initiated a multi-site research project to gain insight in the drug careers—or pathways—of young people and to identify which factors and circumstances are important in the development of these careers. The research was simultaneously conducted in Tehran (Iran), New Delhi (India), Lahore, Peshawar, Quetta, Rawalpindi, Karachi (Pakistan), and Greater Jakarta, (Indonesia) and coordinated from Thailand. In the target countries, site research managers (SRM) were hired who, in turn, recruited and trained their site research teams.

This report is the unabridged Tehran research report.

**Rationale**

Despite widespread calls for evidence-based policy-making and knowledge-based management, the relationship between social science and social policy remains ambivalent at best, and drug and HIV policies are no exception. In their comprehensive study on *Drug Use and HIV Vulnerability*, Oppenheimer and Reynolds recommend that: “... countries give consideration to regular policy review procedures, and consider adopting more evidence-based policies”. Indeed, national drug and HIV policies and programming in many countries throughout Asia often appear based on dubious assumptions or prejudice or seem to rely more on arbitrary regulations, individual preferences, or “the flavour of the month” than on solid, empirical research. As a result, mainstream responses in primary, secondary and tertiary prevention often lack innovative strength and vigour to effectively address the complexities of drug use and its associated harms.

This research primarily seeks to provide urgently needed knowledge to support the formulation of targeted and effective, evidence-based responses at the community and site level. A related objective is to develop mechanisms to facilitate implementation of the recommendations. As such, this study is an effort to come to practical, locally developed, recommendations, while putting in place an infrastructure that increases the likelihood of their implementation.

Existing research, however, tends to focus on supply and demand reduction, thus largely ignoring the proven effects that harm reduction policies have on the prevention of HIV/AIDS and other drug related harms. This research is an effort to make a substantive contribution to ‘harm reduction friendly’ research in Asia.

As the Australian National Council on Drugs concludes:

> “Drug misuse should not be seen as an isolated behaviour, which can be fixed solely by drug-specific education and other activities directed at individuals. It is one of a number of risk behaviours that are affected by macro-environmental factors, including socio-economic gaps, unemployment, social capital, the physical environment and social values and beliefs. The family is a significant mediator of these influences. The structural changes that are needed to address these problems will have positive impacts not just on drug use, but on other risk behaviours and psychosocial disorders among youth....”

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5 Edna Oppenheimer & Adrian Reynolds, 2000, Drug Use and HIV Vulnerability, Policy Research Study in Asia, commissioned by the Task Force on Drug Use and HIV Vulnerability, copyright: UNAIDS and UNDCP.

Geographical scope and structure

As mentioned earlier, the research was conducted in four countries: Indonesia, India, Pakistan, and Iran. In this report, only the details of research in Tehran has been elaborated. The Principal Investigator, based in Bangkok, was in charge of the overall implementation and coordination as well writing this report. AHRN Executive Director and the Executive Committee (AHRNEX) provided overall guidance and direction.

In Iran, the research was limited to the capital city, Tehran. The reasons behind this choice and implications for generalisability of conclusions will be discussed in the Methodology part.

Site Research Committees (SRC), consisting of representatives from Iranian GOs and NGOs were established. This Committee guided and reviewed the research, supplied and helped with the analyses of the existing data in their respective fields, and assisted in drawing valid conclusions and feasible recommendations.

Site Research Managers (SRM), Bijan Nassirimanesh and Mohsen Vazirian were in charge of the research components. They hired local research teams and prepared site reports, which form the basis of this report. The main author of this report is the Principal Investigator with the SRM as co-authors who bear co-responsibility for the accuracy and validity of the data and conclusions that relate to their site.

Stakeholders and partners

The research focused on the interplay of facilitating and impeding determinants of drug use with an emphasis on those factors that are susceptible to be influenced by policy and programming. In other words, organisations and institutions at the local, national, and international level that (can) play a role in the prevention of drug use and the reduction of drug-related harm are the primary stakeholders (or beneficiaries). Secondary stakeholders are PUD in the country, their partners, and the communities they live in.

Partners and thus (further) stakeholders include:

- AHRN, HQ, Chiang Mai, Thailand initiated and largely funded the research. AHRN also bears the final responsibility for the content of this report and holds the rights to this publication.
- AHRN Country Office in Iran was involved in the research through recruiting, appointing and accommodating the site research managers, interviewers and administrative support staff. AHRN had already established this Country Office in Tehran with the help of Persepolis Harm Reduction NGO at the onset of the research. MOUs between AHRN and the respective AHRN Country Office described responsibilities and flow of funds with the SRM also acting as AHRN Country Coordinator.
- Centre for Addiction Research (CVO), Netherlands, with its extensive expertise in drug-related research, provided guidance in the development of the research methodology, monitoring and evaluation, analysis and reporting of results.
- United Nations Office on Drugs and Crime (UNODC), Field Office I.R. Iran are stakeholders, because it funded certain components of the research (see below).

Funding agencies

The Royal Netherlands Government provided funding to AHRN for the main part of the research, including coverage for the regional. In Iran, the local expenses were largely funded by United Nations Office on Drugs and Crime (UNODC) Field Office I.R. Iran after approval of DARIUS committee (Project Review Committee).

Goal and objectives

The Asian Harm Reduction Network (AHRN; www.ahrn.net) aims to promote initiatives and policies that reduce drug related harm. In order to formulate effective strategies to prevent drug use and drug-related harm, an analysis into the environmental factors of drug use in Asian settings is essential. The following research goal and objectives were formulated:
Introduction

Goal:
To contribute to the development of evidence-based policy formulation in the field of drug use amongst young people with an emphasis on HIV/AIDS prevention.

Objective 1: Insight & knowledge
To formulate conclusions on drug use, drug careers and related interventions with an emphasis on injecting drug use.

Objective 2: Policy formulation
To formulate recommendations on improvement of services and policy directions in relation to drug use, with an emphasis on injecting drug use.

Objective 3: Infrastructure development
To set up and develop networks that gather and analyse drug related data on a regular basis with the aim to develop, adjust and implement policy directions.

Key questions

The main research question of this study was:

What are the characteristics of drug careers and what are factors or circumstances that influence their development?

More specifically, the following research questions were formulated:

Context

- What is the scope and what are the characteristics of drug use? (Type of drugs, mode of intake, characteristics of PUD, recent developments and trends, tentative numbers).
- How is drug use and how are PUD and people injecting drugs (PID) perceived? (People with an outside perception of drug use and PUD: media, community leaders, teachers; policy-makers, law enforcement; treatment providers (outreach workers, counsellors); people personally affected by drug use (parents, relatives, friends); PUD themselves.

Drug careers / stages / defining moments

- Initiation: What are the (typical) circumstances surrounding initial drug use?
- Switches: What are the (typical) circumstances surrounding (switching to) injecting drug use? (as well as needle sharing and other unsafe practices, if applicable). What are the (typical) circumstances surrounding switching to using a different drug or a different mode of intake?
- Treatment: What are the (typical) circumstances surrounding a significant decrease in drug intake?
- Abstinence / relapse: What are the (typical) factors surrounding treatment and relapse?

Environmental factors

- What roles do/did parents, family members, spouses, and peers play in one’s drug career? (Family background, drug use in the family, amongst peers; awareness of drug use, treatment efforts / relapse; attitudes; actions / practice; actual role)
- What roles do/did GOs (incl. education and employment) and NGOs (including religious institutions) play? (Drug use in the (N)GO, awareness of drug use, treatment efforts / relapse; attitudes; actions; actual role; interventions (success, effectiveness)
- What role do/did circumstances such as availability of drugs, legislative framework, law enforcement, and price of drugs play?
- What (policy) changes would be appropriate?

Drug use related problems
What are knowledge and awareness levels on drug use and drug use related harms (such as HIV/AIDS and Hepatitis C)?

What are the attitudes towards drugs and drug use, in particular towards opiates and injecting behaviour?

What are drug use related problems and at what stage do they become acute?

What are the attitudes towards PUD amongst PUD and amongst people in their immediate environment?

Emphasis of this study is on the “careers” or “pathways” of people using drugs, i.e. the routes that people typically follow in relation to their drug use. It is presupposed that there are stages or “defining moments/events” on the way to becoming a “full-fledged” PUD. Clearly, these stages or key moments provide an ideal opportunity for primary, secondary or tertiary preventive action. The research aims to characterise these stages or moments to then develop action strategies for those institutions and organisations that are (or should be) involved in implementing measures that lead to less drug use and the reduction of drug-use related harms.

**Theoretical framework**

**Context and vulnerability**

The section below will briefly clarify the theoretical underpinnings of the research. International research suggests that on an individual basis, illicit drug use is a complex process with many, interconnected, facilitating and impeding factors. These factors typically include: family background, (including drug use in the family), individual characteristics and skills, education, employment, ethnicity, migration, homelessness, boredom, hopelessness, peer-pressure, availability and accessibility of drugs, but also actions (or lack thereof), by educational institutions, medical institutions, child protection agencies, law enforcement agencies, the judicial system, welfare organisations, among others, as well as societal or global developments.

Drug use can be seen as the effect of increased vulnerability at several or all these levels, rather than of individual weakness, a bad environment, or institutional failure alone. For the purpose of the development of viable and effective strategies, it is necessary to assess which of these factors are more important than others. In other words, this study aims to pinpoint which of the factors that are commonly seen as facilitating and impeding drug use are of particular relevance in the sites under investigation.

By definition, environmental factors are those factors that are part of the environment, rather than those factors that fall within the realm of the personality of the (potential) PUD. In other words, these factors are beyond the control of individuals. Individuals are exposed to them and, in principle, their alteration is out of their reach. Different environments affect behaviour differently and consequently different interventions are necessary to address these behaviours. Environmental factors influence behaviour i.e. drug use at different levels and in different spheres of life.

The term vulnerability is introduced here to bridge the various factors/environments. In other words, what makes people and in particular young people in the selected sites vulnerable to drug use? In terms of vulnerability, a common and useful distinction is that between root causes and risk factors. Root causes are defined as those factors that generate the need for special measures. Tackling the root causes is often called “primary prevention”. If primary prevention is effective for a sustained period of time, other responses (such as recovery or harm reduction) will, by definition, not be necessary: the problem disappears. From a prevention standpoint, the goal of tackling the root causes of vulnerability is to ensure that the institutions (families, educational, medical, employment organisations, etc) within the immediate environment of all young persons (and within its particular

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8 The notions of “vulnerability” and the distinction between “root causes” and “risk factors” are derived from UNICEF / EAPRO, 2001, Commercial Sexual Exploitation of Children in South-East Asia: A Regional Overview.
Introduction

(societal context), are in a position to fulfil their role and responsibilities to provide sufficient knowledge, skills and alternatives. Root causes can be perceived as having a similar impact on most families in a certain community, yet not every family or young person appears equally affected by them.

Risk factors come into play when trying to analyse what exactly makes an individual young person (or family) more vulnerable than another at a more local level. Identifying risk factors is useful for early detection and intervention, also called “secondary prevention”. Those at risk typically include: young people surrounded by drugs, the poor, dysfunctional families, certain ethnic groups, people from certain areas or neighbourhoods, persons with a certain personality, and members of marginalized or disadvantaged groups in general.

“Problems of ensuring appropriate protective responses must not be confused with the factors that can generate the need for such responses, since they are of a very different nature and require very different strategies.”9 Root causes such as poverty, availability of drugs in a country, unemployment, etc. should typically be addressed by national governments and international NGOs. Risk factors can be influenced by community level interventions. This research aimed to facilitate the development of appropriate strategies at both these levels, yet focus was on the latter.

Towards a model…

The figure below depicts the (optimistic) view that knowledge of the adverse consequences of certain behaviours leads to a change in one’s attitudes towards such behaviours, which in turn leads to a behaviour change towards safer behaviour (see Figure 1).

Figure 1: The KAP-trap

![Image of the KAP-trap diagram]

It appears, however, that matters are much more complicated; many people who engage in various types of risk behaviour appear to have ample knowledge on the possible negative consequences, yet still hold a positive attitude towards that behaviour. Similarly, even those people whose attitudes towards the risk behaviour are negative might still be tempted into unsafe practices. In other words, certain (life) skills are required to translate knowledge and attitudes into practice. General life skills include: self-awareness, empathy, communication, interpersonal relations, decision-making, problem-solving, creative and critical thinking, and coping mechanisms. Specific drug use-related skills could include a range of safe injecting practices, condom use, vein care, and overdose treatment amongst others. “Research has shown that the pull of information is not strong enough to prevent risky behaviour among young people. Knowledge should be provided to young people, together with essential life skills that enable them to think critically about health risks, and take effective action to protect themselves.”10 The figure below incorporates these life skills into the diagram (see Figure 2).

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9 UNICEF, 2000, Towards monitoring child protection in East Asia and the Pacific.
10 UNESCAP, 2003, Adolescent Substance Use: Risk and protection
In addition to the factors illustrated in Figure 2, the social context has a major influence on health behaviours. These environmental factors include the physical, economic and socio-cultural context (including the media), availability, institutions and organizations (including treatment, but also education and religion), legal sanctions and enforcement, as well as significant people (influencers). In other words, a conducive environment where all the factors generally promote positive health behaviours is required to maximize the impact of interventions in the field of knowledge, attitudes and skills.

In Figure 3, the quality of and access to services are distinguished from the (rest of the) environment to do justice to the importance that should be placed on this factor. In summary, conditions are optimized:
- when people have all the required knowledge, awareness, attitudes and skills;
- when high quality services are available and easily accessible; and
- when other environmental factors are conducive to positive health behaviours.

So, the likelihood that a young person will become infected with HIV or will encounter any other adverse health effects is influenced by numerous factors related to a combination of individual predispositions and environmental stressors. Although today all young people are at risk for HIV, that risk is not shared equally among them. It is obvious that education, poverty, employment, geography, and social isolation both shape and influence young people’s choices and vulnerabilities. Interventions to prevent HIV among young people and particularly among young PUD therefore

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11 This model is a simplified representation of the reality offered to illustrate that these factors impact on health behaviours which in turn cause (health) problems. As such, it acts as a conceptual framework for this research and defines the underlying arguments for the transition from conclusions to recommendations in this report.
need a broad focus that take into account behaviour change among young people. This includes social and economic development strategies for poverty reduction geared towards reducing inequalities, increasing public expenditure on essential services for children and young people (housing, health, education, treatment) and developing employment opportunities.

Coordinated and simultaneous action on all these dimensions is required to significantly address risky health behaviours. Environmental factors need to be investigated and addressed, and access to services that facilitate the development and sustainability of safe behaviours are critical components of any integral policy aimed at promoting safe health behaviours.

The tenet of this research was that environmental factors are crucial in formulating comprehensive answers to the questions posed by the issue of young people and drug use. They influence knowledge, attitudes and skills, which in turn have an impact on drug careers and they also directly impact on decisive moments in drug careers. Figure 4 is simplified visualization of the factors at work.

This research is an effort to investigate all these dimensions with an emphasis on the environmental factors at the micro/mezzo level (*immediate* environment), rather than the macro level. After a brief background description of the sites and the sources (Chapter 1 and 2), an assessment is made of knowledgeability, attitudes and practices with regards to drug use and health (Chapter 3)\(^{12}\). Chapter 4 focuses on the role that the immediate environment plays in drug careers, including availability of drugs, key people (parents, peers, partners) and organizations (school, work, services). In Chapter 5, the health and social consequences of certain drug taking behaviours are investigated.

**Figure 4: Drug careers, factors and consequences**

To meet the comprehensive approach detailed in Figure 3 and Figure 4 at intervention levels, a broad range of activities is required. The overview below lists critical components of such interventions in the field of health promotion for people using drugs (see Table 1). In short, it is what is known as the *continuum of care*, combined with activities towards the creation of a *conducive environment*. Among others, such environment consists of requirements at the state level in the field of health, education, legislation, and poverty alleviation.

\(^{12}\) The nature of this research did not allow to assess skills to act on possible *positive* knowledge or attitudes. Instead, unsafe practices were investigated
Table 1: Comprehensive health promotion intervention for people using drugs

<table>
<thead>
<tr>
<th>Area</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach, Drop-in Centres</td>
<td>Primary health care (wound dressing; diagnosis and referral for secondary infections), Voluntary Counselling and Testing (both pre and post), condom distribution, (access to) ARV treatment; referrals</td>
</tr>
<tr>
<td></td>
<td>Basic needs: Food and clothing and further support to access employment, hygiene, housing and social needs</td>
</tr>
<tr>
<td></td>
<td>Awareness raising, campaigns, etc.</td>
</tr>
<tr>
<td>Legal aid</td>
<td>Provision of information and life skills training (e.g. self-awareness, empathy, risk awareness, communication, interpersonal relations, decision-making, problem-solving, creative and critical thinking, and coping with emotions and stress)</td>
</tr>
<tr>
<td></td>
<td>Provision of information and skills training on safer injecting, overdose, vein care and safer sexual practices</td>
</tr>
<tr>
<td></td>
<td>Vocational training and other necessary education</td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Pharmacotherapy (methadone / buprenorphine)</td>
</tr>
<tr>
<td></td>
<td>Needle and syringe provision or exchange (NSEP)</td>
</tr>
<tr>
<td></td>
<td>Self-help programmes, peer-driven programming, participation of PUD in formulation, development and execution of services</td>
</tr>
<tr>
<td></td>
<td>Detoxification and rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Social-economic rehabilitation, (e.g. job provision, referral of clients to potential employers, small loans)</td>
</tr>
<tr>
<td></td>
<td>Aftercare and social reintegration</td>
</tr>
<tr>
<td>Creating a conducive environment:</td>
<td>Clarifying and addressing links between poverty, HIV/AIDS and drug use</td>
</tr>
<tr>
<td>Awareness raising</td>
<td>Awareness raising for young people, communities and their leaders</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Strengthening and mainstreaming of in and out of school education on drug use, sex and HIV/AIDS in general, including early detection mechanisms</td>
</tr>
<tr>
<td>Capacity building</td>
<td>Strengthening of (drug use related) health and social services, treatment services, including in closed settings</td>
</tr>
<tr>
<td></td>
<td>Networking, coordinating, tuning with other stakeholders, coalition building at all levels</td>
</tr>
<tr>
<td></td>
<td>Integration of health promotion in law enforcement and criminal justice systems</td>
</tr>
<tr>
<td></td>
<td>Improving legislative framework conducive to implementation of PUD-friendly services</td>
</tr>
</tbody>
</table>
Part I: Methodology

I.1. Research design

I.1.a. Research sites and implementing partners

As mentioned earlier, in Iran, the research was limited to the capital city, Tehran.

The magnitude of drug use and drug use related problems in Tehran was apparent from earlier studies and from contacts between AHRN and local organisations. Another important factor influencing the choice for Tehran was the fact that AHRN had well established contacts with Persepolis NGO that was in the position to execute the research and that was convinced its usefulness. In other words, practical considerations including infrastructure and access to informants played an important role in the identification of the site.

As it was mention earlier, in Tehran, the NGO Persepolis implemented the research in collaboration with the Ministry of Health and Medical Education (MOHME) and Iranian National Center for Addiction Studies (INCAS) affiliated to Tehran University of Medical Sciences (TUMS). (see Annex 3)

I.1.b. Approach and guiding principles

The research approach is cross-sectional rather than longitudinal. Drug careers and pertinent environmental factors are addressed through targeting a variety of PUD in different stages of their drug careers and by using retrospective techniques at the individual level. This results in a “snapshot” of the current situation in combination with a reflective analysis of drug careers, environmental factors and drug use related problems.

The research methodology consisted of a combination of qualitative and quantitative methods. Focus group discussions and open interviews with key informants and PUD were conducted to gain tentative insight in the research questions. This stage also acted as a means to acquire specific, illuminative case studies and quotes. The conclusions that were drawn from those were then verified and quantified through a questionnaire with a large number of PUD. Whereas the qualitative phase of the research focused on drug careers, the quantitative phase addressed mainly the current state of affairs, including knowledge levels, attitudes, frequency of unsafe practices and the role that parents, peers and institutions play in drug career changes.

Related to this is the principle of triangulation: information was gathered from different sources, using different methods, and by different investigators. Methods of data gathering include: literature research, analysis of existing data, interviews with key informants, focus group discussions, case studies, open interviews, and a survey. These different methods mutually confirmed trends and outcomes, or provided (or updated) information for adjustments and refocusing.

Another key principle of the chosen approach was the inclusion of the target group in the implementation of the research. This participatory approach is seen to have several advantages over the more traditional approach of the “outside researcher”. The SRM had been active in the drug field for many years and had a strong affinity with PUD and people living with HIV/AIDS (PLHA). The interviewers hired and trained were largely PUD and/or PLHA.

Related to the former principle is the involvement of all stakeholders. All relevant organisations active at the site were invited to sit in the Site Research Committee. In Tehran, this committee met three times. During these meetings, the research was introduced and if necessary adjusted to the local circumstances, data were presented and tentative conclusions were formulated.

13 The qualitative methods are similar to a Rapid Assessment and Response; WHO, Rapid Assessment and Response, Technical Guide, TG-RAR, (WHO/HIV/2002.22), downloadable: http://www.chr.asn.au
Further key, ethical principles which drove the methodology were a **non-judgmental** approach throughout the research, informed consent and confidentiality. PUD were approached with respect, treated as equals and not judged for their drug use. All people involved were aware of the objectives of the research, the role they were playing in it, the way data were being used, and all agreed with this. Further, participation was voluntary, anonymous, and all effort was made to prevent any possible, negative consequences resulting from the participation. Finally, monetary compensation or otherwise was available for those PUD that acted as **informants** or respondents.

As may have become clear from the former section, this research can be called an **action research**: it reflects on current action in which all stakeholders are involved in making explicit and answering the problem, while the aim is to come to innovative, yet realistic recommendations, and to put in place mechanisms for their implementation.

### I.1.c. Quality control

A multi-site (as well as multi-country and multi-cultural) research, coordinated from yet another location, requires well-developed and effective mechanisms to protect the integrity and the quality of the project. These are outlined below.

#### Site Research Committees

One of the first tasks of the SRM was the establishment of Site Research Committees (SRC). These typically consisted of organisations and persons that are active in the drug field at various levels. The Committee guided and reviewed the research, supplied (and in some cases helped with the analyses of) the existing data in the individual members’ field, and assisted in drawing valid conclusions. As such, it had a function similar to a Review Board. Through involving the site stakeholders in this manner, the likelihood of drawing valid conclusions and recommendations as well as their implementation increased.

In Iran, the group met three times during the course of this study. Typically, the Committee convened to discuss three reports that were due upon completion of different “milestones”:

- November 2003: Site Research Proposal
- May 2004: Progress Report
- December 2004: Draft Site Research Report

The first meeting took place during the Principal Investigator’s country visit.

An effort was made to include the following areas and types of expertise in the SRC:

- Drug use treatment
- Other service providers including GOs, NGOs and INGOs
- University researcher or group with access to survey data
- Outreach worker (group) that works with PUD (on the street or hidden)
- PUD (group)
- Law enforcement
- UN Country Offices, depending on availability and interest
- Site Research Manager
- Principal Investigator

Identification of participants in the SRC was based on the following considerations:

- Knowledge about their domain, incl. health, research methods, treatment of PUD, crime, etc.
- Familiarity with others in drug use through their own related agencies and organisations
- Skills -academic or research, political, policy, programmatic, planning and front-lines or on-the-street experiences
- Access to data sources and understanding of their limitations and strengths

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14 *Informant*’ is used for those people that were subject to an open interview. *Respondent*” is used for those people with whom the questionnaire was conducted.

15 “A collaborative research, centred in social practice, which follows a particular process, espouses the values of independence, equality and cooperation, and is intended to be a learning experience for those involved, to produce a change for the better in the practice and to add to social theory”, John Owen & Patricia Rogers, 1999, Program Evaluation, Forms and Approaches, pg. 224, quoting Orton, 1992.
Through the establishment of the SRC, local ownership of the research was facilitated.

**Calibration**

In an effort to strike the right balance between central management and local ownership, the following general approach was adopted: the SRM were effectively in charge of all the aspects of their site research, including recruiting staff, data gathering and analysis, as well as budgets. The Principal Investigator focused on matters of common concern, facilitated peer *intervision* (between SRM) rather than supervision and was responsible for the final Research Report.

In other words, the Principal Investigator developed the parameters for the research -in collaboration with the SRM- and loosely monitored the execution at the site. The SRM were responsible for local execution and were urged to tightly manage the research.

*Intervision, calibration and quality control took place in different ways:*

- Daily communication over the Internet (Email, mailing list and chatting) and by telephone
- Participatory design research workshop for the SRM
- Site reports: site research proposal, site progress report and site research report
- Country visits: the Principal Investigator visited the research sites three times

This structure and these mechanisms provided centrally developed guidelines and frameworks, yet allowed for local adjustment and application.

- **Participatory Research Design Workshop**
  
  An intensive five-day participatory research design workshop was conducted in Chiang Mai, Thailand, on December 15-19, 2003 to equip the SRM with the key knowledge, concepts, tools and techniques to successfully execute the site research projects, as defined in the research proposal. The workshop sought to impart knowledge and improve skills, to generate enthusiasm for the research and attempted to set the tone for the future. Most sessions were highly practical, interactive and participatory in nature.

- **Site reports**
  
  SRM produced a research proposal, a progress report and final report for Iran. These were formal moments for purposes of calibration, monitoring and quality control. Formats and guidelines were agreed upon beforehand, thus facilitating calibration and comparison.

- **Site visits**
  
  The Principal Investigator visited the research sites three times (November 2003, March and June 2004), commonly for three or four days. During these visits, focus was placed on guidance, intervision and trouble-shooting. In addition, the SRC usually met in these periods thus providing insights to the Principal Investigator in the level of local expertise and ownership.

**I.2. Data-management**

In order to ensure a broad perspective and internal validity of the data, a variety of sources was use, chronologically. Existing data, interviews with key informants, focus group discussions, open interviews, and questionnaires. The results of the analysis of the existing data assisted in developing the interview guides for the interviews with the key informants. The results of those interviews were used to develop the questions for the focus group discussions, and so on. The results of the one stage of the research were constantly reviewed and fed into the development of the next research tool. As such, the questionnaire -with its many predefined answer categories- was a result of taking into account the preliminary results of all the previous stages.
I.2.a. **Analysis of existing data**

The research started with gathering and analysing of existing data on drug use in the country, including those mentioned below, depending on availability, relevance and perceived validity:

- Public health reports on infectious diseases, including HIV and Hepatitis B/C
- Drug use treatment admissions
- Legislative framework (changes in drug related laws and enforcement thereof)
- Research reports, national action plans
- Specialised departments at relevant Ministries in the drug field
- Private sector institutions, e.g. hospitals and rehabilitation centres
- Juvenile justice correctional system
- Reports by relevant GOs and NGOs, etc, etc.

This phase provided the necessary background to formulate and further develop the other research tools and with some rough and tentative information, which needed to be confirmed in later stages. Elements embedded in such data included: demographics, types of drugs used, route of admission, incidence and prevalence of drug use, as well as recent developments/changes in policy and programming. In the data gathering process, the Site Research Managers also acquired insight in approaches and attitudes towards drug use and PUD held by the organisations that supplied these data.

I.2.b. **Key informants**

In January and February of the year 2004, the questionnaire which was received from the Principal Investigator, concerning the interview with key informants was translated into Persian. Then considering the type of questionnaire, the Site Research Managers assisted selected the interviewers. Interviewers were 5 psychiatry residents of Roozbeh Hospital (Tehran University of Medical Sciences) as follows: Abbas Omid MD, Farzin Rezaee MD, Mehdi Rafiee MD, Mehran Boroomand MD, Najaf Tahmasebi Poor MD. All interviewers were fully qualified to fulfil the interview. The interviews were carried out individually in 6 days from 14th to 19th of February of the year 2004. The answers given by interviewees were written down simultaneously in the questionnaire. Because of a long pause caused by different reasons such as late approval of the plan in DARIUS Committee (the sponsor of the research in Iran) in ending days of February and concurrence with Iranian New Year holidays (March 2004), the analysis of information gathered through interviews was carried out by a board headed by Mohsen Vazirian within 10 days from 3rd to 12th of April of the year 2004.

The Site Research Managers interviewed key informants in each site on the local situation and on the situation in the projects that were “supplying” the informants and respondents. Together with the analysis of existing data, the conclusions from the interviews with key informants provided a tentative overview of the scope and character of drug use as well as the role and function of GOs and NGOs in the efforts to reduce drug use and drug-related harms.

In terms of the role that (N)GOs play in relation to drug use, typical questions that are central in the interview are:

- What are you trying to achieve?
- How is this service going?
- Is the delivery working?
- How could delivery be changed to make it more effective?
- What are the gaps? Future plans?

**List of Interviews held**

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16 Part of the review was done by Bijan Nassirimanesh, the rest of the review and also the assembling and analysis of existing data was done by Mohsen Vazirian.
On the basis of a list of jobs which people working in may be considered as key informants and were
set forth in suggested plan of the main researcher, 16 persons were interviewed. These 16
informants had the following specifications:
- 2 Health policy makers (1 male, 1 female, both working as psychiatrist in Ministry of Health,
  Substance Abuse Prevention and Treatment Office.)
- 2 Police (1 Police Officer and 1 Police noncommissioned Officer, both male and working as
  guards of an addiction treatment center)
- 7 Health care staff (3 Physicians consisting 2 male and 1 female, 3 female nurse, 1 female
  auxiliary nurse (secretary), working in three addiction treatment centers)
- 4 Counsellors (2 psychologists, 1 sociologist and 1 social worker, all female and working in
  an addiction treatment center)
- 1 Male servant, working in addiction treatment ward of Roozbeh Mental Hospital

Obviously, except for two police, the other informants are somehow among the members of the
state health & social welfare system (from a high-ranking decision maker to a low-ranking worker),
however these two police were in contact with health system. Therefore all interviewees were
somehow in contact with country’s health system and people using drugs and can be qualified
representatives of large number of people well-informed of problems of people using drugs. So
research team in Iran believes that there is no need to interview with more interviewees.

The interview guide can be found in the Annex17: Annex 1. Interview with Key Informants
(Guide).doc

I.2.c.  Focus group discussions

In January and February of the year 2004, questionnaire which was received from the Principal
Investigator, concerning the Focus Group Discussions with related people was translated into
Persian. Then considering the type of questionnaire, the Site Research Managers selected the
interviewers.

People with different perspectives towards drug use were approached for participation in FGD:

1. People with an outside perception of drug use and PUD: teachers, community members
2. People who are professionally involved in drug related issues: law enforcement officers
3. Service providers: NGO self-help group workers, counsellors
4. People personally affected by drug use: family members/relatives
5. People using drugs (PUD): Both PID and non-PID

(Tentative) confirmation and additional information was sought on the following issues:
- Commonalities (and differences) in background (neighbourhood, ethnicity, sex, age,
  education, work, etc.)
- Commonalities in drug use (type of drugs, mode of administration, typical drug-careers,
  motivations, impeding and facilitating factors)
- Knowledgeability about drug use and HIV/AIDS vulnerability
- Roles of GOs and NGOs; gaps, constraints, expectations, disappointments, extraordinary
  events

Another role of these FGD was to identify interviewers and informants for the open interviews.

Different topics were discussed depending on the group of informants. Topics were formulated
in the form of a few main questions and/or a few statements. If a certain question didn’t stimulate
discussion going, a statement was provided.

The Site Research Managers planned to hold FGD process in 2 phases. At the first phase 5
FGD with different informants including service providers and consultants (1 FGD), NGOs (1 FGD),
family and relatives (1 FGD), PID (1 FGD) and non-PID drug users (1 FGD) were held. The

17 In the digital version of this report, hyperlinks can be used to quickly access the annexed files: place cursor above the link
and press Ctrl+left click. Hard copies usually do not include the annexes. Please contact AHRN if needed.
The interviews were carried out individually in 4 days from 21\textsuperscript{th} to 24\textsuperscript{th} of February of the year 2004. 2 of FGD were done by one interviewer and one co-interviewer. 3 of FGD were held by only one interviewer. All of the interviews were recorded. Also answers given by interviewees were written down simultaneously in the questionnaire. The tapes then were written down and they were compared with the previously written data and compiled. Because of a long pause caused by different reasons such as late approval of the plan in Darioush Committee (the sponsor of the research in Iran) in ending days of February and concurrence with the New Year holidays in Iran (March 2004) as well as resignation of one of two technical advisors, the analysis of information gathered through interviews was carried out by a board headed by Mohsen Vazirian within 10 days from 13\textsuperscript{rd} to 22\textsuperscript{th} of April of the year 2004.

The Site Research Managers planned the second part of FGD in July 2004 regarding the results of the first phase. 2 FGD were done on 29 July 2004 by Arash Peyberah, the executive manager of Persepolis NGO (at that time) who has good experience of interview with informants. One group was from a community, the other was a group of law enforcement officers.

The following is the list of FGD:

- **Community members**
  - Including 5 persons: all men between 28 and 52 years old. 3 of them were shopkeepers, and 2 were white collars.
  - Duration of Interview: 60 minutes
  - Group atmosphere: Some members were very active
  - Domination: One or two were the leaders of the group
  - Group Consensus: They were generally in agreement
  - Total evaluation: was OK

- **Law enforcement officers**
  - Including 5 persons: All men between 20 and 35 years old. 4 of them were lieutenants and one a low rank soldier of a police station.
  - Duration of Interview: 90 minutes
  - Group atmosphere: Active/animated
  - Domination: Evenly split
  - Group Consensus: They were sometimes in agreement
  - Total evaluation: went very well

- **Service Providers, counsellors**
  - Including 6 persons: 3 men and 3 women between 28 and 40 years old.
  - Duration of Interview: 70 minutes
  - Group atmosphere: Some members were very active
  - Domination: One or two were the leaders of the group
  - Group Consensus: They were generally in agreement
  - Total evaluation: was OK

- **NGO self-help workers**
  - Including 12 persons: 10 men and 2 women between 20 and 54 years old. It is worth mentioning that 9 members of this group were former addicts who are in abstinence now. Duration of abstinence is between 8 months to 6 years. All were the members of Congress 60, which is an active NGO (self-help group) in the field of Addiction in Iran.
  - Duration of Interview: 140 minutes
  - Group atmosphere: Active/animated
  - Domination: One or two were the leaders of the group
  - Group Consensus: They were generally in agreement
  - Total evaluation: went very well

- **Family and Relatives**
  - Including 7 persons: 6 men and one woman between 22 and 52 years old.
  - Duration of Interview: 80 minutes
  - Group atmosphere: Some members were so active
  - Domination: One or two were the leaders of the group
Methodology

Group Consensus: They sometimes were in agreement
Total evaluation: was OK

PID
Including 8 men: between 18 and 26 years old
Duration of Interview: 102 minutes
Group atmosphere: Some members were very active
Domination: -
Group Consensus: They were sometimes in agreement
Total evaluation: was OK

Smoking Drug Users
Including 7 men between 22 and 30 years old.
Duration of Interview: 120 minutes
Group atmosphere: -
Domination: -
Group Consensus: -
Total evaluation: -

In total, 7 focus group discussions (FGD) containing 44 men and 6 women were held with PUD and with groups of people gravitating around drug use to identify the local characteristics and environmental factors of drug use. After analyzing the results the research team in Iran reached into the conclusion that there is no need to hold more FGD.

The FGD guides can be found in the Annex; Annexes\Annex 2. Focus Group Discussion (Guide).doc

I.2.d.  Open interviews

Target group

Based on feasibility of locations, the Site Research Managers selected 3 placed for recruiting drug user: Hejrat Therapeutic Community (Welfare Organizations), Youth Correctional Center of Tehran (Prison Organizatoin), Ghar Drop-In-Center (Persepolis Society). Therefore, different drug users regarding age, socioeconomic status could be included in this phase. Interviewers in Therapeutic Community were Arash Peyberah and Ms. Vaziri. The interviewers at Drop-In-Center were Mohsen Vazirian MD, Azin Khazaeli MD, Arash Peyberah. The interviewers of Youth Correctional Center were all of them are staff of that center. The interviews were carried out individually in 10 days from 29th March to 7th of April of the year 2004. In TC and Youth Correctional Center, tape recording was not allowed. Therefore, the answers given by interviewees were written down simultaneously in the questionnaire. In DIC, interviews were recorded and then wrote down. Permission from the informants was granted through a consent form and it was guaranteed that the tape would only be played back for research purposes. The SRM regularly checked the quality of the interviews and the interview reports and occasionally, an interview was fully transcribed. A codebook was developed, yet only used to give direction to the open questions. Given the number of interviews per site, so-called “grids” were used for analysis purposes. The analysis of information gathered through interviews was carried out by a board headed by Mohsen Vazirian within 40 days from 21st of May to 30th of June of the year 2004 in Farsi and then were translated in English. Some of their data were entered in an spss file which was provided by the main researcher for further study.

In total, 47 open interviews were held. The target group for the open interviews and the questionnaire is theoretically the same; young PUD. However, because of the overlap of some sections in the interview guide and the questionnaire, people who had acted as open interview informants were not allowed as respondents to the questionnaire.

An effort was made to come to a cross-section of the young PUD population, without necessarily being certain that this is representative. Based on the intended foci of the study, the following guidelines were followed in terms of the characteristics of the sample:

- Focus on youth: 15-24 years;
- Due to the intended focus on injecting drug use and HIV vulnerability, ideally 60%, and at least 50%, of the respondents should be PID;
Due to the expectation that it would be difficult to interview women, target as many female PUD as possible;

- **Active** as well as **recovering PUD, with an ideal ratio of 2:1**;

- Inclusion of **children** (at risk; homeless, sniffing glue or smoking Cannabis) up to a maximum of 15% of the total group.

- Inclusion of (young) PUD from the **higher strata of society**, possibly at about 10%.

In Section 2b in the **findings**, it will appear that these targets were largely met.

### The interviews

The interviews lasted approximately 90 to 120 minutes. The main topic of the interview was the informant's drug career, defining moments, role of institutions and organisations. The **circumstances** surrounding first drug use, shifts in drug use, rehabilitation efforts, relapses, current status and attitudes were of particular interest. The results from the key interviews and FGD stage were used in deciding on a detailed list of topics that needed to be covered during the open interview stage - and later the questionnaire.

The following topics were covered:

- Background
- Initiation
- Development of drug career
- Treatment and relapse / abstinence
- Drug use -related problems

For each of these topics questions were formulated that assessed the role that specific environmental factors had played, including parents, friends, school/work, legislative framework, etc.

It was decided to stop conducting these interviews once “saturation” point was reached: once the majority of the open interviews was not yielding any essentially different data, the SRM decided to switch to closed interviews: the survey.

The English version of the interview guide -as well as the questionnaire that was use in the survey below- was developed through elaborate consultation between the Principal Investigator, the Site Research Managers, the Addiction Research Centre (CVO), Utrecht, Netherlands, and in some cases the Site Research Committees.

In Feb. of the year 2004, questionnaire which was received from the Principal Investigator, concerning the interview with key informants was translated into Persian. The same interview guide was used for every informant, yet different parts were covered depending on the career stage. Given the open character of the interview, it was considered unnecessary to back-translate the question guides.

The interview guide, consent form and protocols for interviews as well as data entry can be found by following one of the links below:

- Annexes\Annex 3. Open Interview (Guide).doc
- Annexes\Annex 5. Consent Form.doc
- Annexes\Annex 6. Interviewer protocols.doc

### I.2.e. Case studies

When a particular story, event, or context was deemed particularly interesting or illuminating, the SRM elaborated these into a case study. Some of these can be found in the form of **Textboxes** or **Case Studies** in this report.

### I.2.f. Survey
**Procedure**

The target guidelines for the open interview informants were also used for the questionnaires. In other words, the SRM constantly kept track of key characteristics of the respondents thus far and urged the interviewers to select their respondents in a manner that the target guidelines were more or less reached.

The SRM and the Principal Investigator developed the first draft of the questionnaire during the second round of site visits. This version was then tested by the SRM and suggestions for improvement were sent in. In addition, CVO—a renowned Dutch Research Institute—reviewed the various versions. After three rounds, the final version was agreed upon by all involved.

In Iran, Drug use is heavily criminalised which drives PUD underground. However in some poor districts in Tehran PUD who are using drugs in parks or deserted places—out of sight of police—are quite easily reached.

In May of the year 2004, the questionnaire which was received from the Principal Investigator, was carefully translated into Persian. Then considering the type of questionnaire, the main coordinator of the plan in the Site Research Managers and Arash Peyberah selected 5 places for recruiting drug users: Hejrat Therapeutic Community (Welfare Organizations), Youth Correctional Center of Tehran (Prison Organization), Ghar Drop-In-Center (Persepolis Society), Mellatdust Addiction Treatment Clinic (Welfare Organization) and several private addiction clinics. Therefore, different drug users regarding age, socioeconomic status could be included in this phase. Interviewers in Therapeutic Community were Mr. Arash Peyberah and Ms. Nafisseh Solouk. The interviewers at Drop-In-Center were Arash Peyberah, Ms. Nassim Rasoulian and Ms. Hanieh Biazar. The interviewers of Youth Correctional Center were Mr. Mohammadi and Mr. AnsariNejad, both staff of that center. The interviewers of Mellatdust clinic and private clinics were Nafisseh Solouk. Dr. Mohsen Vazirian. The interviewers were participated in a 2 hour session for clarification for the interviewing. All aspects of the interviewing were discussed in the session. The interviews were carried out individually in 20 days from 5th to 24th June 2004. 281 questionnaires were filled out through interviewing (partly ex/recovering) PUD on their drug careers: 191 in DIC, 35 in TC, 35 in Mellatdust and the private clinics and 20 in Youth Correctional Center. The SRM also acted as supervisors. They monitored the actual conduct of the interviews and checked whether the forms were filled out properly.

**The questions**

The questionnaire addressed many of the same issues as the open interview, yet with a slightly different focus. Whereas the open interview focussed on environmental factors and one’s drug career, the questionnaire emphasised the current situation including knowledge levels, attitudes and practices. The following topics were covered: personal data, knowledge on drug use and drug related effects, attitudes towards drugs, drug use and PUD, unsafe practices, drug career development (e.g. switches, treatment, overdose, and relapse), drug use related problems, legislation, services, drug use in school / in jail. In the Annex, the full -English- version can be found; Annexes\Annex 4. Questionnaire.doc.

The questionnaire consisted of 89 questions, many of which were divided into sub-questions. Most questions came with pre-defined answers, so the interviewer needed only to check the given answer. Towards the end of the questionnaire, there were about 10 open questions, generally about services. Different formats were used: Yes/No questions, Wh-questions, usually with pre-defined answers, statements (Agree/Disagree), Likert-type questions, tables to be filled out, etc.

**Processing, analysis and presentation of findings**

The local data-entry person (Ms. Chamanizadeh) and Site Research Managers initially cleaned the “site-files”. Incomplete questionnaires were completely discarded and when answers were unclear, the interviewers were consulted. The trial period of the questionnaire had ensured that almost all
questions functioned properly. There was hardly any need to make new answer categories. In other words, the predefined options usually covered all, or nearly all, the answers that were given and the Other category mostly remained nearly empty. Also, the "escape-route" provided by No answer or Don’t know was generally used very rarely (generally less than 1%). In such cases, these answers are not presented in the related tables. In the case that any of these categories have a significant impact of the results, they are presented in the findings. The final version of the questionnaire can be found in the Annex; Annexes\Annex 7. Data entry protocol.doc

I.3. Generalisability

As the study is done only in Tehran, the results could not primarily generalized to other cities of Iran. To add more, Not the sampling in any of the tools was randomized nor representative of all the drug users in Tehran. Because of time pressure, we used the most convenient and available facilities in Tehran to reach the target populations for each tool. Therefore, the sample could not be the exact representative of the drug users of the capital. Despite this limitation, many results of the research are consistent with the previous studies conducted in Tehran, which could be a proof to the sound sampling of this research.

The extent to which the conclusions derived from this study are generalisable for the whole city, the whole country remains a difficult issue. However, it's noticeable that near 20 percent of Iranians live in Tehran, the capital. Also, many citizens of Tehran are originated from other parts of Iran. Therefore, it's very probable that many features of drug users in Tehran resemble those of other cities. Certain conclusions are valid only for the research sample, others can logically be transferred to the drug using population in the whole city, and others again might well be valid for larger populations.

In principle, this study sought to shed light on mechanisms and processes that are at work in shaping drug careers. Some of these mechanisms can be considered generic in the sense that they are common social patterns. In that case, tentative generalisations will be offered, particularly if results from the site and from various perspectives point towards the same direction.

Some data is very specific and in those cases, conclusions were formulated to represent this situation.

The fact that to some extent, the sample is largely recruited amongst the target group of Persepolis NGO that conducted the research, produces a bias with respect to certain data. For example, access to NSEP or knowledge levels on HIV/AIDS are likely to be higher among the research sample than among the total drug using populations at these sites. In such cases, the reader will be alerted of such bias in the core text.

In general, the following 'rule of thumb' is applied: When there is a high level of consistency between the data from different target groups, perspectives and research tools, more externally valid and generalisable conclusions can be drawn. On the other hand, when logic or inconsistency between data dictates caution, then conclusions will be formulated in a more tentative manner.

The high numbers of successful open interviews and questionnaires with PUD in combination with the interviews with key informants and focus group discussions provide ample credence to the conclusions that are offered in this report. Indeed, the sheer quantity of data, both qualitative and quantitative, form a solid base for programming and policy formulation at various levels. Data often point in the same direction. However, given the limited coverage within the country, it would be premature and overly optimistic to formulate firm recommendations on detailed programming and policy issues.

In short, this results in a report with conclusions and recommendations at various levels (intervention, community, urban, national) and at various gradations of generalisability. The reader is urged to apply a certain level of 'common sense' in her/his estimation of applicability of each conclusion or recommendation.
Part II: Findings

Chapter 1: Setting the tone

The justification of this research lies in the threat that the link between drug use and HIV/AIDS poses. This chapter describes the situation in the field of drug use and HIV/AIDS in the region and at the sites in particular, both in terms of the problem and the response, based on an analysis of existing data. It is a tentative summary of findings, that formed the basis for the development of the research tools used, particularly those for the interviews with key informants and focus group discussions.

1.a. The problem

History of drug use in Iran

 ➢ Previous Centuries
Drug use in Iran has a long history, the plants of which hashish and opium are gained, are the native plants of Iran. It seems that people who lived in Iranian Plateau were familiar with the psychological and medicinal properties of such drugs (Drug Control Plan of the United Nations, 2000). But the sudden spread of opium abuse occurred in Saffavid Dynasty about 400 years ago. In this period, there were special places called Koukenar Khaneh, for euphoria, they boiled opium poppy and drank its juice (Drug Control Plan of the United Nations, 2002). But the abuse of derivatives of hemp (hashish) was limited to special classes such as dervish (Drug Control Plan of the United Nations, 2000).

In 18th century and the first half of 19th century, cultivation of opium poppy and domestic production of opium were performed to meet the increasing demands of domestic drug users. But from the second half of 19th century, the cultivation of opium was considered as an exportable and yielding currency product. Near the end of the 19th century and during the early days of the 20th century, Iran was considered one of the very active members in opium world trade. Of course, most of the opium produced was used inside Iran and the country’s economy was dependent on production and exportation of opium. But through appearing parliamentary movement and alertness of Iranian people, a number of national and religious leaders tried to fight against taking opium seriously. But political problems as well as high dependence of country’s economy to the currency gained from exportation of opium made any serious actions for fighting against cultivation and abuse of this drug impossible (Drug Control Plan of the United Nations, 2000).

 ➢ Recent Century
The first official law indicating taking prohibition, called “Law of Opium Limitation” was ratified in 1911. Following the ratification of this Act, not only demand for opium did not decrease, but also illegal preparation and sale of opium became widespread. In the way that in 1926, almost 8% of total income of the government was gained on the fund of selling opium. Opium was exported illegally and instead, morphine and other drugs were imported on a limited scale. For this reason, “Law on Prohibition of Drugs Importation to Iran” was ratified in 1921. Due to international pressures in 1928, National Consultative Assembly ratified Opium Government Monopoly Act. On the basis of this Act, cultivation of opium poppy was allowed only under the supervision of Government. Despite of this Act, the areas of under cultivation lands were increased to 1.5 times as much within ten years; because the Government’s dependence to the income resulting from opium caused the Law to be ignored. Meanwhile, due to the reduced price of official price of opium purchased by the Government, illegal distribution and exportation of opium became widespread.

In open space created after the second world war, In 1943, “Anti-drugs & Alcohol Campaign Society”, a group of physicians and open-mined people, reported the number of addicts of the country 1500000 people (out of 14000000 populations of the country. Following the development of aspects of addiction problems and reduction of the incomes resulting form opium exportation for Government (due to domestic taking as well as smuggling drugs to abroad), “Law on Prohibition of Opium Poppy Cultivation and Taking Opium” was ratified in 1955 and was executed seriously. Through prohibition of opium poppy cultivation, for the first time
smuggling drugs such as heroin and morphine from foreign countries to Iran was turned to a profitable business and changed the taking pattern in state gradually and made heroin become widespread. “Law on Smugglers Punishment Intensification” was ratified in 1959 in order to find this problem. Through execution of the recent Act, soon prisons were full of smugglers and addicts and this brought a lot of problems and costs. In spite of such strict actions, the amount of smuggling and number of addicts increased noticeably and on the basis of the report of international police, Iran gained the first place in the world in 1968 in respect of discovering drugs.

Continuation of illegal cultivation and exportation of drugs to Iran by Turkey and Pakistan made the Government to permit opium to be cultivated again in special places of state under the Government’s supervision and Control through ratification of “Law on Limited Opium Poppy Cultivation” in 1968. Also, through ratifying “Law on Intensification of Drugs Smuggling Punishment” in 1969, smugglers punishment was aggravated, i.e. capital punishment as well as assigning trial of the captured people to military courts. In order to prevent addiction of personnel and workers, “Law on Removal from Office or Expelling Addicted People” was ratified. In 1971, governmental opium ration ID card was issued for old addicts (more than fifty years old) and patient (being prescribed by a physician). The number of addicts enrolled reached to 169,512 people in June 1975 and the number of non-official addicts was estimated between 200,000 to 500,000 people. Also in the 50th decade, due to development of travel facilities and travel of a large number of western young tourists to Iran, new aspects of drugs taking culture came to Iran and taking marijuana (hashish) which was before common in special classes especially dervishes, became widespread among young people.

In the 50th decade, especially after sudden increase of oil income, State health officials prepared modern plans for Health & Reeducation Centers of addicts which involved establishment of Clinics and Centers for taking care and treating addicts through using methadone. By victory of Islamic Revolution and change of policies and priorities, these plans were left unfinished.

Attitude of Islamic Revolution statesmen was negative toward addiction. Some of them considered addiction a kind of counterrevolutionary behavior which was propagated by colonizing states. This group of statesmen believed that Iran can and must terminate this important problem through taking serious and strict legal and penal precautions (Drug Control Plan of the United Nations, 2000).

In August 1980, i.e. six months after victory of Islamic Revolution of Iran, through ratification of “Intensification of punishment of those committed drugs offenses as well as taking security and health actions to treat and provide job opportunities for addicts Bill”, a headquarter called central coordination headquarter was founded for fighting against addiction which was responsible for determining policies, general policy, planning, preparing standards and regulations related to drugs. As of Dec. 10, 1980, addiction was considered crime and simultaneously addiction health services were closed down form Ministry of Health & Treatment and the then Ministry of Health omitted this subject from the scope of its activities (Department for Cultural and Prevention Affairs, 1998). From then to 1983, the addict camps founded under the supervision of prisons organizations and managed by Islamic Revolution Committee (and renamed to Reeducation & Job Camps) were responsible for taking care of captured drug users.

In 1983, Reeducation Centers were transferred to newly-established Welfare Office and renamed to addicts Rehabilitation Centers. These Centers were obliged to accept those addicts who were dispatched forcibly for quitting by courts. These Centers usually accepted addicts several times beyond their actual capacity and faced heavy costs and could not answer State health requirements for addicted people.

In 1988, again stricter point of views were preferred and immediately after completion of Iran & Iraq war, the newly-established Foundation of Expediency Council ratified “New Law on Anti-drugs Campaign”. According to this Law, sever punishments were considered for production, storage as well as smuggling and also drug use was considered crime, addicts were given several months in order to take actions for quitting. In this Law, no attentions were paid to the necessity of providing long-term health facilities as well as preventive actions and also scientific classification of drugs was not observed. According to this Law, Anti-drugs Campaign Headquarter established new foundations. Detention of addicts was still continued extensively and Rehabilitation Centers of Welfare Office proved their inefficiency steadily.

During the early days of 1990s, demand reduction attitude was gradually developed in State scientific and academic societies and Department for Cultural and Prevention Affairs of Welfare Office took the first fundamental measure for demand reduction during 1994 to 1996 such as establishment of Outpatient Treatment Centers for addicts since 1996 as well as execution of comprehensive plan of addiction prevention. This movement had a great effect on State politicians.
and finally Expediency Council ratified Amendment to Anti-drugs Campaign Act” in 1997. On the basis of this Amendment, although addiction was still a crime, but all addicts were allowed to refer to authorized centers determined by Ministry of Health, Treatment & Medical Education and could take necessary measures for their treatment and reeducation.

Since 2000, Ministry of Health, Treatment & Medical Education played more roles in demand reduction activities and started to train physicians of private sector in the fields of scientific methods of addiction treatment.

In summer 2002, National Committee of Harm Reduction was established by Health Department of Ministry of Health, Treatment & Medical Education aimed at reducing damages resulting from intravenous addiction especially for campaign against development of HIV / AIDS.

In 2003, the number of outpatient treatment centers of Welfare Office reached to 88 centers. The number of outpatient treatment centers for addicts affiliated to Ministry of Health also exceeded more than 50 centers. Meanwhile, approximately 700 beds were allocated for addiction treatment in State hospitals. The last developments performed in the mentioned Department are the follow-up of combination of prevention and treatment of drugs abuse in State Health-Treatment Council, establishment of clinics treating with methadone as well as damage reduction plan in street addicts.

**Extent of drug use**

To elaborate epidemiology of drug use in Iran we focus on some recent studies:

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

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

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

In 2000, drug users constituted more than half of the prison population and the number of inmates incarcerated for drug related crimes was 80,415 (DCHQ 2001). Eighty per cent of prison authorities acknowledged that drug use took place inside prisons although not at a great rate (Razzaghi et al.
Among the IDUs participating in the RSA study, 72.7% had a history of imprisonment compared to 36.3% among the non IDUs. The mean age of initiation into drugs among IDUs was 20 years and the mean age for starting IDU was 26 years. As a general rule, IDUs in Iran do not seem to be as young as IDUs in other countries. Just fewer than 50% of IDUs were found to have a history of drug use in the family, only slightly more than that found among non-IDUs (Razzaghi 2001). Deaths as a result of drug use have been on the rise in recent years. In 1996 it was 717 people, and in 1997 it was 788 (DCHQ 1998). By 2000, this figure had risen to 1000 people throughout the country (State Welfare Organisation 2000).

Result of the comprehensive search of articles, thesis, books & papers from 43 organizations in Tehran (they are mainly organization that work at national level thus fairly have the maximum information in Iran) that on youth & drug revealed that among publications in this area since 2003 there are 311 books, thesis, researches & papers. This comprise of only %7.5 of the total drug publication in this area. Other point is the weakness of research methodology in finding the root causes of the problem. Based on people have different demographic & socio-cultural background thus different reason for drug use but they have been generalized to larger population of youth regarding this fact that in each criteria we need different set of researches.

Brief review of the data on determinants of youth drug use among available studies in Iran that are abstracts of current research & papers that speak about different items on the cause of the drug use reveals following: These conclude that youth PUD generally have more neurotic sign & symptoms than the normal group. Presence of one PUD in house is an important factor to direct youth to be a PUD. Regarding effect of parent PUD on psychological parameter of youth it showed that their children has more anxiety, less per acceptance, less attractive general physique, & lower cognitive function. Social skills training has some effect on increasing self esteem of students & their attitude over drugs. Regarding who has the biggest effect on directing them toward using drugs some studies showed peer are more important than other members of the society. More than half of the PUD has high school literacy. In university some studies found that economic status has not significant effect on be a PUD & among this group the reason to use drug was: %44 enjoying the time, %18 curiosity, & %38 declaring that prior to use of drug they had a depressed mood. Having a parent-using drug in the family has a significant effect on youth drug abuse (in one study %52 of youth drug users had parent who use drug). Also literacy of parents & having, bad behaviour to children, easy accessibility of drug & lack of knowledge of drug effect, having drug user peers (%28 claimed that it was the main cause of their drug use) were among other causes of youth drug use. Other study showed that loneliness cannot be considered as a cause, but offering disorganized freedom to youth is a cause of their drug use (%60).

On the basis of this study, it was determined that in recent years the rate of yearly growth of incidence of drugs abuse spread and intravenous drug use are 8% and 33%, respectively.

**Study of Epidemiology of Drug Abuse in Islamic Republic of Iran**

This research was performed by Ministry of Health, Treatment & Medical Education and through cooperation of UNODC in 2001. In this research, for the first time a very vast sampling was performed in nationwide from those who referred to emergencies in 85 small provinces which include all provinces.

The results showed that there are at least 3761000 drug users (who take opium, sheereh (boiled and refined opium residue), heroin, buprenorphine), 3313000 of them have been taking drugs for more than one year, 2547000 of them had troublesome consumption (abuse or dependence), 1390000 of them had abuse and 1158000 of them had addiction or dependence. 1214000 addicts took drugs for amusement.

The number of consumption cases and addiction for different drugs were as follows, respectively:

Opium (3105000 and 1079000), sheereh (boiled and refined opium residue) (522000 and 255000), heroin (277000 and 137000), buprenorphine (119000 and 6000), alcohol (1636000 and 253000). In addition to the above-mentioned cases, 391000 people took hashish and 93000 people took stimulants (of course, simultaneous taking of drugs shall be considered and numbers shall not be added together). Approximately 137000 people had intravenous pre-taking of drugs that only 48000 people were addicted to drugs.

For the first time in a local research, the amount of taking dependence inducing drugs in an unprescribed way were estimated. Most of drugs (including Banzodiazpine, Barbiturate,
Findings: Drug use and health; a KAP study

diphenoxilate, dextromethorphan, Codeine, Morphine and Pethidine) were mainly taken for self-treatment, enjoy, removing the signs of high deprivation without prescription of a physician (approximately 4806000 people in the recent month). Among the mentioned drugs users, 1121000 of them also took opium simultaneously. 3734000 of them merely took the above-mentioned drugs. Consumption and addition to drugs in men is 4-8 times to women and the average age of drug users was 42 years old. Contrary to public opinion, age of beginning heroin consumption has been increased.

It has been reported that people with good financial situation tend to take medicine more and people with bad financial situation tend to take drugs or drugs and medicine simultaneously. As a result, opium is usually taken by people with bad financial situation and alcohol is usually taken by people with good financial situation. Hashish was used by both groups of people.

This research considering taking drugs has approved existence of iceberg pattern discussed for all health problems. In all drugs, just a small minority of people was addicted or dependent and most of them were abuser or recreational user.

Considering the fact that research has been conducted in 2001 and two years have passed from the date of research, the mentioned numbers have been probably changed.

➢ Study of Intravenous Drug Use in Tehran

The present research which is a part of international plan of World Health Organization (WHO) named IDU-RAR was performed by some domestic researchers with the cooperation of this Organization and experts of State Welfare Office in 2001 and its information has been published recently.

The place of research was six quarters of Tehran. The target population of this research was key members and drug users.

It was determined that the most common drugs taken were opium, heroin and hashish. Also psychological drugs were used very much. The amount of consumption of opium and heroin was estimated equal. Both key members and intravenous drug users believed that due to increase of opium price during one year before research, the amount of consumption of heroin has been increased. Other findings of this research were increase of consumption spread in women and decrease of age average in starting addiction.

Women intravenous drug users included 2 to 4 percent of the cases and were in critical condition of health and most of them prostituted for earning a living. The movement of consumption from the first experience to intravenous drug use consisted of the following stages:

Smoking or eating opium, smoking heroin and finally injection of heroin. The interval between the first experience of drug consumption in person's life and intravenous drug use was 2 to 12 years.

The shared use of syringe as well as other injection instruments was between 30 to 100 percent in different quarters. The shared use of syringe was a principle in prison.

In most of the target quarters, access to commercial sex workers was very easy. Most commercial sex workers themselves took drugs and half of them were intravenous users. Using contraceptives in sexual intercourse (using condom) was not common. Overdose was one of the common complications of intravenous drug use in target quarters.

Two third of intravenous drug users had been imprisoned and most of them had been jailed for several times. Drug use was common in prisons and half of the drug users who also took drugs in prisons reported injection with shared instruments in prisons. No damage reduction plans were observed in the target quarters.

Researchers believed that this study shows the amount and intensity of drug use in recent years. Movement form opium use to heroin and especially injection of heroin was due to access limitation, increase in opium's price as well as heroin's low purity (WHO, 2003).

The Condition of HIV / AIDS Outbreak in Country
The first AIDS case was identified in 1986. Disease Management Center of Department for Health affiliated to Ministry of Health, Treatment & Medical Education publishes the condition of HIV infection outbreak in the country regularly. According to the last statistics, since 1986 up to now (Dec. 22, 2003), 6337 people have shown signs of carrying HIV Virus and they have been identified in the country. Of course, 213 cases have contracted with AIDS / HIV and 736 cases died. 95.2 % of the affected people were men and 4.8 % were women. 60.6 % cases have contracted with AIDS Virus through drug injection with shared instruments, 7% through sexual intercourse, 3.2% through blood and blood products (of course the statistics is related to the people who took the donated blood before 1986, i.e. when HIV test was not performed on blood samples), 0.4% through mother to child and in 28.8% of cases had contracted with HIV through undetermined ways. The most common age group contracted with HIV / AIDS were 25 to 34 years old. More than half of positive cases have been reported since 2002 up to now (Disease Management Center, Jan. 2002). The experts of this center believe that the actual number of people affected by AIDS Virus is 30000 people in the country.

The Textbox below offers a brief overview of the drug use and HIV/AIDS in Iran.

Textbox 1: Scope of drug use and HIV/AIDS
Drug use

A nationwide epidemiological study of drug abuse performed by the Ministry of Health, Treatment & Medical Education and through cooperation with UNODC in 2001, showed that there are at least 3,761,000 PUD who take opium, sheereh (boiled and refined opium residue), heroin or buprenorphine. 3,313,000 of them had been taking drugs for more than one year. In addition, 391000 people took hashish and 93,000 people took stimulants.

On the basis of a Drug Abuse Rapid Assessment in Iran (RSA), it was determined that in recent years the rate of yearly growth of drugs abuse and intravenous drug use are 8% and 33% respectively. Generalizing such findings to the recent years, the total number of opium users is estimated to be 4,387,000 in 2003, of which 2971000 fall in the category troublesome consumption (misuse or addiction). In terms of PID and dependent PID, the MoH estimated 242,000 people and 85,000 people respectively.

A WHO study of intravenous drug use in six quarters in Tehran determined that the most common drugs used were opium, heroin and hashish. The amount of consumption of opium and heroin was estimated to be equal. Both key informants and PID believed that due to an increase of opium prices one year prior to the research, the amount of consumption of heroin had increased. Other findings include an increase of drug use among women and a decrease of average age of dependency onset.

Women PID included two to four percent of the cases and were in critical health condition. Most of them were involved in sex work to earn a living. The development from initiation to injecting drug use typically consisted of the following stages: Smoking or eating opium, smoking heroine and finally injection of heroine. This would take two to twelve years. The shared use of syringes as well as other injection instruments was 30 to 100 percent of cases in different quarters. The shared use of syringes was very common in prison.

In most of the target quarters, access to sex workers was very easy. Most sex workers themselves used drugs and half of them were PID. Using contraceptives during sexual intercourse (using condom) was not common.

Overdose was one of the common complications of intravenous drug use in target quarters. Two thirds of the PID had been imprisoned and most of them had been jailed several times. Drug use was common in prisons and half of the drug users who also used drugs in prisons reported injecting with shared instruments. No harm reduction plans were observed in the target quarters.

Researchers believed that this study shows the amount and intensity of drug use in recent years. Movement from opium use to heroin and especially injection of heroine was due to limited accessibility, increasing opium prices as well as decreasing heroin purity (WHO, 2003).

HIV/AIDS

The first case of AIDS was identified in 1986. The Disease Management Center of the Department for Health affiliated to the Ministry of Health, Treatment & Medical Education publishes the condition of HIV infection outbreak in the country regularly. According to the latest statistics, since 1986 up to Dec. 22, 2003, 6337 people have been identified as having contracted HIV. 213 cases had contracted with AIDS, HIV and 736 cases had died. 95.2% of the affected people were men and 4.8% were women. 60.6% of cases had contracted the AIDS Virus through drug injection with shared instruments, 7% through sexual intercourse, 3.2% through blood and blood products (related to the people who received transfusions with donated blood before 1986, i.e. when HIV test was not performed on blood samples), 0.4% through mother to child transmission and in 28.8% of cases had contracted with HIV through undetermined ways. The most common age group who tested positive or HIV / AIDS was 25 to 34 years old. More than half of positive cases have been reported since 2002 up to now (Disease Management Center, January 2002). The experts of this centre believe that the actual number of PLHA is 30,000.
1.b. The response: Addiction treatment and HIV/AIDS prevention among people using drugs

State Executive Structure in Demand Reduction

On the basis of laws ratified in 1988 and 1997, the administrative structure of drugs abuse control is a headquarter consisting of directors of systems related to President’s Office. Also, Secretariat of Anti-drugs Campaign Headquarter was established in President’s Office in order to coordinate different systems. The Secretary-General shall be elected by president and has an independent administrative structure. Up to 2002, planning and policy making in different affairs related to addiction were made by more specialized committees which were considered a part of headquarter structure. Demand Reduction Committee as well as Treatment, Reeducation & Vocational Training Committee were two specialized committee related to demand reduction which the first committee was managed by Islamic Republic of Iran Broadcasting and in presence of other State Cultural and Health Systems (including Ministry of Health, State Welfare Office, Ministry of Culture & Islamic Guidance, Basij Resistance Force) and the second committee was managed by Ministry of Health, Treatment & Medical Education and in presence of other systems related to Treatment and Rehabilitation Affair (including State Welfare Office, State Prisons Organization & Security and Educational Actions, Ministry of Labor & Social Affairs, Imam Khomeini Relief Committee). Simultaneous with the appointment of a new Secretary-General of Headquarter in 2002, some changes were made in internal structures of secretariat which also overshadowed some of the structures of the whole headquarter. Specialized committees were actually inactive and some Departments were established in headquarter secretariat level. One of them was Department for Demand Reduction which practically tried to replace the two Specialized Committees of Demand Reduction and Treatment, Rehabilitation & Vocational Training, but with this difference that Department for Demand Reduction was merely a part of secretariat not a headquarter and on the other hand due to absence of specialized experts, systems were not able to take advantage of the scientific – executive capabilities of such experts. The last information indicates the non-activity of this department. Therefore, it seems that there are no stability and coordination in Department for Demand Reduction in headquarter and secretariat level.

Prevention & Addiction Affairs Department within the frame work of Department for cultural and prevention affairs of State Welfare Organization which took the lead in demand decrease, coordinates the activities of Welfare Centers in all over the country whether in early prevention or treatment.

In Ministry of Health, Treatment & Medical Education level, affairs related to addiction treatment in Department for Treatment Affairs were performed in a small office under the supervision of Deputy to Treatment Affairs up to 2001. Affairs related to prevention were also performed in Department for Mental Health within the frame work of Health Department. In 2001, through combination of these two Departments and establishment of Health Department, Prevention and Drug Abuse Department was established which works within the framework of Youth Health Department as well as Schools. This Department organizes and develops activities related to demand reduction in the Ministry of Health and Universities of Medical Science level. Of course considering the relationship between intravenous drug use and diseases transferred by blood such as HIV / AIDS, hepatitis, Management Center of Diseases also works in the field of damage reduction. Centers named Triangular Clinics also work under the supervision of this Center. Health Department has also tried to organize damage reduction resulting from addiction specially for control of HIV / AIDS through establishment of State Committee of Damage Reduction in summer 2002 affiliated to State Committee of AIDS and included different departments of Ministry of Health, Treatment & Medical Education, State Welfare Office, Red Crescent Society, General Department for Health & Treatment of Prisons Organization, Secretariat of Anti-drugs Campaign Headquarter as well as in presence of outstanding academic professors.

General Department of Health & Treatment of Prisons Organization also organizes demand reduction affairs in State prisons level.

In Department for Physical Education and Health affiliated to Ministry of Education, also Drug Abuse Prevention Office works in the field of demand reduction. Of course, General Department of Health & Nutrition affiliated to this Department also works in this regard, especially in the field of preventing HIV / AIDS.
Overview of Legislation
Currently, the amendment of Anti-Narcotic Law is the basis for action in the country. Production, import, export, and consumption of all narcotic drugs (except for medical reasons) are illegal. Also, producers and traffickers of narcotics are punished in different ways (e.g., financial penalty, whipping, prison, and even execution if the crime repeats or is severe). According to this law, drug use is a crime; however, considering drug treatment programs, drug users are not prosecuted during the treatment period. If a drug user is arrested while she/he is not under the treatment, she/he is sentenced to pay financial penalty (one to five million Rials), to be whipped (30 lashes for the first time and 74 lashes for next time), and to be dismissed from her/his governmental job. If a drug user gives up addiction, she/he will be able to come back to the work. Non-addicted drug users are also punished by financial penalty and whipping.*

The demand reduction component of this law has some shortcomings. A noticeable part of the law has been devoted to supply reduction. This again shows that the attitude of supply reduction still overweighs that of demand reduction.

After making of national harm reduction committee & lots of advocacy & training sessions for different GO sections especially police & law enforcement parts recently it is been approved by the high rank governmental sectors to change the entire approach toward the problem: it was decided when see a drug use person (police or others) they will send him/her to treatment centers instead of jail & if the person himself refused to go there (choose treatment) they will send him to rehabilitation camps (prison). Approval of first outreach project with NSEP by high rank police officers still is another step toward shifting the people-using drug from criminal to a patient & medical problem.

Instead of all these efforts comparing the great demand of PUD/PID both for treatment & harm reduction is out of balance significantly & still in pilot stages. Also placing the problem of HIV/AIDS in top priority section of main stakeholders in this field placed harm reduction activities & policy formulations for PUD as a national mandate.

In the Textboxes below, some recent developments in the government responses in the field of drugs and HIV/AIDS are described. Readers who are interested in more elaborate overviews of national situations in this field, are advised to contact the SRM or AHRN, as mentioned in the Acknowledgements.

* The arrested drug users are sentenced to jail if they are unable to pay the financial penalty. For everyday in jail, 10,000 Rials of their penalty is reduced. According to the head of the Prison Organization, in 2002, approximately 622,000 persons were sentenced to jail; 234,000 of them had drug-related crimes. Among this group, approximately 100,000 were only drug users.
Textbox 2: Government response:

**Positive developments**

In 1997, the government passed a law stipulating that whenever a PUD goes voluntarily into treatment, s/he will be exempted from punishment. This legislative change showed that the government tended to consider drug use a health care issue rather than a legislative or a criminal issue. After the establishment of a national harm reduction committee in 2002 and numerous advocacy and training sessions for different GO sections -especially police and law enforcement agencies- high ranking governmental sectors approved a draft to change the entire approach to the problem. It was decided that when confronted with PUD, police or other law enforcement agents would send him/her to treatment centres instead of prisons. If the PUD refused treatment, they would be sent to rehabilitation camps (prisons). The draft is now under final revision by lawmakers.

After many rounds of negotiation, permission was granted by high ranking police officers to open the first outreach project with NSEP and was earmarked as another significant step forward. The project continues to function today, offering basic medical services, VCT, NSEP, MMT, counselling, as well as food and clothing. There is a plan to scale up this model in Tehran and some other major cities by March 2005 with collaborating GO and NGOs.

Recognizing HIV/AIDS as a top priority for main stakeholders in this field facilitated the inclusion of harm reduction activities and policy formulations for PUD in the national government’s mandate. Compared to the great demand of PUD/PID both for treatment and harm reduction, these pilot projects should be seen as significant, yet only as initial stages of a broader and more comprehensive plan to adequately address the challenges ahead.

The prison in Kermanshah can be seen as an example of good practice in the field of harm reduction, including VCT, MMT, and ARV for all inmates who require this. Several other prisons in the country follow the same model.
Textbox 3: Legislation

**Remarkable progress**

Currently, the amendment of the Anti-Narcotics Law (1997) is the basis for action in the country. Production, import, export, and consumption of all narcotic drugs (except for medical purposes) are illegal. Also, punishment modalities vary for producers and traffickers of narcotics (e.g., financial penalty, whipping, imprisonment and execution if the crime is repeated). Drug use is a crime; however, PUD are not prosecuted during the treatment period. If a PUD is arrested while not registered under treatment, she/he is sentenced to pay a financial penalty (one to five million Rials), to be whipped (30 lashes for the first offence and 74 lashes for next), and to be dismissed from governmental employment. If a PUD de-addicts, she/he will be able to resume work. Non-dependent PUD are also punished by financial penalties and whipping.

There are some vague and problematic issues around the current law (UNODC, 2000), including: there is no classification of drugs in the current law and many substances which could be misused (LSD, Ecstasy, etc.) have not been mentioned in this law at all. Thus, it is impossible to use this law to classify drugs based on the severity of their negative social, mental, and physical effect. There are no clear definitions of “addiction”, “dependence”, “abuse,” or “casual use”. In Article 15, there is no attention to “time” and “relapse” aspects of addiction. Treatment has been defined as an absolute concept which is not compatible with sociological, psychological, and biological definitions of addiction.

All drug control activities in Iran are decided, planned and implemented in collaboration with an umbrella coordinating body called the Drug Control Headquarters (DCHQ). Sometimes, plans recommended to UNHQ by supply reduction organizations have faced resistance by demand reduction organizations. Among these was a plan considered to remove homeless PUD from the streets and place them in concentration camps on the mainland as well as on the Persian Gulf Island of Farur (the Bill for Intensified Struggle Against Addicts; Banishment to Remote Areas and Islands) which, unchecked would have had appalling public consequences for the nation both in terms of public health and cultural-political conditions. It was the enlightening, expert opinion of the Ministry of Health and Medical Organization, Welfare Organization and authoritative members of DCHQ and Prison Organization that discouraged the idea and kept this dangerous bill from being adopted.

The Ministry of Health’s emphasis on an approach to substance dependence based on health and treatment has convinced most DCHQ member organizations that in drug control policy there needs to be a balance between demand reduction and supply suppression efforts. The Comprehensive Plan to Relocate, Manage and Relieve Addicts with an Approach of Treatment, Harm Reduction and Labor-Therapeutic Camps which was approved by DCHQ’s Joint Committee in collaboration with several member organizations, is the result of a cooperationist understanding between organizations dealing with demand reduction. This was the first bill of its kind in which the Ministry of Health specialists, law enforcement as well as other stakeholders jointly considered the issue of dealing with street drug abusers.

The plan stipulates three levels when dealing with drug abusers. In the first stage, voluntary treatment is an option. At the next stage, a certain group of high risk drug users are to be provided with harm reduction services. Only those clients that could not be placed in either category are to be dealt with legally by the judiciary (i.e., stage three). This group, obviously, constitutes only a very small number of drug users who are deemed dangerous. As it is, the prisons are currently filled with drug abusers who have never received any treatment or harm reduction services. It goes without saying that the implementation of the plan will significantly reduce the number of imprisoned drug abusers, thus relieving the police, the judiciary and the prison organizations of a great burden.

At the same time, a new draft for tackling drugs is prepared to be reviewed by judicial bodies in the near future. According to this law, out of treatment drug users would be mandated to go to treatment and harm reduction outpatient centers. Only those PUD who refuse any treatment or harm reduction intervention would be sent to short-term residential rehabilitation camps in which treatment and rehabilitation facilities are provided.
Strategic plans

“The First Five-Year Program on Demand Reduction 2000-2004” of the MOH was prepared in 1990 (Drug control program of UN, 2000).

The goals of this five-year program were: to reduce the social desirability of drug use through education; to promote the culture of the society and increase the protective/safe behaviors, to intervene, consult, and support at-risk populations; to control illegal substance use; to provide drug use therapeutic support for all volunteers and diagnosed drug users; to continue follow-up of drug users after quitting and to help them go back to their jobs; to reduce the negative health impacts of drug use such as HIV/AIDS; and to reduce crime among drug users.

Some proposed strategies for reaching aforementioned goals includes: to make an appropriate structure for drug use in MoH; to create drug use educational/research institute; to utilize medical universities capacities; to utilize primary health care (PHC); to utilize media, to develop special plans for students, soldiers, workers, and other vulnerable groups, to implement community projects in different provinces, cities, regions, and quarters; to utilize private sector capacities; to develop and utilize non-governmental organizations (NGOs) and scientific/national associations; to develop cigarette smoking prevention programs; and to promote health/therapeutic/diagnostic services quantitatively and qualitatively.

Although MoH and Welfare Organization continue their drug demand reduction activities, the predicted timeline for each component of the program is not respected. This could be due to the irrationality of time planning, change in the executive staff of health/treatment organization and budget deficit.

As mentioned earlier, the national HR committee was established in 2002. One of the activities of this committee was to draft the five-year program of HR (2002-2007). General goals of this program included: to develop, support, strengthen, and coordinate different HR interventions; to reduce injection drug use-related harm (e.g., infections, crime, corruption, and mortality); and to control HIV, hepatitis, and other blood-borne infections (National HR Committee, 2002).

International cooperation

Iran is a member of the Convention on Narcotic Drugs, 1961 and the Convention against Illicit Traffic of Narcotic Drugs, 1981. Also, Iran has signed the Convention on Psychotropic Substances, 1971, too. Several bilateral agreements have been/are being signed with neighboring/Middle East countries (Drug control program of UN, 2000).

United Nations Drug Control Program (UNDCP) which changed its name to United Nations Office on Drugs and Crime (UNODC) in 2002, opened its office in Tehran in 1999 and developed and signed a four-year cooperation program with the government of the Islamic Republic of Iran, titled “Narcotics Reduction Unitized Program” (NORUZ). NORUZ includes four components; one of which is “Drug Abuse Reduction Unified Strategy for Iran” (DARIUS). DARIUS is the demand reduction component of NORUZ. The budget of this program has been provided by eight European countries. Its goal is to make a network of drug demand reduction institutions and NGOs to fight drug use in the national and regional level.

Recent developments in terms of drug research infrastructure

There are several organizations involved in research in drug area in Iran but recently it seems that they become more interested in expanding their research & analysis than before. DCHQ increased its publications regarding substance abuse & research with the same name for a periodical they publishing. They invited researchers to participate in series of films regarding drug both nationally produced & internationally to be discussed & analyzed & this is a new approach toward other side of the matter of drug. Another important issue is establishing a section in DCHQ named harm reduction office, which allocated staff & programs for supporting these activities in near future in Iran. After Bam disaster (earthquake) from ministry of health some studies started to know the change in pattern of drug use after such a big change in atmosphere & infrastructure of the area & the new finding proves the possibility of rapid change of both type & mode of drug use in this area like shifting from previous opium smoking to Heroin injection that further RSA needed to see if any urgent harm reduction measures are mandated.

Welfare organization designed a serious of training workshops for harm reduction thus preparing themselves more in the area of research in this field in spite of being an important member of two bog national studies RSA/RAR.

An Important national research institute named INCAS (Iranian National Center for Addiction Studies) by the ministry of health in the medical university of Tehran has established that obtained approval
from WHO as a center for such studies on drug. It has supported the first pilot project on MMT in Iran with the support of UNODC & now for the first time has expanded its MMT services to a NGO (Persepolis) in a completely different setting this is community-based outreach. Based on approval of Iran in global fund for HIV/AIDS there is a great possibility of having more research in HIV & PID in Iran & also in 3/5 initiatives.

Some Important Executive Plans & Activities

- Health Promoting Schools Plan

Health promoting school is an innovation introduced by World Health Organization (WHO) to the people of the world through school as a pattern for facing with health and education problems in 1995. Health promoting schools have spread all over the world because of their efficiency and effectiveness. At present, health promoting schools are active in all continents of the world and different scientific articles have referred to the achievements of these schools in promoting health and education.

It has been tried in this plan that lifestyles of people are improved for life and some of the high risk behaviors such as drug abuse, violence, venereal diseases (including AIDS / HIV and affecting by its virus) as well as smoking are reduced in secondary schools.

The general objective of this plan has been the promotion of preventive and healthy behaviors in young students studying in secondary education.

Up to now, 65000 people of the effective personnel have been trained in the form of in charge of health promoting schools and life skills plan (Department for Prevention of Drug Abuse, Education, 2003).

Other activities of Education Department are preparation of life skills book especially for students studying in the first grade of middle school. This plan is under execution in 1500 institutes and will be developed during Academic Year 2003. Also, one of the most important activities of Ministry of Education was the execution of telephone directory especially for the questions of students regarding addiction as well as preparation and development of smoking control plan (Department for Prevention of Drug Abuse, Education, 2003). On the other hand, the Mentioned Ministry together with Ministry of Health, Treatment & Medical Education took actions to establish a Joint Higher Committee. The objective of the committee is to promote schools health and works in the field of development of preventive plans. On the other hand, this ministry with Welfare Office is reviewing joint plans for prevention of addiction.

In the level of Health Departments of Universities of Medical Sciences, different preventive plans have been designed and executed. One the most important plans directed by Department for Mental Health of Ministry of Heath, Treatment & Medical Education is life skills training plan. Department for Prevention and Drug Abuse Treatment has paid special attention to prevention subject and is designing preventive strategic plans through using the last scientific findings in this field. Also the plan of combination of prevention and drug abuse treatment in network has also paid a lot of attention to preventive activities.

- Addiction Clinics

From the last quarter of 1996, Outpatient Treatment Centers for addicts were gradually established by Welfare Office in provinces with the goal of presenting outpatient treatment services for volunteer addicts for quitting (self-introducing). At present, totally more than 88 centers of this Office are responsible for outpatient treatment of self-introducing addicts in all over the country.

In spite of all these achievements, on one hand, the number of clients of Welfare Clinics and State Universities of Medical Science was limited and is estimated between 55 to 65 thousand people per year and therefore can not answer a large number of drug abuser and on the other hand, since the main pattern of treatment is on the basis of detoxification and other short-term medicinal and non-medicinal actions, it will not have long-term effect on the status of drug use in clients. What confirms this fact is the research conducted by State Welfare Office considering treatment with naltrexone and is supposed to be published very soon. According to this research, only 20% of the patients participated in plan, could stay in treatment for 26 weeks and the rest of the patients gave up
treatment (Department for Cultural & Preventive Affairs, 2003). Probably, the rate of failure of treatment in detoxification is more than this in the country.

- **Methadone Maintenance Treatment Clinics**
The first center started its activities in Rouzbeh Hospital in Tehran in Oct. 2002 and the second center started its activities in Behavior Counseling Clinic of Health Center located in West of Tehran in Feb. 2003. The recent reports indicate that Methadone clinics have also started their activities in Shiraz and Mashhad. Ministry of Health intends to establish at least ten other methadone clinics in the country in case of allocation of budget. State Welfare Office and Prisons Organization also put in their agenda plans for maintenance treatment.

- **Addicts Self-helping Groups**
Since 1994, some activities have been performed to attract the participation of addicts quitted and also their family members in the field of treatment and continuation of improvement. In this line, anonymous addicts group (narcotics anonymous) was organized with the membership of addicts treated and an other group including women who are the member of addicts family in patients finding, referring as well as attracting the participation of addicts and their families in continuation of improvement and living without drugs. Most of the addicts have regained their improvement through joining these groups. Some of the positive effects of anonymous addicts group have been as follows: preventing relapse of addiction in the members of the group (Drug Control Plan of the United Nations, 2000). At present, anonymous addicts meetings are held in three groups consisting of women, men and addicts families and with membership of thousands of addicts treated in all centers of provinces and some of the small provinces (Department for Cultural & Preventive Affairs, 2000).

We can refer to Aftab Population and Congress 60 as other active addicts groups which have thousands members in the country.

- **Counseling Clinics of Behavioral Diseases (Triangular Clinics)**
These clinics which were established within the frame work of Health Departments of State Universities of Medical Science and work under the supervision of Disease Management Center of Health Department of Ministry of Health, Treatment & Medical Education, take actions to reduce damages resulting from intravenous addiction, treat venereal diseases as well as taking care and supporting those contracted with HIV / AIDS. All these three disorders and diseases are transferred to people through high risk behaviors and they can be considered as a kind of conduct disorder, too. Through considering these three disorders in one unit, we can provide patients with comprehensive and combined services. This activity also prevents negative labeling to clients. Such clinics combine prevention and care together and provide different services such as HIV / AIDs Test, counseling related to such tests, distribution of instruments necessary for damage reduction (including condom and syringe), diagnosis and treatment of venereal diseases and opportunistic infections accompanied by AIDs, AIDs anti-virus treatment, referring to specialized services (including addiction clinics, dentistry and hospitalization services), prevention from transferring HIV from mother to child and as a result of accidental contact, vaccination of Hepatitis B, treatments and protective activities, cooperation with other relief organizations such as Red Crescent, Imam Khomeini Relief Committee, as well as follow-up of patients at home. The target population of such clinics includes the following groups: intravenous drug users, drugs users in general, high risk populations, volunteers of counseling and training in respect of HIV, those contracting with HIV Virus, the family members of those contracting with HIV, patients suffering from venereal diseases and those who contacted with polluted physical excretion (WHO EMRO, 2003).

Directors of Disease Management Center reported that 21 counseling clinics of behavioral diseases have started their activities up to now. The first and maybe the most active triangular clinic started its activities in Kermanshah in Oct. 2000. Two counseling clinics of behavioral diseases are working in Tehran, too.

- **Triangular Clinics of Prisons Organization**
During recent years, General Department of Health & Treatment of Prisons Organization has tried to reduce the damages resulting from drug abuse; according to the officials of this General Department,
24 triangular clinics have been established with the objectives similar to the objectives of clinics of the same name in Ministry of Health, Treatment & Medical Education in a number of state prisons up to now. Considering the fact that there are more than 200 prisons in the country, and the large number of prisoners takes drugs and intravenous drug use is common in prisons, continuation of such actions plays important role in reducing HIV spread in the society.

➢ Harm Reduction Plan in Street Addicts and High Risk Dependent Population

The effectiveness of outreach plans is well documented in decreasing high risk behaviors of intravenous drug users. A large number of intravenous drug users after being exposed to such plans, changed their behaviors. Outreach plans can be an effective pattern for access to those groups that usually do not enter treatment system (Vazirian, 2002).

Through execution of this plan, Department for prevention and drug abuse treatment of Ministry of Health, Treatment & Medical Education intends to reach HIV spread reduction objective among street addicts and high risk dependent population. Through execution of this plan, the high risk group which is not accessible by Treatment System can be provided with first and necessary health, medical and social aids, and can slowly participate in treatment systems and social security (Vazirian, 2002).

Using a non-governmental organization (Persepolis Society) for establishment of a relationship with street addicts and providing them with services is the major strategy of this plan.

a. Treatment and Rehabilitation (approaches, results)
b. Current drug policy / government responses to drug use
c. Drug policy development

In General, a tentative\(^{18}\) inventory (see Table 56) summarizes GO and NGO responses in terms of availability of drug use related services, based on the analysis of existing data as reported by the SRM. In the same table, perceived availability of services in the eyes of the PUD respondents is offered for comparison. It appears that PUD have limited access to most types of drug use related services and certain types of services are not available at all.

Hospital/medical services for PUD are reportedly to some extent available in Tehran. Detoxification centres and residential rehabilitation centres are generally less available. Going down the table, the mentioned interventions become less and less available: needle and syringe exchange programmes are rarely available in Tehran. A cautious start has been made with making pharmacotherapy interventions available.

Tentatively, it can be concluded that given the severity of the problems outlined in section 1.a, the national response has been meagre across the board. On the other hand, the recent developments in Iran, do indicate that the linkages between drug use and HIV/AIDS are starting to be taken seriously and are gaining a foothold at national policy levels. However, availability of services for PUD and particularly those services that address the link between drug use and HIV/AIDS transmission are generally limited to a small part of the total drug using population. Also in the legislative field, some significant developments have taken place or are expected soon (see Textboxes on Legislation below).

\(^{18}\) The types of programmes often overlap and the extent of availability and is not clearly defined. Hence, this overview should be interpreted as tentative report.
Chapter 2: Profile of the sources

As mentioned earlier, a variety of research methods and techniques were used, including open interviews, questionnaires, focus group discussions and analysis of existing data. This chapter provides some selected background data on those people that provided the data during this research. The first section deals with the key informants and the participants of the focus group discussions, the second section describes the people using drugs that took part in the open interviews and the questionnaire.

2.a. Key informants and participants of the focus group discussions

The table below provides an overview of the number of interviews with key informants and focus group discussions (FGD) that were conducted, split up according to target groups, based on the level of involvement that one has with drug use (see Table 2).

The decisions on who to interview and how many interviews and focus group discussions to conduct were made by the SRM, based on the perceived usefulness of these interviews as well as on practical considerations. In Tehran, with its limited number of NGOs, focus was on government run services.

Table 2: Interviews with key informants and focus group discussions

<table>
<thead>
<tr>
<th>Involvement</th>
<th>Group</th>
<th>IKI</th>
<th>FGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly involved</td>
<td>PUD: non-PID</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PUD: PID</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Personally involved</td>
<td>Family members</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service providers</td>
<td>GOs</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>NGOs</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Professionally involved</td>
<td>Law enforcement</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Policy makers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Outside perception</td>
<td>Community leaders</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Site Research Reports

It appeared quite difficult and extremely time consuming to organise the FGD, particularly those with policy makers. The number of participants in the FGD varied from five to twelve with most consisting of six to eight people. The atmosphere in which the discussions were held was generally conducive to data collection. The key questions and statements that were developed for the FGD appeared to generate a lot of discussion and often, there was little agreement on the issues among the participants.

The interviews with key informants and FGD provided interesting data and viewpoints, some examples of which will be included in this report. They were also helpful in the formulation of tentative conclusions which needed to be confirmed in the following stages; the open interviews and the questionnaires.
2.b. **Open interviews and survey sample**

Below follows an overview of the number of people that were targeted during the open interviews and the survey stages, divided in PID and non-PID. The respondents—and occasionally also the informants—will be described using some key demographic indicators. This data should not be considered representative for the whole drug using population in the particular city. Instead, this section is presented here to provide background information on the research sample.

In total, 47 open interviews and 281 valid questionnaires were conducted (see Table 3). A guideline of 50-100 open interviews was set centrally, yet the SRM decided themselves when saturation was reached. Similarly, the number of questionnaires that were administered at a certain site depended largely on perceived usefulness, local circumstances and constraints, yet a minimum target of 300 respondents at each site was agreed upon. However, the rather sample size in Tehran is largely due to constraints relating to the hidden nature of drug use in the country.

**Table 3: Number of informants (open interviews) and respondents (questionnaire)**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Non-PID</th>
<th>PID</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informants</td>
<td>23</td>
<td>24</td>
<td>47</td>
</tr>
<tr>
<td>Respondents</td>
<td>96</td>
<td>185</td>
<td>281</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>118</td>
<td>210</td>
<td>328</td>
</tr>
</tbody>
</table>

*Source: Site Research Reports*

**Sex**

Although a concerted effort was made to include women using drugs, almost all (90%) respondents were male, 6% of respondents were female and 4% were transgenders. It is believed that these percentages more or less reflect the actual proportions “on the street”, yet it is unclear to what extent women PUD form a larger hidden population. Further research that specifically targets female PUD would be required to shed more light on the issue of female PUD.

**Age**

The target group of this research was young people as defined by the United Nations: those aged 15-24 with an extension of this age group if needed. On average the respondents were 28 years old (see Table 1).

It appeared that people who could be targeted for this research were somewhat older than originally planned. As appears later, initiation to drugs in Tehran also tends to occur somehow late. However, the informants of the open interviews were on average 12 years younger than the respondents, because they were largely recruited from a youth correctional centre.

**Migration**

Sixty five percent of the respondents were born in Tehran (see Table 82). Interestingly, the large majority of those that had moved to the city, did this when they were younger than 19. In other words, it can be assumed that most went to the city with their parents, rather than by themselves. The qualitative data indicates that most of those who were originally from outside the city had moved there from rural, impoverished parts of the country.

**Residence**

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19 The term ‘Informant’ is used to designate those people that were subject to an open interview, whereas the term ‘respondent’ is used to designate those people with whom the questionnaire was conducted. As a rule, the qualitative and quantitative data collected on a certain topic will be reported and discussed together.
In terms of where the respondents usually spend the night, data from each site varies a lot (see Table 3). Large numbers of respondents mention Street/Park/Open area as the place where they usually spend the night, confirming a much more open and visible drug scene as well as the marginalised position of people that use drugs. Further analysis indicates that, overall, this marginalisation is much more likely for PID than for non-PID; 43% vs. 17% are living in ‘public areas’.

**Educational background**

Only one-tenth of respondents had not finished primary school, whereas almost one-third had at least completed high school (see Table 914).

**Religion**

Muslims make up the entire sample. In general, the religious affiliations seem very similar to those of the general population in Iran.

**Marital status**

The large majority of respondents were single at the time of the interview (59%), with a relatively old drug using population 19% of the respondents were divorced, 14% being married, 5% were separated and 3% were widowed. Interestingly, further analysis indicates that PID are much more likely to be divorced than non PID.

**Sources of income**

Odd jobs on the street are the most common source of income, including rag picking, collecting and selling junk/garbage/scrap, occasionally helping out/messenger, parking/traffic assistant, and the like (see Table 15: 46%). PID are less likely to hold a steady job (36% vs. 17%).

*Theft* is mentioned by very few respondents as their main source of income (1%). It is, however, expected that the high percentage of *no income* includes a number of people who engage in theft or dealing drugs, yet were apprehensive to mention this during the interview.

**Concl. 1:** Large proportions of young PUD (16%) have migrated to their city of current residence before they turned 19.

**Concl. 2:** Large proportions of PID (43%) usually spend the night in ‘open areas’, such as the street or a park.

**Concl. 3:** Only 10% of PUD have not finished primary school.

**Concl. 4:** In terms of source of income, a mixed picture arises: PUD appear to be involved in all kinds of work, including street-based work, steady work, and illegal activities. In addition, dependency on family members is quite common.

**Concl. 5:** Injecting drug use seems to lower one’s chances to hold a steady job significantly.

→ **Rec. 1:** Target urban as well as rural settings in primary prevention.

→ **Rec. 2:** Strengthen outreach work and drop-in-centres in the areas with high concentrations of street-based populations in order to reach street-based PUD and, in particular, PID.

→ **Rec. 3:** Strengthen, out of school interventions to reach those PUD that drop out of school (or never make it to school) at a very young age.
Chapter 3: Drug use and health; a KAP study

This chapter summarizes the findings of a Knowledge Attitude Practice (KAP) section that was conducted as part of this study. These findings draw largely on the questionnaire and focus on the current situation in terms of knowledge, attitude regarding drug use and health, with an emphasis on HIV/AIDS and Hepatitis C. In terms of practices, emphasis is placed on unsafe injecting and unsafe sex over time.

The relatively high proportion of respondents that was recruited through the client base of the implementing NGOs probably created a bias in the sampling. Knowledge levels, positive attitudes, and safe practices among these respondents are probably higher than among the general drug using population. Therefore, the data presented in this chapter should be viewed as a slightly optimistic representation of the general state of affairs.

3.a. Knowledge levels on HIV/AIDS and Hepatitis C

Most respondents (78%) had heard of HIV/AIDS but significantly fewer had heard of Hepatitis C (36%). Nevertheless, 22% of the respondents had never heard of HIV/AIDS, representing a substantial group of people that urgently requires attention in terms of the most basic HIV/AIDS awareness raising.

Mass media appear to be successful in reaching large sections of the population, including PUD (see Table 16: 64%).

However, educational institutions and parents fail to impart knowledge on these issues (see Graph 11). During the interviews with key informants and focus group discussions, it was sometimes argued that school was not the right place for discussion of these topics and that relationships between teachers and pupils—and possibly between parents and children—might be such that a fruitful, open discussion of HIV/AIDS and its relation with sex and drug use would be very difficult at best. Others offered the opinion that teachers and parents are often more ignorant than their pupils and children, respectively. Regardless where the truth of the matter lies, urgent action in this area is required.
Graph 1: Most important source of knowledge on HIV/AIDS and Hepatitis C (n=211)

From the open interviews, it appeared that many PUD know the two main modes HIV/AIDS transmission: unprotected sex and unsafe injecting (see Quotes 1). The questionnaire addressed knowledge levels on transmission, prevention and cure of HIV/AIDS and Hepatitis C through open questions with scores being awarded depending on the correctness of each answer (see Table 17).

Near a half of the respondents mentioned unprotected sex (45%) and sharing injecting equipment (46%) as possible ways to acquire the HIV virus. Majority of respondents were not aware of blood transfusion and vertical (or mother to child) transmission as possible ways to contract the virus. One third of respondents had heard of Hepatitis C (36%). Knowledge with regards to modes of transmission was extremely low.

In general, there were few misconceptions on how HIV/AIDS can be transmitted. Sharing a razor blade was mentioned by 15%. Principally, whether the HIV virus can be transmitted in this manner is not so important: Even if it cannot, it would be advisable to use a personal razor blade. Another incorrect answer, was sex with boys/males (without clarifying whether this is unprotected or protected sex: 3%). This points towards stigmatisation of men who have sex with men (MSM) and perpetrates the (incorrect) idea that HIV/AIDS is primarily a disease that is spread through sex between men. On the positive side, hardly anyone at all said that HIV/AIDS is not transmittable (0%).

In an effort to come to a total score on knowledge on HIV/AIDS transmission (and prevention), correct answers were awarded one point, and incorrect answers minus one point. Those with a total of three or more points were deemed very knowledgeable (Table 19). Following this measurement, on the whole, only 5% can be considered very knowledgeable on HIV/AIDS transmission (and very few on Hepatitis transmission (1%).

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20 The percentages reported below include all the respondents; those who had not heard of HIV/AIDS were not asked any further questions on transmission, cure or prevention and were deemed not knowledgeable on these issues.

Quotes 1: Knowledge levels on HIV/AIDS and Hepatitis

How can you get it?

“Contaminated syringe causes ‘hepatic’ (hepatitis), you may get disease from spoon, syringe, the cigarette which has been on lips of an infected bloke…”

“…I heard from my husband about ‘ids’ (AIDS) and ‘hematip’ (hepatitis). He said that ids could not be diagnosed soon. You become ill and get jaundice. You become week and little by little you die.”

An addict may have fear of AIDS but when he is in withdrawal he doesn’t care about AIDS or hepatitis that he might get from using other people’s syringes.

“A person with AIDS could live 20 years but with hepatitis he could live no more than 3 months! Because it shows its symptoms very soon…”

Cure

Again, over half of the respondents actively knew\(^{22}\) that there is currently no cure for HIV/AIDS (63%) while in regards to Hepatitis C these figures were very low at an average of 17% (see Table 19: 17%). The questionnaire did not address issues of treatment of HIV/AIDS or Hepatitis C.

Prevention

The most common answer to the question what are ways to prevent acquiring HIV/AIDS? (Q21) was protected sex / condom use with almost one-third of the respondents (Table 18: 34%). using one’s own injecting equipment (32%), new sterile injecting equipment (20%), and no sharing (16%) are also mentioned quite often. No sex is mentioned hardly at all (2%). Monogamy scores very low (1%).

Personal hygiene (10%) and a healthy lifestyle (2%) are also mentioned as HIV/AIDS preventive measures. If no further details were provided, these answers were deemed incorrect and can be viewed as quite worrisome. If descriptions amounted safe sex or safe injecting, the answers were noted under these categories and not elsewhere.

Few respondents were deemed very knowledgeable\(^{23}\) in the field of prevention of HIV/AIDS (11%) and very few had good knowledge on prevention of Hepatitis C (2%). These numbers are extremely concerning, particularly because comprehensive knowledge on prevention is an absolute requirement for behavioural changes towards safer drug use and safer sexual activities.

Overall HIV/AIDS and Hepatitis C knowledge

The knowledge levels on transmission, cure and prevention were combined into one score that indicates the respondents’ general knowledge level in regards to HIV/AIDS and Hepatitis C. Respondents were deemed very knowledgeable when they had been considered very knowledgeable on at least two of the three aspects above (Table 19). About one in five respondent can be considered very knowledgeable in regards to HIV/AIDS (10%), while hardly any respondents have good knowledge on Hep C (1%). Knowledge levels among PID were not significantly higher than among non-PID.

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\(^{22}\) Those people that answered There is no cure -or similar- to the question “How can HIV/AIDS be cured”?

\(^{23}\) There are many ways to prevent acquiring HIV/AIDS and/or Hepatitis with varying degrees of effectiveness and, as a result, any attempt to quantify knowledge levels on prevention through a questionnaire is a complicated matter. The approach taken here is to ask an open question and check the given answers on pre-defined options that were based on the trial phase. Five of the 14 resulting answers were deemed correct (1 point), three were deemed neutral (0 points) and the others were deemed incorrect (minus 1 point) (see Table ). A total score of two points or more was considered very knowledgeable. It is believed that by doing so the label very knowledgeable is awarded rather generously. It could be argued that a lot depends however on the extent to which the interviewers urged the respondents to provide further answers. As a general guideline interviewers were trained to gently probe for more answers and move on to the next question when no more answers were forthcoming.
Concl. 6: Mass media can reach a large group of people, whereas school, parents and other family members fail to spread information on health issues such as HIV/AIDS and Hepatitis C.

Concl. 7: Drug use and drug use related issues are commonly discussed with fellow PUD. GOs and NGOs that specifically target people at risk have an important role to play in spreading of knowledge and raising awareness in regards to HIV/AIDS and Hepatitis C.

Concl. 8: Knowledge levels among PUD (regardless whether they were injecting) in regards to HIV/AIDS transmission, cure and prevention are low. Knowledge on Hepatitis C is extremely low.

→ Rec. 4: Use the mass media to reach the general population with information of HIV/AIDS and Hepatitis C.

→ Rec. 5: Include parents and communities in education and awareness campaigns, such as information and contacts on what to do when a young person uses drugs, drug use related risks and available options.

→ Rec. 6: Improve HIV/AIDS and Hepatitis C information and awareness in regards to transmission and prevention among PUD through educational institutions.

→ Rec. 7: Regularly assess knowledge levels pertaining to health risks involved in drug use and drug related practices and develop and/or revise awareness techniques and materials accordingly.
3.b. Attitudes towards drug use and health

Drug use and its perceived effects

The questionnaire gauged the (perceived) effects of the use of certain drugs, regardless whether the respondent had ever used those drugs.\textsuperscript{24} In other words, the troublesome distinctions between correct versus incorrect knowledge on effects and between knowledge and attitude per se are avoided here by using the term perceived effects. The answers were labelled positive (\(+\)) or negative (\(-\)) and were then summarized into a total score, divided into three categories; (largely) negative, mixed, or (largely) positive\textsuperscript{25}.

The total score can be seen as the image of a drug amongst young PUD, regardless whether one uses the drug in question (see Table 20). Overall, this image is quite positive with three drugs being viewed in a largely positive light by more than half of the respondents. The drugs that are commonly available (opium and cannabis) score between 50 and 70 percent, with exception of heroin (31%). Designer drugs and ATS have a relatively positive image, which is probably related to the fact that intensive use as well as injecting use of these drugs is limited.

Drug use related health risks

When asked about physical health risks related to their drug use\textsuperscript{26}, almost all respondents listed several (Table 21). The mentioned health risks consist of many different ailments and include both physical and mental phenomena, as well as injury and death.

Worse general health is at the top of the list with near half of the respondents providing an answer that can be summarised in that manner (42% and 46% in non-PID and PID respectively).

Generally, PID did not mention more health risks than non-PID, with exception of health risks that are logically associated with injecting, such as abscess, HIV/AIDS, and Hepatitis C. Death is also mentioned significantly more often by PID (38% versus 13% among non-PID). Some PID are aware of risks related to their behaviour, yet few specifically mention the actual consequences. For example, HIV/AIDS is mentioned by 12% of the PID (versus 4% amongst Non-PID). Technically speaking, HIV/AIDS would not directly be a drug use related risk for non-PID. Along these lines, those 4% non-PID could be construed as having an exaggerated fear, while the 12% among PID should be considered a worryingly low proportion, particularly given the high prevalence of Unsafe injecting practices, which will be covered in the next section.

\textsuperscript{24} Q15, column 4: What is the effect on your mind after the drug takes effect? (More answers possible) Not more than 3 effects: Happy (\(+\)), Sleepy (\(+\)), Aggressive (\(-\)), Paranoia (\(-\)), Confident (\(+\)), Depressed (\(-\)), Energetic (\(+\)), Sad (\(-\)), Occupied in thought (\(\pm\)), Relaxed (\(+\)), Fantasizing/Daydreaming (\(+\)), Enhanced Sexual Pleasure/Orgasmic (\(+\)), Desiring sex (Horny) (\(+\)), Heightened concentration (\(+\)), Numb (\(+\)), No answer, Don’t know, Other.

\textsuperscript{25} Mixed is the results of two answers: \(1\) positive and \(1\) negative, leading to a total score of zero. Overall, about one quarter of the respondents fell within this category. Largely positive consists one, two or three answers that are in majority positive, i.e. maximum one negative answer accompanied by two positive answers.

\textsuperscript{26} Q16: What are physical / health risks related problems to regular use of your current or latest drug, if any? (DO NOT READ THE OPTIONS. More answers possible)
Quotes 2: Attitudes towards injecting amongst PID

**Did/does the risk of acquiring HIV influence your injecting behaviour?**

“No it does not. Basically I do not care anymore. I know that I cannot give up drugs anymore and have resigned to living on the roads and eventually dying on the road. Therefore if I get infected and die it is good. This way my present suffering will be over sooner.”

“Now I never use anyone else’s needle and syringe. If someone uses mine, I wouldn’t use it after that person.”

I knew that if one uses other people’s syringes or needles, one can get HIV, so that is why I always used to take my own needles and syringes to the doctor. “If I have to inject, it is better to inject alone or use my own needle and syringe rather then get into more trouble by becoming HIV positive.”

“Yes, I’m scared, I don’t think I’ll ever inject in my life, because of the fear of getting HIV/AIDS.”

**To what extent do you consider the act of injecting addictive rather than the drug that is being injected?**

**Majority opinion:**

“For me it is the high that matters.”

**Minority opinion:**

“For me the act of injecting is much more addictive than the drug. In some occasions when I do not have any drug to inject I have punctured my veins with an empty syringe, and drawn blood and flushed it back into my veins.”
Attitudes towards injecting and PID among non-injecting PUD

Non-injecting PUD were asked to what extent they agreed with the statement *people injecting drugs are generally disliked by non-injecting PUD* (Table 22). The vast majority agreed with the statement (87%). In other words there appears to be widespread dislike of PID amongst non-PID.

Perception of injecting drug use itself amongst non-PID was gauged through the statements *I do not inject drugs out of fear for my health* (15) and *I would try injecting if it was offered to me.* The large majority agreed with the first statement (64%) and disagreed with the second (72%). In other words, non-injecting PUD tend to consider injecting bad for one’s health and the large majority have made a conscious decision not to inject because of that.

Attitudes towards injecting among PID

The open interviews reveal that for many PID that are aware of the risk of acquiring HIV, this knowledge influences their injecting behaviour (See Quotes 2). Many said, they “became more careful”, while others "ensured" to not share “even in severe withdrawal”. For some informants, knowing the risk of acquiring HIV did not alter their injecting behaviour in terms of sharing needles and syringes. Even though they were aware of the “HIV risk” the lack of money to purchase their equipment and because of lack of availability led to their sharing behaviour. Having given up the hope of giving up drug use, one informant mentioned that he did not “care anymore” and had “resigned to eventually dying on the roads”. He mentioned that it would be “good” if he got infected, then that would cut short his “present suffering”.

The questionnaire gauged how PID view injecting, through checking the extent they agreed with four statements on injecting. The first conclusion would be that many PID do not look at injecting as particularly bad for one’s health. 78% agreed with the statement that *in terms of health, injecting drugs is not different from other modes of intake* (78%). Yet, roughly three quarters of the respondents were of the opinion that *injecting is more addictive than other modes of intake* (72%), and the majority thought that *the act of injecting is as addictive as the drug* (88%). Paradoxically, the vast majority agreed with the statement: *I can stop injecting completely if I set my mind to it* (87%).

Most PID viewed injecting as more addictive than other forms of intake. The addictive quality of injecting itself and the enjoyment of the injecting ritual, rather than (or besides) the drug that is being injected, was echoed often during the open interviews.

Concl. 9: Most respondents describe the effects of most drugs in a largely positive manner.

Concl. 10: Amongst young PUD, the image of a drug does not significantly differ between those who have used that particular drug and those who haven’t.

Concl. 11: Most non-PID are aware of health risks related to injecting and this is a major factor in the decision not to inject. Very few non-PID would readily start injecting if they were offered to do so.

Concl. 12: There are reports of antipathy amongst non-PID towards PID.

Concl. 13: Many PID appear to be unaware of the health risks that are associated with injecting. HIV/AIDS is mentioned by few PID as a drug use related health risk.

Concl. 14: The addictive nature of injecting is widely recognised amongst PID, yet PID remain optimistic about the possibility to be able to abstain.

27 The percentages shown are those that agreed with the statement on a scale: Disagree – Somewhat agree – Agree.
Rec. 8: Focus on HIV/AIDS prevention information and awareness, including drug use related harms, within those services that target PUD and specifically PID.

3.c. Unsafe practices

This section contains data on unsafe injecting practices and sex, with a focus on the former. The questions on injecting were only asked to those respondents that had (ever) injected, roughly 66% of the total group.

Unsafe injecting practices

The questionnaire included a number of questions about unsafe injecting behaviour (Q46-48). A five-point frequency scale was pre-defined (from never to always). First, the questions related to unsafe injecting, followed by some of the most striking results, are presented, including some scores that combine results from certain answers to provide insight into “prevalence of unsafe injecting behaviour”. Although some of these sharing behaviours are believed to be less risky than others (in terms of disease transmission), all are considered “examples of bad practice”.

Active sharing (Q46) reflects behaviour that actively puts the respondent her/himself at risk. Passive sharing (Q47) refers to putting other PUD at risk. The answers to Q48 are summarised as “unsafe injecting practices”. Roughly 30-50% say they often or always share needles and syringes, as well as other injecting materials (average: 41%) (see Table 4 below).

Table 4: Prevalence of sharing of injecting materials (often or always) (Q46 & Q47)

<table>
<thead>
<tr>
<th>Reason / Factor</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle</td>
<td>26-46%</td>
</tr>
<tr>
<td>Syringe</td>
<td>27-45%</td>
</tr>
<tr>
<td>Cooker/Spoon</td>
<td>54-59%</td>
</tr>
<tr>
<td>Cotton filter</td>
<td>33-52%</td>
</tr>
<tr>
<td>Water to clean needle</td>
<td>32-49%</td>
</tr>
<tr>
<td>Ampoule bottle</td>
<td>32-46%</td>
</tr>
<tr>
<td>Cleaning cloth / Handkerchief</td>
<td>30-48%</td>
</tr>
<tr>
<td>Average</td>
<td>41%</td>
</tr>
<tr>
<td>Respondents</td>
<td>182</td>
</tr>
</tbody>
</table>

Source: Q46: Do / Did you ever use the following items after they had been used by someone else before you? If so, how often? Q47: Do / Did you ever let someone else use the following items after you had used them yourself? If so, how often? Percentage of respondents that answered “often” or “always”.

Prevalence of other unsafe injecting practices (as defined in Q48) are quite common (Table 23). On average, roughly a third often or always (31%) said to be engaging in these practices. The prevalence of using the services of a street doctor or professional injector is particularly relevant in connection with the increased risk of acquiring HIV/AIDS and other blood borne diseases. The Percentage is 35%.

The percentages in Table 5 below represent those PID that did NOT say never (on a 5-point scale from never–always) when asked about unsafe injecting behaviour. In other words, these are people

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28 Shooting up after someone else has squirted drugs into syringe; re-injecting your blood (jerking or booting); using street doctor / professional injector; flushing after injecting removing blood and re-inject; sharing needle and/or syringe; Using make-shift equipment, (pens, straws, plastic pipes).
that do, in one way or another, put themselves at risk. It appears that the large majority of PID engage in sharing injecting equipment and other unsafe injecting practices.

**Table 5: Unsafe injecting practices (Q46-Q48)**

<table>
<thead>
<tr>
<th>Unsafe practice</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active sharing (Q46)</td>
<td>70%</td>
</tr>
<tr>
<td>Passive sharing (Q47)</td>
<td>76%</td>
</tr>
<tr>
<td>Unsafe injecting practices (Q48)</td>
<td>89%</td>
</tr>
<tr>
<td>Respondents</td>
<td>185</td>
</tr>
</tbody>
</table>

Source: Q46-48: Those who answered differently than “never”.

**Access to new injecting equipment**

During the open interviews, many informants said they did not use new needles because of withdrawal, so there is no time to go shopping and one becomes careless and focuses on withdrawal rather than on the danger. Another recurring reason was that it was better to use the money to buy additional drugs than to buy new needles/syringes. In addition, needle sharing was occasionally viewed as promoting the feeling of belonging or community.

These comments are echoed by the results, obtained from the questionnaire; besides the obvious didn’t have his/her own syringe (77%), no money and withdrawal symptoms are mentioned the most often (Table 24: 36% and 30% respectively) as reasons for sharing injecting equipment. Other financial reasons are rarely mentioned [ave money (2%), someone else paid (1%)]. Also, reasons related to the quality of the syringe appear to be less important [broken/dull (2%), cleaned (5%), clogged (2%)]. Other rare reasons mentioned include: don’t really care (5%), injecting with people one trusts (1%).

The pharmacy appears to be the most common place to acquire needles and syringes (97%) (Table 25)29. PUD friends are the next important source (6%). Other sources remain low at 5% or less.

NSEPs play an important role in the reduction of risks that are related to the use of unsterile needles and syringes. However, in Tehran where such services are largely absent friends play a more important role.

Overall, price is the most often mentioned constraint to access to new syringes (Table 26: 54%). Distance and Too desperate to fix is also often mentioned (21% and 18%, respectively). The price of needles and syringes -as compared with the price of the actual drug is estimated to be about 2-4%.

The noted prevalence of sharing needles and other unsafe injecting practices is alarming. Other constraints mentioned include lazy (11%) and other obligations (work/study) (8%).

**Unprotected sex**

Roughly one third of respondents answered yes the question: have you had sex in the last four weeks? (Q58) (33%), with remarkably few people who refuse to answer and withy no significant differences between PID and non-PID. Overall, half of these sexually active PUD say that they often or always have unprotected sex (Table 27: 50%). About one quarter of respondents say they never have unprotected sex, (28%). PID appear less careful than non-PID.30

The most commonly given reason for not using a condom is don’t like using it (Table : 33%) followed by don’t really care (23%) is named by 10% of respondents. This indicates that condom promotion

29 More than one answer possible
30 $X^2 = 23.985$, df = 4, p = 0.000
campaigns have somehow failed to stress the necessity of condom use, regardless of whether one likes using it or not. Many people mention reasons that are connected to a presumably monogamous relationship: trust sex partner (20%), sex within marriage only (12%), in monogamous relationship (5%). Availability, not available / difficult to get (13%), appears to be a factor in some cases, yet expensive (2%) is hardly mentioned.

Answers such as don’t know how to use it (23%) and what’s a condom? (2%) show that there is some ignorance regarding condom use. Overall, shame/embarrassed (8%) and afraid to suggest use (1%) is not mentioned a lot. The reason to intentionally spread disease was never mentioned. However, this is an issue that should be looked into closer.

As appeared earlier, high knowledge levels on adverse consequences of injecting do not necessarily lead to negative attitudes towards injecting or to safe injecting practices. It would seem that, for example the factors outlined in the previous chapter—and elaborated on the next chapter—can outweigh certain knowledge and/or attitudes, leading to unsafe behaviour despite knowing that the (possible) negative consequences of that behaviour. It is therefore pertinent to note that interventions do not stop at building knowledge and awareness, in the hope that safer behaviour will automatically follow. Instead, projects and programmes that work with PID should conduct activities that build the capacity of clients to successfully translate imparted knowledge and attitudes to actual behaviour. Such skills could include life skills, but also more specific, practical skills on safe injecting and safe sex.

Concl. 15: Sharing injecting equipment and other unsafe injecting practices are quite common (about 40% often or always and near 90% answer differently than never).

Concl. 16: Being injected by a fellow PUD with a used needle is quite common when one first starts injecting.

Concl. 17: Desperation, as a result of withdrawal symptoms, is the main reason for not using clean injecting equipment.

Concl. 18: The cost and effort involved in buying new injecting equipment every time are important factors in sharing needles. Needles for individual use are often used many times.

Concl. 19: Applied cleaning practices are not effective in preventing the spread of blood borne diseases.

Concl. 20: For many PID, the ritual that accompanies injecting is an important part of its attraction.

Concl. 21: Half the sexually active PUD often or always had unprotected sex. The most often mentioned reason is don’t like it (using a condom). Other main reasons include (presumed) monogamy and lack of availability of condoms.

→ Rec. 9: Develop and scale up free and easily accessible needle and syringe exchange programmes. Provide information on safe injecting.

→ Rec. 10: Improve information and awareness on risks related to unprotected sex and insure availability and access to condoms.

→ Rec. 11: Develop and conduct activities that focus on imparting practical skills on safe injecting and safe sex.
Chapter 4: Drug careers and environmental factors

The question of how drug careers develop is one of the main questions of the present study. Many questions and sub-questions, in both the open interviews and the questionnaire, dealt with the ‘defining moments’ of one’s drug career and the influence that the environment had on those moments. The questionnaire provides a detailed profile of the respondents’ drug career, including the drugs used, mode of intake, age of first use of listed drugs, duration of use, frequency of use in the last three months and the effects of the drugs. It further explores the two most crucial switches in terms of mode of intake, type of drug, and age at the moment of first intake.

4.a. Characteristics of drug use

Drugs availability

Numerous organisations, such as law enforcement, hospitals, treatment centres and NGOs provide insights in the drugs that are available. Also, the SRM filled out a table that contains information on availability, prevalence, mode of intake, price, and local names of types of drugs (see Annex 2). It appeared that traditional drugs such as marijuana / hashish, heroin, opium and ‘brown sugar’ are widely available. The data from the questionnaire (see Table ) perfectly confirms this picture. On the other hand, knowledge of a drug being available clearly is different from using the drug.

It is unclear from this data whether the reported availability of methadone and buprenorphine (often used as substitution drugs, available in pharmacotherapy programmes) at some sites refers to MMT or BMT programmes or whether these drugs were available at pharmacies or on the streets. In the sections below, this issue will be addressed.

Types of drugs and mode of intake

The questionnaire covered the respondent’s drug career from initiation until the time of the interview (May/June 2004), detailing mode of intake, frequency and age. The drugs mentioned were categorised in the 15 types of drugs that were distinguished elsewhere in the questionnaire. From this data, life time prevalence (LTP) and last quarter prevalence (LQP) the last three months up to the data of the interview, also referred to as active use were calculated (see Table 30).

The use of opiates is 89%. However, this data should not be taken as representative for the whole drug using population in Tehran. This is likely to have a bias towards opiate use –and injecting use for that matter.

Those respondents that had ever injected were categorised as PID (people injecting drugs). The rest were labelled “Non-PID”. It appears that near two-third (66%) of the respondent had injected drugs.

As presented earlier (see Table 30), heroin is prevalent (LTP 71%). As may become obvious from Table injecting is the most prevalent mode of heroin intake and inhaling is relative uncommon.

31 “Crucial switches” were defined as switches towards or away from injecting, or -if not applicable- switches towards or away from an opiate drug. In other words, priority was placed on switches towards or away from injecting, with a maximum of two switches described.
Graph 2: Last quarterly prevalence (LQP) of selected drugs

The following conclusions can be drawn from the data:

Concl. 22: Despite current supply reduction efforts, all kinds of traditional drugs are widely available. Consequently, harm reduction and demand reduction strategies remain important.

Concl. 23: In terms of which drugs were being currently used, opium use is the most significant, then heroine and marijuana / hash.

Concl. 24: The type of drug used appears highly dependent on local circumstances with availability being the main factor.
- Heroin and opium are the main drugs.
- The category “other” consists largely of “alcohol”, which the research team had decided to not include.

Concl. 25: Logically, life-time use (LTP) is markedly higher than current use (LQP). LTP percentages total more than 200, confirming that careers are rather flexible and fluid; switches from one drug to the other or experimenting with certain drugs for a short time are quite common. Many people have used a wide range of drugs throughout their lifetime, thus displaying a ‘willingness to try anything’.

Below, several selected conclusions are formulated based on further analysis of the data related to mode of intake of certain drugs at specific sites:

Concl. 26: Opium in Tehran (n=175) is generally smoked (75%), while 37% have eaten it and 6% mention injecting.

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32 The terms “drug of choice” or “preferred drug” are avoided here, because they imply that the drug used is the drug that the person likes best. Oftentimes, the drug used is a result of complicated decision-making processes that take into account factors such as availability, price, risk of getting caught, effects of the drug, and perceived health risks, among others.
Findings: Drug careers and environmental factors

Duration of use

On average, the respondents started using drugs 8.8 years ago (see Table 32). After factoring out age\(^{33}\), though, the picture is quite different: The respondents had been using relatively short —6.0 years (see Table ). As expected, PID had started using drugs longer ago than non-PID.

Stage of drug use

For lack of a better word, one’s *stage of drug use* refers to the extent at which one is (or is not) using drugs.\(^{34}\) Overall, two third of respondents considered themselves *active users* at the time of the interview (66%). Theoretically, these figures should be in line with the results from the *stage of drug use* that the interviewers identified (Q37), based on the profiling questions. *Recovered/recovering users* (25%) are *non-active* users which results in roughly similar proportions of *active* users (75%).\(^{35}\) Only 1% of the sample was deemed *experimental/habitual* users and 74% of the sample were excessive/dependent users.

Intensive drug use

Respondents that indicated using a certain drug *more than once a week* during the last three months were considered *intensive* PUD, (see Table 34). Logically, these percentages are lower than the LQP rates in Table 30, yet differences are not as large as one might expect: *active use* versus *intensive use* of heroin: 59% vs. 57%; brown sugar: 4% vs. 4%) and opium: 37% vs. 30%. For marijuana/hashish and the so called *party drugs*\(^{36}\), the difference between *active use* and *intensive use* is also very small: cannabis: 29%: vs. 23%, Ecstasy: 3% vs. 2% and ATS: 1% vs. 0%. This is much in line with the observation that many young people (initially) tend to take these drugs over the weekend only.

Concl. 27: Most *active users* can also be called *intensive users*, particularly those who use opiates.

\(^{33}\) Logically, the respondent’s age is a factor in the variable “years of use”. Through a regression analysis this influence can be factored out, providing a clearer picture.

\(^{34}\) Based on the *profiling* of the respondents’ drug career, the interviewers assessed —albeit somewhat rough— assessment of one’s career could be made; among the *active users*, two groups were distinguished: *experimenting/habitual* and *excessive/dependent*. The latter was then categorised in those who had had treatment and those that had not.

\(^{35}\) However, in Tehran, about 10% of the respondents considered themselves *not currently using*, whereas the interviewers rated them as *excessive / dependent* users. This difference is most likely the result of the fact that Q34 (Are you currently using?) was not specified further, leading to interpretation problems. This data describes the sample and should not be viewed as indicative for the whole drug using population.

\(^{36}\) ATS and XTC are often referred to as *party drugs*, because they are often used in discotecues or clubs.
4.b. **Initiation**

In this section, the start of one’s drug career is under investigation, including demographic data, the drug used, factors that are associated with the initiation and reactions from people in the immediate environment of the PUD. In addition, some case studies and quotes from the qualitative research tools will be presented to exemplify the conclusions.

**Age at initiation**

The questions that dealt with ‘profiling the drug careers of the respondents’ reveal that initiation to drug use tends to occur at a very young age. Overall, over one fifth of the respondents say they were younger than 16 years old when they first used their first drug (Table 35:22%). The average initiation age is 19 years old.

**Graph 3: Age at initiation (Q30)**

Concl. 28: half of people start using drugs before they reach the age of 19, and sizable proportions start before they turn 16 years old.

→ Rec. 12: Target primary intervention at a very young age group; probably 14-15 years old is the time at which the most impact can be generated.
Case Study 1: Initiation

Firstly, we went to a friend's house to drink (alcohol). Then my friend told me "do you like to buy hashish and smoke it after drinking." I told him "no problem." When he came back he had heroin with him. He said heroin after drinking is very nice. Then we drank and then he poured some heroin on foil and we smoked together. After that day, I didn't drink anymore and went towards heroin.

The first time, I dropped opium into my tea and drank it. I did that once or twice... Then, I started smoking it.

I used opium for one month while I was bedridden. After a month, my burning scars were better but I couldn't get out of bed. My legs had lots of pain. I told my husband...

When I was 20, I was a body-building athlete. My brother was an opium user. His friend persuaded me to eat a small piece of opium as a doping drug.

In my city, it is customary that the groom offer a little bit of opium at the wedding ceremony, in a separate room. I used opium for the first time there. It was so tasty. We were 7 or 8. Because it was a wedding it was not important.

**Initiation drug and mode of intake**

Table 36 lists which drug the respondents first used. The following conclusions can be drawn:

**Concl. 29:** More than 50% mention opium-based drugs as their drug of initiation and near one-third started their drug career with cannabis-based drugs (32%). High perceived availability of a certain drug (as presented in Table 29) goes hand in hand with high initiation rates for using those drugs.

*Immediate* opiate users and injectors, as the proportion of their respective total groups provide a good indication for the formulation of preventive recommendations. The larger those proportions, the more serious the need would be for primary interventions that focus on the differences in health consequences depending on the type of drug and mode of intake.

The proportion of *immediate* opiate users -respondents who mention an opiate as their first drug- as part of the total group of opiate users (n=251) is extremely high (71%).

Amongst PID -those who have ever injected (n=181)- on average 23% actually started with injecting and 77% switched towards injecting. The most commonly injected drug is heroin, which means that these people started their drug career with a combination of drugs and mode of intake that is associated with extremely severe health risks.

**Concl. 30:** Opiate use (largely heroin and opium) is extremely common (LTP=89%) and 71% of the opiate users started their drug career with an opiate. About two thirds are PID and almost a quarter of them initiated through injecting (heroin).

The high prevalence of *immediate injecting* requires urgent action at various levels.

→ **Rec. 13:** Urgently develop, improve, (tools available for) and/or scale up primary and secondary prevention interventions that stress the adverse effects of using opiates and injecting as compared with other drugs and modes of intake.
Textbox 4: The Gateway Theory revisited

An unclear picture that requires a clear distinction

The theory that softer drugs -like cannabis- act as a gateway to harder drugs -opiates-, has been a talking point for many years. Although this, and other, research shows that many people indeed start their drug use with cannabis and shift to opiates later on, the overall picture is far from clear. In Tehran, 89% had used an opiate, yet only 29% of them started with a non-opiate. In other words, many people do not “progress” to harder drugs, while considerable proportions start their drug career with an opiate.

It remains difficult to pinpoint the exact factors that determine whether people switch to opiates (or to injecting). However, factors such as legislation, law enforcement, availability of drugs, peer pressure and curiosity, appear to play an important role in this transition. The fact that one has smoked cannabis –if so– is only one of many factors, at best.

It is common knowledge that in terms of related health problems –and other adverse affects– cannabis (the most common, non-opiate, illicit drug) and heroin (the most common, opiate, illicit drug) are essentially different, especially when (heroin is) injected. The all too common practice of lumping together opiates and cannabis-based drugs in terms of legislation, education and overall discourse creates or reinforces a situation in which both types of drugs are viewed in a similar fashion, dealt with by the same people, and ultimately taken by many of the same people.

In other words, not distinguishing between types of drugs, strengthens the gateway-effect of cannabis-based drugs to opiates. Vice versa, if drug information, education, legislation and law enforcement clearly differentiated between drugs, depending on their related health risks, these drug types would also become separated in peoples’ minds as well as in practice. Furthermore, when less harmful drugs were disconnected from more harmful ones, energy and resources could be targeted better to areas where they had the greatest positive impact.

Contributing factors to initiation

What are friends for… and… I just wanted to know…

During the open interviews, peer pressure was mentioned as the main reason to start using drugs (see Quotes 3). However, a vast majority also stated other reasons associated with initiation of drug use which created an enabling environment for them to accept the offer of drugs from their peers.

The predominant reason for the choices of substance and the mode of intake appeared to be that they were offered that particular drug along with that particular mode of intake: it was what was being done at the time. Smoking an opiate were most commonly mentioned.

The vast majority of the informants stated that they were offered drugs by their friends. Very few refused the first offer and almost immediately started using. Some of the informants initiated drug use in a bid to socialize with others or while participating in social gatherings where drug use was common. The key informants and focus group discussions are in support of the finding that peer pressure is the primary factor of initiation into drug use. It was also mentioned that the company one keeps ultimately influences individuals. Acceptance by friends was also said to be a part of peer pressure.

Peer pressure was said to include the perception of a safety net within the group, applicable especially for teenagers who are trying to fit in and are searching for who they are. Finding a friend or a group of PUD increases the chances that the teenager will also become a PUD.
Findings: Drug careers and environmental factors

Quotes 3: Initiation and peer pressure

“I had no plan for the first time. My friend told me eat this and see what happens when you go to gymnasium (doping).” He then said: “I nauseated for the first time. But the second time it gave me a special condition. I became high and enjoyed it.” He also mentioned: “Eating opium gives me more high than smoking it.”

“Firstly, we went to a friends house to drink (alcohol). Then my friend told me “do you like to buy hashish to smoke it after drinking.” I told him “no problem”. Then he went to buy both and he said: “When he came back he had heroin with him. He said heroin after drinking is very nice. Then we drank and then he poured some heroin on foil and we smoked together. After that day, I didn’t drink anymore and went toward heroin!”

“… I was an athlete… I had a friend at that time. He told me if you use this (opium) it’s like doping… I ate ( a piece of opium) as small as lentil!”

“My friends persuaded me to quit drugs. They provided me liquor and told me “Come on, drink liquor! Don’t smoke heroin or hashish! They are useless.”

“ My friends rather liked me to quit drugs but were not serious. They only said some words indifferently”

“My girlfriend had an opium-user father. She broke up with me for a while after she was informed about my drug use.”

“When we were 8-9, we drank liquor. We got drunk. We lost our control. Our friends quarelled with each other. And I liked to fight with them… (alcohol) gave us pleasure. It was better than hashish and heroin…” he also said: “my non-drug using friends didn’t know my drug use. But after a while when they understood, some of them told me not to drink…but some others said it’s better than hashish. Don’t smoke hashish. Drink alcohol!”

The results of the survey are generally in line with what the qualitative findings suggested (see Table 6). The two main reasons/factors given for one’s start of drug use were peer pressure and curiosity.

Table 6:  Reasons / Factors mentioned for start of drug use (Q39)

<table>
<thead>
<tr>
<th>Reason / Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer pressure</td>
<td>34%</td>
</tr>
<tr>
<td>Curiosity</td>
<td>17%</td>
</tr>
<tr>
<td>Loneliness</td>
<td>18%</td>
</tr>
<tr>
<td>Boredom</td>
<td>11%</td>
</tr>
<tr>
<td>Fashionable</td>
<td>4%</td>
</tr>
<tr>
<td>Attraction to drug culture</td>
<td>3%</td>
</tr>
<tr>
<td>Respondents</td>
<td>280</td>
</tr>
</tbody>
</table>

Source: Q39: What are the main reasons or factors for your start of drug use? DO NOT READ THE OPTIONS (More answers possible). Only answers that scored >10% at least one site.

About two thirds of the respondents agree with the statement: the large majority of PUD is persuaded (or talked) into it by peers (60%), further confirming the importance of peer pressure in the start of drug use. (see Table 37). The statement the large majority of PUD try to persuade people around them to start using drugs finds agreement with fewer people (51%).
Other relatively important factors that did not stand out during the qualitative stages of the research include loneliness, boredom, fashionable and attraction to drug culture. Feelings of loneliness appear quite important with about 20% of the respondents mentioning this as a main factor. This could be explained as wanting to belong to a peer group, yet not succeeding. Boredom can logically be associated with curiosity and the latter two could also be part of peer pressure. During the focus group discussions, curiosity and experimenting were identified as being common factors for people initiating into drug use. While the members of families affected by drug use mentioned peer pressure, curiosity and experimenting as the main causes of initiation to drug use, service providers in some sites stated pleasure seeking as one of the main causes.

Once a friendship bond has been established, rejecting a friend’s offer becomes harder. Seeing friends using drugs can set off curiosity and yearning to try. A common perception is that drugs are trendy and the people who refuse to try are considered uncool, and subsequently marginalized.

With near two-third of the respondents agreeing with the statement: People start using drugs out of boredom or loneliness (see Table 37), these factors should be considered quite important indeed.

**Family ties…**

In the focus group discussions, a recurring theme in the role that the family plays in relation to one’s drug use was that the outcome of peer pressure situations is heavily influenced by how the parents responds to their children as “individuals”. Adequate communication between parents and child, openness and a sense of belonging are seen by many as crucial elements of a functional parent-child relationship. As may appear below, the data from the questionnaire indicate that in many cases a communication break-down between parents and children had taken place very early in one’s drug career, yet, few informants saw a clear link between broken families or the (low) social-economic status of the family and drug use.

A sizable proportion of respondents (43%) agree (on a three-point scale) with the statement a drug career usually goes hand in hand with a dysfunctional family (see Table 37). This picture was confirmed during the focus group discussions and interviews with key informants. To some extent, conflict situations at home and complete alienation between parents and children were reported.

Possibly related to familial context, personal problems (70%) and boredom or loneliness (65%) appear to be viewed as important contributing factors as well.

In quite a few cases the family members or close relatives were using drugs or drugs were being used by someone closeby constantly exposing the informants to drug use behaviour. This generated a sense of curiosity among young people and also normalized drug use.

**Free and easy…**

When investigating availability as the access one has to a particular drug at a specific time, it is clear that this is important in one’s initiation, both in terms of the fact that one started using drugs, as well as which drug to take and how to take it. Initiation tends to occur with friends in parks, neighbourhood streets, hotels, parties and campus, while most informants stated that their friends accessed the drug for them. One tends to have limited or no knowledge about (other) drugs at the time of first drug use and it seems that the fact that they didn’t need to go out and get the drug themselves greatly facilitated the initiation. Again, therefore, this availability is strongly connected to the peer group.

In terms of the effect of availability of drugs in a larger sense -the drug being for sale on the streets, parties, on campus, etc. Many participants in the focus group discussions as well as key informants argue that easy availability leads to increase of drug use. The open interview informants tended to look at availability in a micro sense and most of them rated it highly as a contributing factor.

_How did it feel?.._
At the time of their first drug use experience, the majority of the informants were unaware of the effects that the drug would have, nor had they planned on using the drug (see Quotes 4). Generally, it was a spur of the moment decision. Some had been told what to expect in quite some details. Most informants liked the effect and felt it was a positive experience, with only very few reporting an overall negative experience. In some cases, a negative physical reaction (often in the form of vomiting or otherwise feeling unwell) was ‘compensated’ by the psychological and/or social effect (acceptance, being part of the group, and therefore still ‘evaluated’ positively.

Quotes 4: Initiation: level of planning, enjoyment and regret

<table>
<thead>
<tr>
<th>Had you planned it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No, wasn’t planned, suddenly was offered, so I tried”</td>
</tr>
<tr>
<td>“Not before but when I saw my friend doing then I made up my mind that I will try it too”</td>
</tr>
<tr>
<td>“I just thought let’s try it.” / “No, there was no planning involved”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How was it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Firstly, we went to a friends house to drink (alcohol). Then my friend told me “do you like to buy hashish to smoke it after drinking.” I told him “no problem”. Then he went to buy a drink and hashish… when he came back he had heroin with him. He said heroin after drinking is very nice. Then we drank and then he poured some heroin on foil and we smoked together. After that day, I didn’t drink anymore and went toward heroin!”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you regret it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Regretful” / “At that time I felt regretful”</td>
</tr>
</tbody>
</table>

Reactions to initial use

Data from the open interviews and the survey indicate that PUD tend to turn to fellow PUD if they feel the urge to talk about their drug use or drug use related problems. Overall, more than one-third of the respondents answered fellow PUD to the question who do you talk with MOST about your drug use or drug-related problems? (see Table 38: 35%). Parents, other family members, non using friends, or (N)GOs play a minor role in this regard. The second most frequently given answer was nobody (34%).

In terms of the closest person that does not use drugs, relatives (see Table : 74%), and siblings (8%), appear to be quite important. Overall, friend/peer was ranked seventh (1%).

One question in the questionnaire tried to gauge the reactions of non-PUD in the respondents’ environment towards their own drug use, including parents, boyfriend/girlfriend/partner/spouse, friends (non-PUD), and person closest to the respondent. Interpretation of this data is somewhat problematic, because of the qualitative character of the subject, the limited number of questions and categorization of answers given. The initial as well as the current and desired reactions / behaviour of persons in the PUD’s environment are presented in a tentative format, after having been verified with the data from the open interviews (see Table 40). The sections below summarize those findings.

Closest person and parents
Overall, the closest person tended to know of the drug use and the respondents viewed that as the desired situation. The most common responses to finding out about the drug use are urging to stop, breaking relationship and/or anger. Desired positive responses, such as general positive support, love, affection, or respect, are initially rare, yet become slightly more common as time goes by.

Quotes 5: Parents’ reaction to initial use

How did your parents react?

“Well they’re parents, of course they’d get angry…”

“Don’t try to use these... don’t ever try it again…” (PID, quoting parent)

“In the beginning they didn’t know...

“...my brother hit me. They (family) took my children and threw me out of the house.”

“My brother was the first one in the family to find my drug use. He cried at first. Then a storm happened in the house... I went out of the house and used drugs 10 times more than before to become calm. I became calm!”

“My father told me “sit here beside me and smoke opium! Don’t go toward heroin!”

During this initial phase, most informants were living with their parents. Only a minority of the total group noted that they did not have a good relationship with their parents. From both the open interviews and the questionnaire, it appears that parents would often not find out for quite some time that their child had started using drugs and for many, that was the desired situation (Table 41). Almost half of the respondents answered that parents initially didn’t know of my drug use. Anger was mentioned most, followed by urged me to stop and suspicion. As above, positive responses that were often desired by the respondents were rare. The parents’ reaction did not prompt the PUD to stop. This data is reinforced by the open interviews. Informants often appeared disappointed in their parents for their lack of positive support and lack of skills to deal with the situation. Some parents appeared to not care less, while in other cases, parents would keep trying to help.

Logically, current knowledge of the respondents’ drug use is higher than initially. Anger appears to subside with time, yet prevalence of indifference and broken relationships increases. Love and affection is the kind of reaction that is most respondents mentioned as the desired response by the parents, followed by general positive support and moral support. These reactions appear negligible in the initial stages and are also rarely mentioned as the current response.

Urged me to stop and stricter were mentioned relatively often as desired responses. Another high response is broke the relationship initially and this persists to this day.

There is a very large discrepancy between the ‘received’ and ‘desired’ response from the parents. The ignorance and general lack of supportive responses among parents is indicative of less than healthy relationships between parents and their children. There were also reports of drug use in the family, including the parents.
Findings: Drug careers and environmental factors

Quotes 6: Friends’ and partners’ reaction to initial use (non-PUD)

You’d better stop...

- “My friends persuaded me to quit drugs. They provided me liquor and told me “Come on, drink liquor! Don’t smoke heroin or hashish!”
- “My girlfriend had an opium-using father. She broke up with me for a while after she was informed about my drug use.”
- “I had some friends who were not using and there was a distance creeping between us. Yes, they urged me to stop.”
- “My friends from school did not like the fact that I was smoking. They tried to get me to stop, but I didn’t listen to them. Slowly, slowly, they stopped hanging out with me. My using friends, however, would encourage me to use, as I was using with them.”

Other

- “I didn’t inform them”

Friends / peers / boyfriend / girlfriend / partner / spouse

From the open interviews, it appeared that PUD tend to hide the fact that they are using to their non-PUD friends. Upon discovery, usually the PUD is urged to stop using drugs (see Quotes 6). This is echoed by the findings from the survey: the most common initial reaction by non-PUD friends in the know was Urged me to stop, followed by didn’t know of drug use and anger (Table 42). In contrast, the two most commonly desired responses were moral support and general positive support. These PUD noted that being around non-PUD did not influence or entice them to stop using drugs; only a select few non-PUD friends eventually realized that PUD are in need of peer support to stop. Some informants were in relationships and others were single. Among those in relationships, there were some with boyfriends/girlfriends who were also using. Informants in a relationship with a non-PUD generally receive moral support to stop.

Boyfriends/girlfriends/partners tend to know of the respondents’ drug use only somewhat more than parents (Table 43). Of those that did know, a response of anger was most common. Again, the more positive responses were very rare. Reactions from non-PUD in one’s environment tend to be similar as above. Generally, people do not know for quite some time. Once they find out, their response can be characterized as anger or urged to stop. Some people are indifferent and few offer the positive support that would have been desired by the PUD.

School

Drug use in school appears uncommon. Very few of respondents said it was common or very common (see Table 44: 5%), and about one-fifth said, they used when they were in school (17%). Lecturers and teachers do not know that their students are using drugs. If teachers know about it, the PUD will possibly be expelled. Lecturers might have chosen to ignore the symptoms or are perceived as ignorant or indifferent. Many informants relate stories about drug use at work (see Quotes 7).

Concl. 31: Although most PUD are living with their parents at the time of initiation and their relationship was not considered bad, the parents usually don’t find out about drug use until much later (if at all).

Concl. 32: Those parents that do know commonly react with anger—not the reaction that is desired by the PUD.

Concl. 33: Peer pressure, loneliness and curiosity are the most important factors that drive initiation. Having friends who use drugs is an important factor during the initiation stage. Mostly, the drug is given for free by friends and taking drugs is done with some good friends during initiation, as well as afterwards.
Concl. 34: Initiation tends to be unplanned and free of cost. Generally, it is viewed as an enjoyable experience, with some people feeling regret as time passes.

Concl. 35: PUD tend to turn to fellow PUD if they feel the urge to talk about their drug use or drug use related problems. Parents, other family members, non using friends, or (N)GOs play a minor role in this regard. Many PUD, have no one to turn to.

Concl. 36: Reactions from the non-PUD in one’s environment tend to follow a similar line: generally, they do not know for quite some time and, once they find out, their response can be characterized as anger or urged to stop. Some people are indifferent and few offer the positive support that would have been desired by the PUD.

Concl. 37: Teachers and the school system are commonly viewed as being focused on knowledge and job skills only, rather than adopting an approach that fosters development of strong personalities or social skills.

→ Rec. 14: Sensitise and raise awareness amongst teachers and school administrations in order to improve primary and secondary prevention of drug use among children towards the development of an early detection, case management and referral system rather than punishment and expulsion.

→ Rec. 15: Review educational system and curriculum in a manner that emphasizes development of individual strength as well as social skills.

→ Rec. 16: Identify and make use of the positive aspects of the prevailing youth culture to develop primary and secondary prevention interventions.

Quotes 7: Drug use at the work place in Tehran

Drugs at work
"Many of the personnel used drugs at the workplace...There were lots or people who both sold drugs and smoked it." / "My employer used drugs" / "Most of my clients used drugs" (sex worker).
"My workplace was very affected (by drugs). So, if the personnel knew a worker was an addict, they didn't say anything in order to continue their own addiction."
"My boss was my friend and we used drugs together at work. Drugs were abundant at the workplace... it was very usual for us, like drinking water."

4.c. Development of drug use

Changes in frequency or quantity (without switch in drug type or mode of intake)

More than two-thirds (70%) of opioid users were injecting the drugs and 66% of drug users were PID. The majority of the respondents mentioned that after a period of two or three months of initial use of the drug, the frequency and/or quantity of drug use increased, yet overall, there is a large variety of responses (see Quotes 8). Most of the informants cited the increased need for a “high” as the reason for this development. The reasons for the “increased need” were simply because they enjoyed the high and/or due to ‘lack of satisfaction’ with the same dose.

Most of the informants were well aware of the change in this stage of development in their drug careers, as indicated by withdrawals, frequency and quantity of drug use. Some informants perceived their development of drug use with desperation and guilt in relation to the lack of control over intake and the financial costs arising from it. While some of the respondents were not aware of the change, some of the other mentioned answers reflected a “don’t care” attitude.
Findings: Drug careers and environmental factors

Quotes 8: Development of drug use (part 1)

<table>
<thead>
<tr>
<th>How fast did your drug use develop?</th>
<th>(from rapidly to slowly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I enjoyed the high, I wanted more and more.”</td>
<td></td>
</tr>
<tr>
<td>“After one month my frequency and quantity increased to about 1 gm a day and I was using about 4 times every 24 hours.”</td>
<td></td>
</tr>
<tr>
<td>“At first, I could smoke a little bit of opium and go to work swiftly. Sometimes it gave me the strength to work until two am! But my opium use increased gradually after two to three months. After five to six months realized I was addicted. My mental condition worsened. My family found out…”</td>
<td></td>
</tr>
<tr>
<td>“It increased as the high got less”</td>
<td></td>
</tr>
<tr>
<td>“Within one year my opium use was on the rise and I needed more and more on a regular basis.”</td>
<td></td>
</tr>
</tbody>
</table>

Crucial switches

For health promotion policy purposes, switches towards and away from injecting as well as switches towards or away from an opiate are of great importance. Here, switches towards an opiate or injecting are considered negative switches and switches away from opiates or injecting are considered positive switches. The interviewers were instructed to identify the two most crucial switches during the conduct of the questionnaire and then to ask further questions about them. The percentages in Table 7 represent the proportions (of the total group) that undertook the described switches, with certain switches being counted twice.37

On the whole, 26% switched towards an opiate and 50% of the respondents switched towards injecting at some stage in one’s career. The vast majority of respondents agreed with the statement -the large majority of PUD uses soft drugs before switching to harder drugs.

Expectedly, the occurrence of positive switches is low, compared to negative counterparts, yet maybe not as low as one might have expected. It appears that very few PID make the -HIV/AIDS preventive- switch away from injecting (1%).

Three quarters of the respondents do make such crucial switches (Table 7: 73%). As appears throughout this report, drug careers of young people tend to be rather dynamic and flexible. Shifts from one drug to another as well as from one mode of intake to the other occur regularly and sometimes very quickly.

---

37 Someone, who switched from smoking heroin to injecting non-opiate pharmaceuticals is included in both the above percentages. If a respondent then switched back to smoking heroin, the two crucial switches were counted four times.
Young people and drugs – Towards a comprehensive health promotion policy

Table 7: Crucial switches (Q31)

<table>
<thead>
<tr>
<th>Type of switch</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never injected</td>
<td>36%</td>
</tr>
<tr>
<td>Started with injecting</td>
<td>15%</td>
</tr>
<tr>
<td>Switched towards injecting</td>
<td>50%</td>
</tr>
<tr>
<td>Switched away from injecting</td>
<td>1%</td>
</tr>
<tr>
<td>Never used opiate</td>
<td>11%</td>
</tr>
<tr>
<td>Started with opiate</td>
<td>63%</td>
</tr>
<tr>
<td>Switched towards opiate</td>
<td>26%</td>
</tr>
<tr>
<td>Switched away from opiate</td>
<td>5%</td>
</tr>
<tr>
<td>Made ‘crucial’ switch</td>
<td>73%</td>
</tr>
</tbody>
</table>

Respondents: 281

Source: Q30: Column A: Which drugs have you ever used? WRITE DOWN IN CHRONOLOGICAL ORDER. Write down local names if in doubt. Back to main text

In terms of how or where the crucial switches took place, there appear to be few differences with initiation. The main difference is that often, these switches appear to be planned and preparations were made to facilitate them. To some extent, this is inherent to the nature of most of the switches; injecting equipment needs to be acquired and, in some cases, the new drug needs to be purchased from a different source.

When asked, “Was it a clear or a gradual switch?” (Q31), about two-third of the respondents indicate that the first switch was a clear switch (Table 45: 63%), compared to 76% for the second crucial switch (76%). In other words, the switches often occur over a period of time rather than from one day to the next, during which both (or several) types of drugs or modes of intake are used.38

It appears that those who switch to injecting tend to do so after having used drugs through other modes of intake for a considerable length of time (See Graph 4).

Table 46 indicates that, more than 40% of the respondents switched to injecting after having used other modes of intake for more than five years.

Graph 4: Period until switch towards injecting

38 The terms clear and gradual were not defined and no further questions were asked on this matter, so the data should be viewed in a tentative manner.
Quotes 9: Development of drug use (part 2)

Were you aware of these changes? How did you feel about it?

“I started to realize the increase in my dose when I had to use them too frequently and I was really aware of the changes to a great extent.”

“What else could I do? I was aware of the fact that my drug use had become worse and my health as well. I never thought of it from the addiction angle. I justified it by blaming others.”

“I didn’t really care, it didn’t bother me. I just kept thinking about the high, nothing else.”

“Someone who uses heroin, is like a person who is going up stairs. Heroin goes up step by step, you don’t like to go up at all, you like to stay at that step. But… heroin is in such a way, as if, it comes toward you and you go toward it.”

“My use developed primarily because of easy availability, due to my friend, opium was always available and for the pills I would reach the nearest chemist.”

Injecting opiates

Given the related health effects of both injecting and opiate use, their relationship is studied in greater detail in the section below.

- The vast majority of PID who initiated drug use by injecting, injected opiates.
- Of those people who never used an opiate, few had ever injected. In other words, those people who stay away from opiates are very likely to stay away from injecting as well.
- Only very small percent of PID had never used an opiate. This, together with the two conclusions above, justifies the conclusion that opiate use acts as a gateway to injecting use.

Case Study 2: Some switches

Withdrawal and a friend on hand...

“Once I was arrested for three days. When I was released, I had no money because they didn’t give anything to us in jail. I used the money for food and so... I saw a friend and told him “I’m in withdrawal, I’m dying... He said “I inject drugs, if you like come along...it gives the same euphoria as smoking...” I had never heard of injecting drugs. I followed him even though I was in bad shape. We went to a dark, deserted area. He brought a spoon, poured something in it, later I found out it was citric acid,... then he boiled heroin... filled two syringes which we had bought on the way. He lifted my arm and said “what good vessels you have! They are main pipes!”... Immediately after injection, I fainted... he told me later that he injected citric acid for me and I came back... The euphoria of injection was twice the first euphoria of heroine smoking. I realized it was very tasty. It was very easy and didn’t need complicated preparations... After three times of injecting heroin, I felt regrets. I wanted to return to smoking, but I realized that smoking didn’t fit any more.”

“It was 1999 or 2000 when opium disappeared all of a sudden. There was no opium for a year... I searched the entire city with my car but I couldn’t find opium. I was in withdrawal. All of my body was wet... They said they didn’t have opium, only white. I told them “what’s white?” He said “It’s heroin”. I called one of my friends. I told him I’m dying of withdrawal. My friend came and told me to use one, two or three puffs of heroin to get rid of withdrawal. Then we went to a drug dealer in neighborhood who sold opium up to the night before but now he was selling heroin.”

Concl. 38: Drug careers of young people tend to be dynamic and changeable. Shifts from one drug to the other as well as from one mode of intake to the other occur regularly and sometimes very quickly.

Concl. 39: More than 40% of the respondents switched to injecting after having used other modes of intake for more than five years.
Concl. 40: Only a small numbers of PID had never used an opiate. In other words, opiate use can be seen a gateway to injecting use.

→ Rec. 17: Effectively target the period between the onset of drug use and switching to injecting (if at all) for secondary prevention and harm reduction interventions.
**Contributing factors**

The open interviews revealed that the problematic character of the first drug or mode of intake were not considered a reason for switches to opiates or injecting (see Quotes 10). Rather, dissatisfaction, being bored with the former drug or mode of intake or looking for new sensations were often mentioned as a main reason. Availability and financial reasons also feature often: with increasing dosages and related expenses, the switch to injecting was made in an effort to save money, while experiencing similar effects. There is also a preference for a certain kind of drug over others because of the better taste.

Most of the informants said that the new drug was easily available to them. Being already familiar with the network helped; it would be easy to get the required drugs anytime. Some said that this easy access kept them to continue use it, while others said it was more because of their friends’ offer. If at any time, availability was problematic in one particular place then there would still be drugs available in other places.

These findings are echoed by the findings from the survey. Question 32 assessed the importance of 22 suggested factors with answer options: not at all, somewhat, and very much (a factor in Switch 1, respectively Switch 2). Strength of current/new drug (get high quicker), easier availability of current/new drug, relaxation/sleep, peer pressure, curiosity, and bored with previous high were suggested as most important factors for crucial switches towards injecting and/or opiate.

Generally, the same factors were rated as very important, regardless whether it concerned a switch towards or away from an opiate or a switch towards or away from injecting. In negative switches, the strength or effect of the new drug or new mode of intake was the most often mentioned factor. Also, again, factors such as peer pressure and curiosity scored high. There were however some (logical) differences: for example, the factor getting high quicker was of little importance in a switch away from injecting, whereas scared of diseases and thrombosis of the veins gained in importance for such switches. An important factor was the easier availability of the new drug; rated by more than half of the respondents in switches towards injecting and away from an opiate as very important.

Table 47 lists those factors that were deemed very much a factor in switch 2 (the respondents’ second crucial switch, often a switch towards injecting) for a total of 86 respondents.

**Quotes 10: Crucial switches; crucial factors…**

<table>
<thead>
<tr>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effect / Boredom / Fed up / Curiosity</strong></td>
</tr>
<tr>
<td>“By injection the effect is immediate”</td>
</tr>
<tr>
<td>“Starting heroin was not because of curiosity, it happened in such a way that it came to me automatically. I don’t know how it happened. I had heard that you could quit heroin much easier, in three days. So, I told myself it's better to be on heroin for a while. I did so because I thought opium withdrawal was worse to tolerate.”</td>
</tr>
<tr>
<td><strong>Availability / Financial considerations</strong></td>
</tr>
<tr>
<td>“Opium became expensive and I bought heroin, I found it better, it made me high more.”</td>
</tr>
<tr>
<td>“Well, because dosage is increasing, of course much money is needed.”</td>
</tr>
<tr>
<td>“Easy” / “At that time, it was easy, the supply was abundant” / “It was so easy”</td>
</tr>
<tr>
<td>“It’s easy, so keep using it” / “It’s so... so... so easy.” / “It used to be easy...”</td>
</tr>
<tr>
<td>“It affects me, if it’s hard to find, I can’t do anything”</td>
</tr>
<tr>
<td>“…it was easy in 1999-2000, all I needed to do was walk a bit”</td>
</tr>
<tr>
<td>“Of course there’s an effect if the goods aren’t available, same goes if there’s no money”</td>
</tr>
<tr>
<td>“Not so hard, there’s always some, if there’s none in this hole we’d definitely check out other holes cause they’re users over that way”</td>
</tr>
<tr>
<td>“After nine months when Moharam and Safar months (holy Islamic months) were coming and so I couldn’t drink, I started to use opium.”</td>
</tr>
</tbody>
</table>

**Development of drug use and the immediate environment**
Many people did not see any reaction from people in relation to their increased drug use as they had already isolated themselves. The alienation process (see Section 6.e) -parallel to increasing use and/or switching to injecting- had already taken shape. With increasing use, PUD and non-PUD - whether parents, schoolmates, colleagues, or neighbours- seem to become different, irreconcilable entities that mutually exclude each other. While the PUD might feel the wish or need to be accepted, there is also a tendency to reject the mainstream non-PUD. While parents or friends might still love or like the PUD, her/his behaviour is rejected. The more drug use becomes a lifestyle, the more incompatible normal relationships with non-PUD seem to become.

With drug use increasingly taking a central place in one’s life, non-PUD become excluded and rejected by PUD. Also, from a societal perspective, with the development of drug dependency, PUD are in turn marginalized for their unacceptable behaviour. Clearly, these processes take place gradually and often there are periods of reversal or recovery. Nevertheless, key moments in terms of these processes seem to include getting caught while using, switching to injecting, financial problems and related borrowing and theft.

Quotes 11: Crucial switches; some comments

Where? / How?

"It was planned, together with friends"
"They bought it and I went with them" / "Everything was there, I didn’t do anything"
"I bought two syringes. We (my mother and I) boiled heroin together. Our syringes were apart but our spoon was the same, I know today that (sharing) spoon causes disease. If I had known at that time I would have bought two spoons..., my younger brothers and sisters were watching us..."

How was it?

"I can’t describe how good it was so I can’t really explain the effects or taste, it was good"
"I didn’t like it at first" / "it was the most terrible experience."

Family

Very few said that other family members or close relatives urged them to discontinue or reduce their drug use. However, those requests made no impact on PUD in almost all cases. Again, many parents were ignorant of their child’s drug use or change thereof, yet - compared to the time of initiation of drugs- more informants told their parents/family members about their switch (see Quotes 12). The reactions of those parents that knew of their child’s change in drug use were very similar to those described under the section on initiation to drug use. Many informants pointed out that -in case of switches towards injecting or towards heroin- the parents were best to be kept in the dark.

The mother is usually the closest person in the family to the PUD, followed by sisters and/or brothers. Often, parents did not realize that their children were using drugs. Some parents were shocked to find out, while others gave punishment or only advise. Parents usually requested that drug use stop or simply sent their sons and daughters to rehabilitation centres. Sometimes, older brothers were also using. They often kept urging them to stop without success.

Quotes 12: Crucial switches; how about the parents?
Family reactions were harsh in quite a few cases and episodes of violence were reported by the informants. In other cases, support was offered by the family members. In a few cases the parents or family members were accommodative for use of softer (previous) drugs, used before a switch to heroin.

In general, the effect of the parents’ reaction was negative and was not effective in terms of increased efforts to undo the switch or to curtail consumption. By the time of the second crucial switch, many respondents had become fully integrated into drug use [and people around them just did not bother to interfere anymore, coupled with the fact that they started associating only with PUD.

**Peers**

The most common triggering factor influencing a switch towards injecting and/or opiates for informants was peer influence; a friend would offer a different type of drug or they saw a friend using a different type of drug or a friend would tell them about the experience of using a certain type of drug. This in turn created curiosity and desire to try, reported informants (Error! Reference source not found.). Those informants that had good non-PUD friends at the time of their switch said that they generally offered no support except urging them to stop using drugs or revert back to softer drugs. Most of the informants did not in any way consider their non-PUD peers as an important factor which had influenced their drug use switch.

Concl. 41: In crucial switches, factors related to the (perceived) effect of the drug are considered very important. For example, the strength (quicker high) of the new drug scores very high, as well as factors such as relaxation/sleep, suppression of feelings, bored with previous high and to enhance confidence. Expectedly, since injecting creates a quicker high, the strength of the new high is of little importance in switches away from injecting.

Concl. 42: Social factors appear quite important, with peer pressure being a major one. Factors such as curiosity, fashionable and to be different also are rated highly. Enhance performance at work/school (work, for most respondents) appears significant. Attraction to drug culture is relatively important.

Concl. 43: Parallel to increasing use and/or switches towards injecting, a process of alienation from mainstream develops: non-PUD slide to the background as fellow-PUD gradually become all important and ever present.

Concl. 44: Factors related to price and availability appear rather important with easier availability of the new drug rated very much a factor. Lack of availability is associated with a switch towards a more effective mode of intake -usually injecting- to counteract the lack of availability or higher price.\(^\text{39}\) Health related factors seem only of importance in the switches away from injecting.

\(^{39}\) Indeed, 85% of those who rated this factor highly switched towards injecting
Rec. 18: Develop preventive interventions that take into account the influence of social factors which appear to contribute significantly in the decision to switch towards injecting.

Rec. 19: Take into account the effects that (current or planned) legislation or law enforcement might have on the availability of a certain drug, particularly if changes in availability are likely to adversely affect health behaviour.

Poly-drug use

This section attempts to explore the reasons for the use of more than one drug and its related problems and effects, based on data from the open interviews only. About 15-25% of the informants reported using several drugs at a time. The reasons given for poly-drug use were mainly to enhance pleasure/intoxication, the desire to try other types of drugs and also to find other sensations. Some started using other drugs to reach the same high as previously experienced (yet disappearing because of increasing tolerance).

Concl. 45: Poly-drug use is quite common and takes many different forms.

Overdose

The open interviews indicated that almost half of the informants had gone through episodes of overdose during their drug careers and most of those experienced it once or twice. Having excessive amounts of money to purchase drugs came up as one circumstance that led to the overdose. In many cases, fellow PUD helped the informants at the time of overdose while in few cases family or friends took care of them. In most of the cases, the informants were not taken to the hospital and care was provided on the spot. Oftentimes, carers did not know what to do and in some cases they panicked. It was mentioned that fellow PUD tended to not show surprise or sadness at someone OD-ing.

In most of the cases, heroin was the drug involved in overdose and many cases occurred after injecting drug use. Some indicated that their overdose experience resulted in consuming less quantity to avoid future overdoses.

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40 From the open interviews, it appeared that ‘overdose’ is quite well defined amongst most PUD: an occasion that drug use leads to -immediate- adverse health effects, assumedly as a result of having taken too much of the drug(s). During the questionnaire, that definition was provided -yet, only when asked.
Table 8: Frequency of overdose (n=279) (Q52)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>68%</td>
</tr>
<tr>
<td>Once</td>
<td>13%</td>
</tr>
<tr>
<td>Twice</td>
<td>7%</td>
</tr>
<tr>
<td>Three times</td>
<td>7%</td>
</tr>
<tr>
<td>4-10 times</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;10 times</td>
<td>3%</td>
</tr>
<tr>
<td>N/A</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Q52: Have you ever experienced an OD? If so, how often? (One answer only). If “No, never”, go to Q55

The survey provides similar data. On average, nearly one-third of the respondents had experienced overdose (33%). PID had more overdose experiences, compared to non PID. Six percent said they had had more than three OD experiences.

When comparing this data with the occurrence of overdose in one’s immediate environment (65%), it appears that one third of the respondents stating that no one in their immediate environment has experienced an overdose. In general though, near two thirds of the respondents have knowledge of overdose occasions around them. There appears to be no statistical correlation between such knowledge and personal experience of overdose.

The proportion of respondents that stated that the overdose was somewhat or totally intended (see Table 48) can be considered very high (49%). During the open interviews this aspect of overdose was not elaborated upon.

**Quotes 13: Overdose**

**What drugs were you using?**

“My friend offered me to inject heroin… this bastard injected in such a way that I saw my death… I stood up… syringe dropped… my arm was bleeding… I was dizzy. I fell several times. Another friend helped me… I wanted to go out of this situation. To become normal again… I heard my pounding heart beat. My face and hair were wet because of the sweat. My friend poured a bucket of water on me… I was insulting everybody including my mother…”

“…It was morning, my husband said “…go and get drugs.” I told him “24 hours a day I should go and get drugs. Once you, man, go!” I can’t go.” I insisted, so went to get drugs but he never came back… I thought maybe he is arrested… but then I was informed that he had injected drugs in the park and had passed away.”

“Twice I have overdosed… When we used poor quality drugs that didn’t make us high. We bought once again and injected it. We thought it was poor quality like the previous one, so we injected a lot. Actually it was good quality, which made us overdose.”

**Who looked after you?**

“Friends” / “My parents”

**What did they do?**

“Someone took me to the side of the park and took care of me…”

“One fellow PUD helped me by throwing water on my face”

“I saw a PUD OD and informed others and then we called an ambulance”

**Any effect?**

“No effects… continued using as before ” / “Nothing, as always” / “Nothing at all”
Two common answers to the question (Q54: who looked after you when you OD’d?) was friends (PUD) or no one (Table 49: each 32%). Some respondents were looked after by their Partner / Spouse (8%) or parents (6%) and a few by non-PUD friends (5%) or others. A relatively high proportion was treated by a doctor (7%).

Amongst the open interview informants, exposure to overdoses (rather than experiencing it firsthand) tended to result in decreased and more careful use among PUD. Yet none of them mentioned that these episodes triggered their decision to quit drugs or switch to a less harmful drug or mode of intake.

Most of respondents said that overdose experiences -personal or by people around them- had no effect on one’s attitude towards drug use (see Table 50: 72%). Six percent stated that they became more careful and an average of 15% decreased their drug use. Overdose rarely resulted in going to treatment or in switches in drugs type or mode of intake.

Concl. 46: Overall, one third of respondents have experienced one or more cases of overdose, 33% and with higher rates among PID. In terms of overdose in one’s immediate environment, the rate was 65%. In other words, most PUD know of overdose cases around them and about one third have experienced overdoses themselves.

Concl. 47: Roughly half of the respondents indicate that they somewhat or totally intended to overdose.

Concl. 48: The PUD often has to deal with the overdose her/himself. In other cases, drug using friends are commonly the people who look after the person who experiences an overdose. Parents and non-drug-using friends appear to be of little significance in this respect. Very few are looked after by professionals and carers often do not know what to do in case of overdose.

Concl. 49: Overdose seems to act as a warning signal to many PUD, yet rarely leads to initiation of treatment or change of drug or mode of intake.

Rec. 20: Develop and improve IEC –possibly in the form of a manual– and awareness rising on overdose response among PUD and parents. IEC/ABC materials on drugs should be non-judgmental and enable young people making well informed choices. While an emphasis may be on primary prevention, secondary prevention and harm reduction should be incorporated.

Rec. 21: Include early detection of self-destructive or suicidal behaviour in counselling and treatment services.

Rec. 22: Consider the provision of services available to PUD that test the quality and safety of drugs before intake.

4.d. Efforts to reduce drug use: treatment and relapse

In this section, the actions that one takes to stop or reduce one’s drug intake are investigated in chronological order. The first section deals with how people view abstinence. This is followed by a section on efforts that PUD undertake to reduce their intake without outside help. Then, treatment by GOs and NGOs is studied in terms of availability, access, quality and improvement. Finally, relapse and abstinence as the result of such treatment, receives attention. Throughout the section, factors that influence decisions in these areas are covered.

Perceptions on abstinence
The majority of the FGD informants agreed with the statement that *once you're an addict you'll always be an addict*. At one period in time, one can stop using drugs but relapse rates are high. Other informants suggest that drug dependent people may recover at some point. Key informants for the most part acknowledge that drug dependent people have a hard time when it comes to putting a stop to drug use. However, some suggest that quitting is possible as long as there is individual commitment, supported by a conducive environment.

During the open interviews, PUD appeared divided on the issue of abstinence and de-addiction. Some said, they would be able to, *if they really wanted*, while others were not so confident. PUD largely agreed that the craving would always be there, even though they might have stopped using.

The questionnaire contained several statements that were aimed at gauging attitudes or perceptions of drugs and drug use. Most PUD apparently *wish to quit, but find themselves unable to do so* (65%). Paradoxically, a similar proportion amongst PID (not PUD in general) estimates that they can *stop injecting completely if I set my mind to it* (87%). In other words, many PUD appear confused or are in a state of denial regarding the addictive properties of the drug they are using or regarding their own dependency on these drugs.

### Quotes 14: Abstinence

#### Will you be able to abstain completely?

“No (not difficult), once there’s commitment to quit, nothing else will happen” (key informant)

“I agree; once an addict always an addict…” (counselor)

“Cannot (abstain)”

#### Have you ever tried to abstain by yourself?

“I entered the job market with my addiction. I realized I couldn’t continue. I decreased my consumption little by little. I told myself that it’s better to make sure I look better at least. Whenever I worked a little bit, I could eat more and get better. But I didn’t have a place (for quitting drugs), a place where you can go for 10-15 days and recover your health then return to work. So, most of the time when I decided to quit drugs I was unsuccessful. I even lowered my addiction to a half of gram a day but then it rose again.”

“once or twice I told my family that I wanted to quit at home… I was at home for a week. Afterwards, I went out to buy a cigarette. When I returned home they looked at me in a bad way. Their attitude was bad. I swore I have not used drugs… but they told me your eyes show you have used drugs… I told them “you don’t believe me, ok, I go and use drugs…”

The optimism on being able to abstain from drug use is echoed by other results from the questionnaire (Table 51): the vast majority of active PUD, responded *yes, possibly or yes, definitely* to the question; *what are the chances of you ever being able to stop using drugs?* among both non-PID and PID (92% and 87%).

Whether it was essential to *move away and stay away* from drugs when one tries to stop using, there is widespread support for the above statement (74%).

In conclusion, the goal of abstinence remains a contentious issue amongst PUD as well as those who work with PUD.

### Concl. 50: Most PUD wish to quit, yet find themselves unable to do so. Meanwhile, they tend to be optimistic about their ability to stop using.

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41 Q29: To what extent do you agree with the following statements? (GO THROUGH LIST ONE BY ONE), 3 point-scale: Disagree - Somewhat agree - Agree
Rec. 23: Improve awareness and knowledge levels amongst PUD on the addictive properties of drugs, the actual workings thereof, as well as the (different) potential related risks.

Self treatment

The occurrence of efforts to reduce drug intake without outside help differ significantly with more than 27% (see Table 52: 27%). Clearly, large groups of PUD have no or little urge to stop or are very pessimistic about the chance of success. On the other hand, overall, most PUD go through periods that they try to reduce their intake or abstain.

As expected, self-treatment efforts are somewhat less common amongst experimental users as compared to excessive/dependent users, and less than one-third of those who were considered recovered/recovering\(^{42}\) say they never tried to reduce intake themselves (before they went into treatment).

“I tried to give up drugs on my own and was successful for one year as I had moved out of city but as soon as I came back to my own city, I straightaway started using again...”

Those respondents that try to reduce their intake tend to do so by avoiding those situations and people that they associate with drug use (see Table 53). Occupy oneself (43%), avoid drug using friends (22%), avoid going to certain places (15%) were often mentioned. In addition, pursue hobbies (9%), move (10%) and spiritual / religious focus (3%) were also mentioned as possible strategies. The shift to alcohol - mentioned by about 9% - is quite different in nature from the other behaviours and calls for further research.

When asked: who should be / have been involved to help you to stop? (Q44), the parents are mentioned most often (see Table 54: 50%). Siblings come in second. Non-PUD friends, partner/spouse, and relatives are also mentioned by some.

Concl. 51: Most PUD go through periods during which they try to reduce their intake or abstain.

Concl. 52: PUD identify their parents (and to a lesser extent non-PUD friends and partners) as the people who should be involved in such efforts.

Concl. 53: In efforts to reduce one’s intake, PUD largely avoid those situations and people that they associate with drug use.

Rec. 24: Maintain contact with PUD to gauge and exploit periods of readiness and willingness to reduce intake or abstain. Develop mechanisms to recognise increased motivation to reduce one’s intake and link such with referral to treatment interventions.

Rec. 25: Mobilize and involve parents and other family members as early as possible in primary and secondary prevention, including during and after treatment, follow up and after care.

Rec. 26: Develop treatment interventions that take into consideration that a prolonged stay away from situations and people associated with drug use might well be crucial for success.

Treatment by GOs and NGOs

The questionnaire reveals that 43% of the respondents had been at in treatment-commonly detoxification, followed by residential rehabilitation (see Table 55). The percentage of respondents

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\(^{42}\) The term “Recovered / Recovering” is used for those people who hadn’t been using drugs for the last three months.
Findings: Drug careers and environmental factors

treated is likely to be partly attributable to the respondents recruitment mechanisms. For this reason, these figures should be viewed as descriptive of the sample, rather than the whole drug using population. Interestingly, majority (90%) of those PUD with treatment experience had undergone more than one treatment.

Also, in terms of perceived availability of drug related services, in the sections below, findings are summarised (see Table 56). Since certain services target PID only, the results on knowledge of availability are given for non-PID and PID separately. Again, for the same reason as above, these findings should be treated with care.

Knowledge levels of available services are very low. Even the reportedly widely available services (hospital/medical services and detoxification centres) appear to be unknown to the large majority of PUD and surprisingly even more so among PID. Overall, use of drug-related services appears very low (see Table 57), whereas the large majority of respondents reported severe drug-related problems. A large number of PUD appear to go through life without ever accessing any drug-related services.

Concl. 54: Use of drug-related services - and particularly treatment services - is low. Most PUD are never treated for their drug use. However, those that do enroll in treatment tend to do so repeatedly.

Quotes 15: Reasons for going into treatment

<table>
<thead>
<tr>
<th>What made you decide to go into treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-motivation / Tired / Bored / Fed up</strong></td>
</tr>
<tr>
<td>“I felt bored then / “I was tired and wanted to quit”</td>
</tr>
<tr>
<td>“After using for years I was just fed up with the habit.”</td>
</tr>
<tr>
<td>“I also felt really ashamed and regretful towards society, all my relatives and family members had lost respect and trust in me. I wanted to regain their trust and respect.”</td>
</tr>
<tr>
<td>“I wanted to give up drugs; I did not want to be drug dependent anymore.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Parents / Family</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“I had treatment after I was caught. I was high at that time at home. That’s when my parents asked me to enroll in treatment. I obeyed, because my mother cried; i can’t stand to see her crying.”</td>
</tr>
<tr>
<td>“My parents really wanted me to seek treatment and, to a very large extent, even I felt that I needed help.”</td>
</tr>
<tr>
<td>“My parents found out.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Because my health had gone down and as a result my financial situation got worse.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“I was arrested because of theft and I was made to quit in the youth correctional centre.”</td>
</tr>
<tr>
<td>“I was told that if I didn’t want my son to be fatherless I should quit because after my son was born my wife petitioned for divorce.”</td>
</tr>
<tr>
<td>“I didn’t enrol into treatment myself... because I saw some people who went to doctors several times and started drug use again... they only wasted their money...”</td>
</tr>
</tbody>
</table>

What made you decide to go into treatment?

From the open interviews, it appeared most went into treatment after having used for several years, mostly after using heroin. The first conclusion that the data evokes is that no story is the same and that any generalization will be countered by many examples to the contrary. In many cases, PUD were ready to go into treatment, in the sense that they made the decision themselves and they were tired of life of drug-dependency. Parents often were instrumental, either as the instigator or as the main reason for going. Health problems are often cited as the main concern (see Quotes ).
A variety of reasons were stated, including pressure from family and relatives as well as the pressure from the employer, reduced social relations and depression, health, fatigue, being fed up of using drugs, job issues, fear of being arrested and imprisoned, encouragement of friends, wishing a good and safe life, marriage, obligation in prison, ruined life and regret. Nearly half of the informants had made the decision to be treated themselves. Others had been referred by brothers, mothers, friends, employers, or had been forced to quit in Youth Correctional Centre or prison. Most had never rejected a treatment offer.

Quotes 16: Who was behind it?

<table>
<thead>
<tr>
<th>Was anyone in particular behind the decision?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parents</strong></td>
</tr>
<tr>
<td>“She (mother) wants me to be fine”</td>
</tr>
<tr>
<td>“Her response is good; she’s glad his son is getting different and begins to get along the program”</td>
</tr>
<tr>
<td><strong>Peers</strong></td>
</tr>
<tr>
<td>“By my brother, he informed me”</td>
</tr>
<tr>
<td>“From my friends”</td>
</tr>
<tr>
<td><strong>Myself</strong></td>
</tr>
<tr>
<td>“I myself want to recover”</td>
</tr>
<tr>
<td>“I wanted to stop, I am tired, I want to live as a normal one”</td>
</tr>
<tr>
<td>“Just try, I wish it will succeed”</td>
</tr>
<tr>
<td>“I want to be cured”</td>
</tr>
<tr>
<td>“I’d planned it…”</td>
</tr>
<tr>
<td>“Certainly you will not go into treatment if you don’t want to”</td>
</tr>
<tr>
<td>“I was fully prepared this time and decided to quit it completely (last treatment)”</td>
</tr>
</tbody>
</table>

In most cases, family members - particularly parents - influenced the decision to enrol into treatment. Those living on the streets were approached by service providers and decided themselves to enrol into drug treatment. However, availability of free drug treatment was a motivational force behind informants’ decisions. Some of the informants mentioned not having been ready for drug treatment earlier but gave in, due to pressure from family, being fed up of drug use or deteriorating health. As may be clear from Quotes, peers also played a role in many cases, yet others stress one’s inner motivation in the decision process.

Concl. 55: Parents are the main driving force behind enrolling into treatment with peers playing an important role in some cases. Some PUD go into treatment when they are ‘not ready’ for it.

Concl. 56: A main reason for going into treatment is boredom or being fed up with drug use (or its related problems), often leading to a willingness to abstain.

→ Rec. 27: Review treatment intake procedures to ensure that people that go into treatment are psychologically ready to do so.

Constraints to access or complete available drug use related services

From the questionnaire, the constraints to accessibility of drug-related services most often mentioned by informants include no knowledge of services at 58% and lack of available services at 51% (see Table 58). This data is very much in line with the results that were presented at the beginning of this section, where knowledge levels on the existence of these services appeared to be rather low.
The questionnaire also points towards *price* as a major constraint (24%). Commonly, though, the parents take care of the finances which tends to lead to a situation wherein private treatment centres are largely used by people from richer family backgrounds.

**Quotes 17: Constraints to access or complete available services**

**What are constraints to access or complete available services?**

- **It’s all about the money.**
  - “If you have money, you buy drugs”.
  - “It was a financial problem” / “It’s very expensive”.
  - “The range is from expensive to cheap”.
  - “Expensive, whereas PID can’t afford that” (key informant).
  - “The number of health services is increasing. The weakness is a matter of high prices” (key informant).
  - “Right now the rehabilitation services can only be reached by those who are rich” (key informant).

- **Other**
  - “It’s difficult to access” (counsellor, officer).
  - “At this moment many kinds of services are available…and each one has its own place and approach, so the PUD can chose which one is suitable for himself” (key informant).

For many PUD, the duration of treatment constitutes an important obstacle. This can be seen as an underestimation of the severity of their ‘condition’ (21%). Relative to the time it usually takes to become a ‘dependent user’, treatment periods tend to be extremely short. Indeed, many service providers would rather argue for an increase in the duration of treatment programmes. One related aspect, is the fact that those PUD that are at the main breadwinner for their family can often not afford to stay in residential treatment for any length of time, regardless whether the treatment itself is offered for free or not.

Other constraints mentioned quite often relate to the stigma that is attached to going into treatment. There, *fear of exposing addiction* and *discrimination/stigma* are mentioned by 10-20%. From the open interviews, it appears that PUD friends mostly know of the PUD going into treatment, yet other people in one’s environment are often not told.

The key informants and participants in the FGD point toward several shortcomings of the available treatment services common amongst the sites. Many comments relate to the need for expansion, coordination, aftercare and follow up. Other areas of concern are legislative framework and the lack of support groups. Expenses seem to be a major concern and there are doubts among the informants about the efficacy of many of the available services.

**The services**

This section summarizes the comments from interviews with key informants and focus group discussions on the available services. Although emphasis differs per site, the pictures that arise are remarkably similar. Main concerns include:

- Insufficient (residential) treatment services;
- Insufficient coordination and networking between services and between NGOs and GOs;
- High expenses to avail treatment (particularly private treatment facilities);
- Underfunded treatment centres (particularly in the NGO sector);
- Large differences in quality of treatment offered; bad reputation of certain treatment centres;
- Stigma attached to going into treatment;
- Insufficient low-threshold services;
- Insufficient treatment facilities that target or admit female PUD;
- Insufficiently client-centred treatment, inflexibility, and maltreatment of clients;
- Insufficient attention to social and economic circumstances in treatment;
- Insufficient after care; and
Insufficient involvement of parents or relatives

In relation to current treatment efforts, by and large, the key informants felt that efforts are “poor” or “inadequate” or “unsatisfactory” or “need improvement”. Many significant points were mentioned, one of which was that there is a huge disparity in terms of demand and supply: the number of beds being available versus the number of PUD seeking treatment. For an individual from a low socio-economic background, there are few centres that can be accessed which are free or that are affordable, and these “few” centres are always full.

Some of the key informants mentioned that the quality of treatment services is poor. The non-government centres are often not adequately funded, staff are underpaid and often lack training and guidance, which results in low motivation and lack of interest and frustration, which in turn has a negative effect on the clients. Lack of comprehensive services was another factor that was mentioned. Some key informants felt that centres provide only detoxification and they think, “It is enough”. Most informants praised the treatment facilities run by (non-profit) NGOs which were providing free of cost drug treatment and they remember their stay in the treatment facilities as being pleasant. Generally, people were happy with the role of their families and friends (non-PUD) during treatment. There is a lack of awareness among the general population in terms of where and how to access services that are related to drug dependence. The government hospitals are sometimes viewed as not well equipped” or “totally warped in their style of treatment”.

Quotes 18: The services…

What was the treatment like?

“Yes, starting to stop is hard, but it’s better at the end”
“It was hard first, but finally I could manage”
“I was there for 2 days, I couldn’t stand it”

How could the services be improved?

“It would be better if the doctor treated the addict both physically and psychologically”
“When a person finds refuge in drugs, you should know that s/he has got a problem… I went to drugs because of being unhappy and alone”

“The more the treatment services the lower relapse rates will be”
“If the staff are experienced, the probability of relapse is lower”
“Relapse occurs a lot because treatment centers don’t pay attention to patients finding jobs”
“If the family checks up on the patient more, relapse rate would be lower”. If the family is included in treatment processes, the rate of relapse decreases”.
“The rate of relapse is high because the addicts have easy access to narcotic substances”.

The rules of the treatment centres were generally considered flexible, free going and coming and patients did not experience physical abuse.

The questionnaire tentatively assessed the (perceived) benefit of the services that respondents had previously accessed by asking which of these services helped you most physically. And which of these services helped you most to stay off drugs?43 (see Table 59 and Table 60) It appears that services are generally evaluated quite positively with residential rehabilitation centres being the most

43 More answers possible. Maximum of three services.
effective service on both counts and drop-in centres, detoxification centres and NSEPs being well appreciated across the sites.

**Concl. 57:** Demand for residential treatment exceeds supply. Expense is a major constraint to going into treatment. A further obstacle is lack of knowledge of available services. There are insufficient low-threshold, client-centred treatment facilities, that specifically target female PUD or PUD from the lower socio-economic classes.

**Concl. 58:** There seems to be some stigma attached to going into treatment, with some PUD not informing anyone unless they have to.

**Concl. 59:** Drug related services -particularly those run by NGOs- are generally evaluated positively.

**Concl. 60:** There is insufficient collaboration, mutual referral and coordination between service providers.

**Concl. 61:** During treatment, there is insufficient emphasis on social and social-economic aspects of drug dependency.

**Concl. 62:** Within the sites, there are big differences in policies and rules inside treatment facilities. There are reports of physical punishment.

**Concl. 63:** Drug use related services -particularly those run by NGOs- are generally evaluated positively.

→ **Rec. 28:** Scale up residential treatment services. Ensure that drug treatment is low threshold, voluntary and accessible to all income groups.

→ **Rec. 29:** Improve awareness of the availability of treatment services and work towards removal of the stigma that is attached to going into treatment and to the people that have gone through treatment.

→ **Rec. 30:** Strengthen coordination, collaboration and mutual referral between (GO and NGO) services providers.

→ **Rec. 31:** Monitor and evaluate treatment services in terms of humanitarian standards, particularly in relation to physical abuse.

→ **Rec. 32:** Consider adopting more “open” and voluntary treatment policies and programmes, recognising the fact that relapse is part of the healing process, and develop responses that take into consideration high relapse rates.

→ **Rec. 33:** Involve parents and family members during and after treatment.
Relapse and abstinence

Prevalence of relapse

The data in Table 61 shows that, overall, success rates of treatment are disappointing with an average of 11% of the respondents indicating that they never relapsed and 4% reporting that they are on and off all the time. The majority of respondents that had gone into treatment relapsed a couple or many times (64%).

Quotes 19: Contributing factors of relapse

Easy...
"Always available" / "still easy" / "it's easy" / "it's currently easy"

Bored...Lonely...Friends...
"Mainly because of boredom, and I earned money at that time – especially in the off day from work I was thinking about going out and using to kill time."
"At that time I was so worried as I was alone in the street and struggling to survive."
"May be it was hidden in my mind but I went there to see my friends" / "...I was with my friends."

Overpowering urge...
"I felt the overpowering need to use to enable me to carry on with my work. I couldn’t work without" / "I was ashamed of myself but could do nothing..."
"I had already decided to use drugs after coming out of the drug treatment"...
"Injection was very tasty for me...nothing could take injection's place. Methadone is nice and very effective but doesn't take its place...Previously (before methadone maintenance treatment) I injected heroin 3 or 4 times a day. But now I eat metadone...So I use heroin much less..."
"I had already decided to use drugs after coming out of the drug treatment"...
"I thought injection is easy to quit."
"As I had run away from the centre after about fifteen days the first thing I did was to use."
"When I got out of prison, as I was not using drugs inside so much (only ate a little piece of opium once every 10 to 15 days), I told myself to be in comfort for the first day, so I used drugs again. But I didn't use for a while. However, I started drug use little by little again."

Family...
"It was because of death of my sister." / "It was because of quarrel with my family."
"Once or twice I told my family that I want to quit at home...I was at home for a week. Afterwards, I went out to buy cigarette. When I returned home they looked at me in a bad way. Their attitude was bad. I swore I have not used drugs...but they told me your eyes shows you have used drugs...I told them "you don’t believe me, ok! I go and use drugs...""
"After going back home all my family members were using and one day I was not feeling well and started using. / "I had started worrying about how to support my family.""

Other...
"If you break the vow of repentance for hundred times, again do penance."
"I was unable to control my emotions"

Connected to the above is the issue of availability and knowing how to acquire the drugs one wants. Informants agree that access to drugs was extremely easy, and availability was sufficient. At difficult times in terms of availability, they could find what they were looking for with a little more effort. Informants suggested that this easy access to drugs influenced them towards a relapse.

44 “Relapse” was defined as “a period of use after a treatment”. A “slip” (one off lapse into drug use) was not considered a relapse.
The survey addressed the factors that contribute to relapse. Twelve answers were pre-defined after trialling the questionnaire and hardly any other answers were given. **Constant exposure to PUD friends** (generally the most mentioned factor) was mentioned by 17% (see Table 62).

The data does, however, paint a picture quite similar to the factors that the respondents mentioned when asked about their switches and generally confirms the data from the open interviews. Peers appear to be a major factor in relapse behaviour: **Exposure to PUD friends** and **Persuasion from PUD friends** score quite high. Factors that relate to the strength or power of the drug (**Wanted to use**, **Irresistible urge to use**, and **Underestimated power of drug**) are also of importance. The importance that is placed on **Emotional/mental state**, possibly points towards some type of relationship problems. **Family problems** also scores quite high, but **Lack of moral support** don't appear to be of importance. The latter two factors might be related through the possible expectation that the family should be (more) supportive in times of emotional or mental discomfort. Finally, **Unemployment/Financial reasons** were mentioned by many respondents.

**Rejection/discrimination/stigma** was mentioned by 4% of the respondents.

**Case Study 3: Two clients; methadone programme at DIC**

| Widow, 23 years old | I got married when I was 12. My former husband used drugs. Due to marital problems, I attempted suicide while pregnant with my second child through burning myself with oil. When I was recovering at home, my family gave me opium as a painkiller. Then, I became dependent on opium smoking at 13. After one year, when there was shortage of opium on the black market, my husband provided me with heroin and I used that for five years. My husband persuaded me to inject heroin and I injected I did so for two or three months, but I had bad veins so I changed back to smoking. My first husband died and my family, once they discovered my addiction, got my children and threw me out of the house. I then married another PUD in Tehran. He died of heroin overdose in a park. Now I am a beggar, but I was recently admitted in a methadone maintenance programme at Ghar-DIC in Tehran. |
| A 32 year-old single man | I was persuaded into using hashish and alcohol by my friends when I was 16. My father was an ex-opium user. After two years, I switched to opium when I was with opium user friends. Also, my employer used opium. After four years, when I was 22, I started injecting heroin. Because of my family's reaction, I left the family. I was arrested and imprisoned for addiction once. I continued heroin and opium injection inside the prison with hand-made injecting devices called "pump" shared with many other inmates. I was homeless and wandering when I met Persepolis outreach workers who guided me to Ghar-DIC. I entered the methadone maintenance programme a few months ago. Nowadays I am doing well on MMT and I am employed in the DIC as an outreach worker. |

**Relapse and the immediate environment**

The majority planned to re-use drugs and felt very good immediately after using the drug at that time; however, in retrospect it was often considered a negative experience. Most informants were living with their families at the time of relapse and were enjoying good relations as a result of having been treated and being drug free (see Quotes ). The majority of the parents initially did not know that their children were back on drugs, yet they did notice the relapse very soon. It was typically discovered when their kids returned home while high. Parents in general urge their children to quit and/or take them to rehabilitation centers. Family members and the closest persons' reactions were getting sad, advising and putting them under pressure or sometimes rejecting. However, these reactions didn’t have any positive impact, yet caused the PUD to feel lonely and rejected. In some cases, as soon as the family members came to know about re-use, the reaction was even harsher as compared to when they came to know about the initial drug use. Almost all informants thought that it was their own mistake and did not blame their family members’ attitude for their relapse.
Most of the friends by that time comprised of fellow PUD. Non-PUD friends could only urge them to stop but it had no effect. Many expressed that there were strong feelings of shame and guilt after relapse but it was too late by that time.

Quotes 20: Relapse and the immediate environment

Did the parents know? How did they react

"No, don’t let them know" / “No one knows” / “Not really” / “Of course they don’t know”
“Parents are not so strict” / “Just suspicions, only up to suspicions…”
“At first they didn’t know, after a while they found out.” / “They told me to stop”
“He gave me advice, he got tired of telling me, gave me advice, I kept quiet, I didn’t care”
“I was in a very bad mental conditions because my family didn’t believe that I could quit the drugs”
“She (mother) had empathy and sympathy, understanding. Sometimes she counselled me and helped me with money.”

No relapse

Given the low prevalence of successful treatments amongst the informants and respondents, data on this issue is scarce. The available data from the open interviews indicate that those few informants that had thus far remained clean were extremely pleased about that and looked at their lives in a profoundly different and more positive manner. An often mentioned (side) effect of remaining abstinent was the fact that they had fewer financial problems.

Informants attributed a lot of this success of the treatment to the support that they received from their parents during and after their treatment, yet others very much gave credit to their own effort. Ironically, the treatment centre was not often mentioned as crucial in the success of the treatment.

Concl. 64: Relapse is extremely common, regardless the kind of treatment that preceded it. Out 119 respondents who had gone into treatment, 89% had relapsed.

Concl. 65: Exposure to PUD friends and the urge to use are two major relapse factors. Drugs are widely available and easily accessed.

Concl. 66: Parents and schools do often not know for quite some time that a PUD has relapsed.

Rec. 34: Improve and/or develop a holistic or integrated approach, including social rehabilitation, follow up and after-care for all exiting clients.
Chapter 5: Drug use related problems

In this chapter, problems associated with drug use are described under the headings: onset of problems, health problems, financial problems, judicial problems, and alienization, stigmatization, and criminalization. Clearly, these are artificial distinctions and the different areas interact and influence each other in many different ways. For example, health problems might lead to financial problems and vice versa and the same can be said for the other spheres. Rather than being concerned about what is the cause what the effect, it seems more useful to view these spheres as interconnected and acknowledge that drug use dramatically increases one’s chance to fall victim to any or all of them.

5.a. Onset of problems

Although it is difficult to formulate generalised conclusions on individual issues such as drug related problems, certain trends and similarities can be deduced from the open interviews (see Quotes ). The initial stage of one’s drug use tends to be without any serious adverse effects or problems. After some time, health problems and social relationship problems within family, peers, school or community develop. Problems usually start -or become more serious- when dependency develops and money becomes an issue, which, in turn, can lead to criminal behaviour. Financial consequences of one’s drug use is often mentioned as the core problem. Clearly, if incarcerated, further problems at many levels are the result.

The time period till the use of that particular drug(s) had become a problem ranged from a “couple of months” to a “few years”. About half of the respondents felt that the use of that particular drug had become a problem after some months (1-6) while the others felt that it took a few years (1-3). Some respondents did not acknowledge any problems or avoided the question “difficult to say”, but almost all informants did confirm the problematic consequences of their drug use -after time. As expected, problems tended to become more pronounced, when people had switched towards injecting or towards an opiate.

While half of the respondents mentioned distinct quantities (depending upon the drug) and frequency of their drug use, the others stated that the onset of drug-related problems depended on the “availability of money”.

As mentioned, many initial problems were of a social nature. The starting PUD goes through changes at various levels: At times, s/he might behave differently, look differently, dress differently, chose different friends, and the people in the PUD’s immediate environment react to these changes. An important moment in this regard, is when these people find out that about the PUD’s drug use. Clearly, people react differently to this discovery, but usually it signals the start of problematic relationships with many people in one’s (former) immediate environment. In that sense, a start is then made with the process of alienization and stigmatization that is described in a later section.

Concl. 26: Many PUD experience few problems during the first stages of their drug use. Relationship problems (within the family, as well as with friends and at school or work) tend to be the first signal that drug use might have a problematic side to it.

Concl. 27: More concrete drug related problems tend to develop when dependency starts to become apparent, particularly, because of the financial and health consequences of increased use.

→ Rec. 35: Develop and conduct community-building activities towards early detection of drug use and a positive response towards it.
When did your drug become problematic?

Drug use itself
“I was excessively using without any limits.”
“There was no limit. It was dependent on the availability of money. Sometimes 8-10 times a day and at times 3-4 times a day.” / “After initiating injecting....”
“I was using too much, mostly I used to inject for about four to five times a day. But, in some good days I injected for 10 to 12 times.”
“Just because of the addiction” / “Since I was starting to be an addict”
“After all, it became a need” / “After my OD” / “Since I use heroin.”
“When I have the money I used more and when I have less I used less amount.”
“I was doing it as often as I could. It depended on the availability of the money.”

Money, theft
“Untrustworthy and then criminal, manipulate, tricky, steal, what else! Everything”
/ “I started stealing from my own house...”

Immediate environment, stigmatization
“... the harsh behaviour of others was one of the problems...”
“The problem is, it hard for me to get a job, lack of trust, my life is all screwed”

Other
“I became introvert after I was using it”
“We don't think about our lives when we are using drugs until we reach such a stage that everything is lost including relationships with family, respect and dignity. Even we don’t care about the support offered from family members and friends. Now we need to get out of it and there is nobody to help - who should we look forward to?”
5.b. **Health problems**

In Chapter 3, a number of issues related to drug use and health were covered. In the section *attitudes towards drug use and health*, the answers to the question: *what are physical / health risks related problems to regular use of your current drug, if any?* are described under the heading *Drug use related health risks* (Chapter 3.b). The question is phrased in a manner that allows answering it, regardless whether one had personally experienced such health problems. However, the answers confirm that PUD are aware of a wide variety of drug use related health problems (see Table 21) and the open interviews indicate that many PUD experience a large variety of drug use related health problems.

Drug use related health problems that were mentioned during the open interviews include declining mental capacity, HIV/AIDS, Hepatitis, STDs, collapsed veins, abscess, pneumonia, emboli, lung, liver, kidney problems, memory loss, etc. (Quotes). Often symptoms are ignored or not taken seriously and self-medication is common. The timing of the onset of health problems varies enormously from person to person, yet, usually, these problems occur after a period of regular and sustained use.

During this study, no effort was made to gain insight in the HIV-positivity of informants or respondents, yet occasionally informants brought up that they were diagnosed HIV-positive.

**Concl. 28:** The large majority of PUD, if not all, suffers from drug use related health problems after time, yet often symptoms are ignored or not taken seriously at first. Self-medication is common.

→ **Rec. 36:** Improve health information and awareness on the adverse health effects of drug use to PUD.

→ **Rec. 37:** Improve access to health services for PUD.

**Quotes 22: Health problems**

<table>
<thead>
<tr>
<th>How about your health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Nothing, I just felt tired, I didn’t take a rest so I lost my appetite”</td>
</tr>
<tr>
<td>“...something wrong with my body”</td>
</tr>
<tr>
<td>“I feel very hard to breathe, but it’s usual, I can handle it myself”</td>
</tr>
<tr>
<td>“I’m thin. I used to be fat, I’m getting thinner because of injecting”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do/did you do about it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“To the hospital” / “I went to hospital because of my fever” / “Not too serious, just hospitalized…”</td>
</tr>
<tr>
<td>“It’s free of charge here (medication)”</td>
</tr>
<tr>
<td>“For instance I have a respiration problem, I bought some antibiotics to heal my pain.”</td>
</tr>
<tr>
<td>“I didn’t do anything”</td>
</tr>
</tbody>
</table>

5.c. **Financial problems**

Financial issues related to one’s drug use have been a recurring theme in many of the earlier sections. It appeared that lack of finances or the price of a specific drug may be a factor in switches towards stronger drugs or towards injecting. In addition, financial considerations are mentioned by many PID as a barrier to access to new needles and syringes. Also, the price of treatment services appeared to be a major constraint for many PUD who wish to go into treatment.
During the open interviews, ways mentioned to get over financial problems include: working, dishonesty, borrowing from friends, and criminal activities. In the questionnaire, two questions addressed financial issues, yet because of some interpretation problems, the resulting data should only be viewed in comparison with each other, rather than at face value. It is, for example, not possible to derive conclusions on the economic status of the respondents. In addition, conclusions based on this data will have remained tentative at best. Keeping this in mind, Table 63 and Table 64 still provide some insight in the level of income or total expenses per day in relation to one’s expenses on drugs.

The average expenses on drugs as part of the average total expenditures was 97%. It can therefore be concluded that compared with income -or total expenditure- levels, drug expenses are extremely high. Such proportions clearly point towards a lifestyle that revolves around drug use and that is likely to cause financial problems.

The situation is markedly worse for PID; the average proportions of expenditure on drugs getting close to 100%.

Non-PID report higher total expenses/income than PID. This is in line with the relative difficulty, for PID to get or retain a job.

Concl. 29: PUD, and particularly PID, spend large proportions of their total expenses on drugs.

→ Rec. 38: Consider measures that would break the link between drug dependency and related high expenditures (e.g. provision of needles and syringes, decriminalization of certain drugs, provision of drugs / pharmacotherapy).

5.d. Judicial problems

How about the law?

Almost all of the informants knew that it was illegal to use drugs but almost none of them had a clear idea about the penalties and they mostly based their answer on their personal -or close friends’- experience of being jailed, rather than on any other source of information. Some had been arrested either during buying, using, or selling. Generally, the informants deemed the arrests justified (see Quotes).

From the questionnaire (Q75), it appears that, overall, more than half of the PUD had been in contact with the police due to their drug use (Table 65: 71%). Of those 193 people, about three-quarter were imprisoned (74%) and 20% were kept in police custody. Physical abuse appears quite common (52%) and confiscation of money and/or drugs seems rare (3%, resp. 9%).

Overall, drug possession and use form the main reason for this contact with law enforcement agencies (Table 66).

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45 These data could not be processed at the individual level, because of some interpretation difficulties related to the income question. In short, it was not exactly clear, whether Q11 referred to income or expenditure. A further difficulty was the issue of grey areas in terms of income. Nevertheless, the averages provide some insight in how expenses on drugs relate to total expenditure.
Findings: Drug careers and environmental factors

Concl. 30: Overall, more about three-quarter of the respondents had been in contact with the police due to their drug use and the most common offences were possession and use of drugs.

The usefulness of imprisonment is questioned, since drugs tend to be available inside.

**Drug use and unprotected sex in prison**

Overall, more than half of those respondents that were imprisoned reported that drug use in prison was very common (Table 67: 78%).

Most informants said that in prison they could easily get drugs as an exchange for money, and all reported that drug use was common in prison. However they had decreased their using dose. More than half said that drugs were used in the prison commonly. In the Youth Correctional Center, however, all PUD believed that there were no drugs, therefore prison made them quit. Regarding the most common drug in prison, there was little difference between opium, heroin, and hashish. Reportedly, the most common method of drug use in prison was injecting with a pump (hand made syringe) and eating respectively. Some also mentioned smoking as a common way. The pump was reportedly shared by many inmates.

Nevertheless, many respondents said that they stopped using drugs while in prison (Table 68: 35%) or decreased their intake (42%). However, 12% stated that their drug use increased while they were imprisoned.

**Case Study 4: Drug use in prison**

“It was in 2000 in Bandar Abbas near a dock when police arrested me because of drug dependency. I was ruined. A police told me to show my tongue... I was high, I could not open my eyes. I had just used drugs. After 3-4 days I was sent to the judge. I was in withdrawal, which he immediately understood. I was sentenced to imprisonment for 2 months and quarantined for 7 days. ... There were no drugs, no medication. I saw hell at that time because I had never stopped drug use for 7, 8, 10 days before. When I entered the prison, I had still lots of pain. A fellow townsman came to me... They gave me drugs within 30 minutes of entering prison! It was much easier than outside. There, I had to walk 4-5 kilometers to reach drugs. But in the prison it was right there in the cells.”
When asked what they had to do to get drugs while in prison, the most common answer was *pay fellow inmates* (Table 69: 81%). Bribing of officials and *other favours* appear common (10%), while the answer *nothing / presented* was relatively rate (2%). Also, 8% report *sex* as a means of *compensation*.

Very few respondents (9.2%) reported having engaged in unprotected sex while in prison: 2.1% answered *always*, 1.4% *often*, 1.4% *sometimes*, and 4.3% *rarely*. The majority (89%) said that condoms were not available in prison. For those who said that they were available, it is unclear what the source would be.

**Concl. 31:** Drug use -including injecting drug use- appears quite common in a number of prisons. In such prisons, unsafe injecting practices are rampant. Yet, the large majority of those respondents that went to prison said their drug use decreased or stopped completely while imprisoned.

**Concl. 32:** Access to condoms in prison is problematic.

→ **Rec. 39:** Consider the implementation or scaling up of harm reduction interventions in closed settings.

**Quotes 24: Drug use in prison**

**Were drugs being used inside prison?**

"It’s very easy, as long as there is some money” / “Plenty (who used drugs)"

“It is so common there; if we want to use drugs, just use it, as long as you have the money”

“When my family visited, they gave me some money, and then I used it to buy drugs.”

“There are lots of drugs in prison... When I came out of prison I used drugs because of my pigheadedness.”
5.e. **Stigmatisation, alienation, criminalisation**

**Self-stigmatisation and self-alienation**

Many PUD tend to look at themselves in a negative way. During the focus group discussions and open interviews with PUD, many self-stigmatising comments were made.

"... We are parasites of society. If we didn't exist, it would be better for society. If you really like to curse somebody, wish him/her to become addicted... I would prefer to have incurable cancer, not addiction."

The questionnaire contained a question on how the respondents view PUD. Positive traits, such as confident, happy, trustworthy, and reliable tended to score low, whereas negative traits such as pleasure seeking, manipulative, emotional, self-centred and others tended to receive more Yes-votes.

In generalised terms, many PUD would describe PUD as manipulative, pleasure-seeking, self-centred, emotional, dishonest, not to be trusted and unreliable. The data from Table 70 were combined into one score on a variable called Image of PUD by awarding points to positive traits and negative points to negative traits. It appears that few PUD (11%) have a positive image of PUD, while well over half fall within the negative group (67%).

From the data above, it can be concluded that many PUD perpetuate a negative image of PUD and come close to stigmatising PUD themselves.

**Stigmatization, marginalisation alienation**

While relationship problems (with non-PUD, including parents and partners) become increasingly bad, the process of alienation becomes more concrete. One is not invited to certain gatherings - or it is made clear that is not welcome. Disagreements or fights with formerly good friends or family members become commonplace, and relationships with partners become difficult to sustain. The open interviews were full of examples of such events that were clearly remembered and that were mentioned as important moments in the process towards exclusion (see Quotes).

Similar to self-stigmatisation above is a process what could be called 'self-alienation'; PUD form there own sub-cultures and sub-groups in which non-PUD have no place. The question, what comes first; alienation of PUD by the outside or self-alienation is irrelevant. The fact of the matter is that both phenomena tend to take place and they mutually reinforce the idea that a useful or pleasant co-existence is difficult at best. A new status quo develops in which PUD and non-PUD lead separate lives at many different levels.

"The social stigma and discrimination, I -and especially my wife and children- have faced was also very strong in my neighbourhood. When we were financially down and she would ask the neighbouring people for help so that she could feed the child, they would not help her because they would suspect that she would use the money for her husband's drugs. Nobody would sit with me anymore. My friends would show sympathy but would not associate themselves with me. The whole neighbourhood would view me as a criminal. People cut off their relationship with my wife because she was a drug user’s wife."

PUD reported being refused at hospitals and clinics because they are known PUD. Other examples of blatant stigmatization occur in neighbourhoods, schools and work. PUD are refused entry, expelled, or fired, because they look like PUD, hang out with PUD, or because they were caught using.

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46 To what extent would you describe people using drugs as... trustworthy...self-centred...reliable... etc. Answers were marked in a 3-point scale: No – Somewhat – Yes; Table presents the Yes answers only.
Street-based PUD (relatively common) are a physically and therefore visibly marginalised group of people without access to the most basic living standards, such as housing, clean water, basic health care, let alone education or a sustainable livelihood. Drug use tends to thrive in these communities, either as a cause or effect of these dire circumstances. Non-street based PUD are relatively speaking in better shape, yet they also tend to be recognizable as PUD, which in turn leads to decreased access to health care, education and/or employment.

Quotes 25: Stigmatisation, alienation, criminalisation

Exclusion has many faces...
- "...hated by the society, and also by friends" / "...my environment is not helpful"
- "Everyone including people from my family, neighbourhood lost their trust and respect"
- "Talking about me, stop trusting, suspiciously staring at me when I met them in the street"
- "They do not accept me and do not help because of my using. No body was willing to give me a job because of my appearance" / "All my close friends are PUD"

Key informants and focus group discussions
- "Addicts cannot be cured and they are useless creatures" (FGD; police officer)
- "The manner of behavior with patients in governmental centers is very bad and dismissive"
- "The most important effect of the Drop-in Center is availability of an environment in which drug users are not belittled or blamed and are treated respectfully"
- "Rejection and discrimination"
- "...reaction of the society is mostly to avoid PUD, reject them from daily life"
- "The drug users are always the outsiders, they are never accepted in the society"
- "The community stigmatizes and discriminates the drug user this is because of the cultural values and lack of knowledge"
- "Whatever decision a drug user makes it will be stigmatized and doubted by family and society"
- "The community needs to take a step towards PUD rather than take a step away from them"

Many PUD reported to not talk about drug use related problems with anyone other than fellow-PUD, if with anyone. People tend to form their own sub-groups which increasingly dominate one’s live and which tend to be frowned upon by non-PUD society. As a result, predominantly negative attitudes towards health, education, services, and society as whole are formed within these groups, further pushing its members away from the mainstream.

The above processes are generalised accounts of what tends to happen when drug use starts to take over one’s life. The main message would be that mainstream society is largely at fault in alienating this vulnerable group and that the process becomes increasingly harder to reverse, the further one has gone down the spiral. Secondary prevention and harm reduction are highly needed to prevent or reverse this process of alienation.

Criminalization
As mentioned earlier, possession of injecting equipment and of certain drugs is an offence at all the sites and PUD are routinely taken in for questioning, harassed, and incarcerated for possession, using of dealing in drugs. From a harm reduction point of view, these actions are largely counter-productive, since they do little to reduce the harms associated with drug use and in some cases, they can be seen as making matters worse.

The idea to legalize (certain) drugs, evokes a variety of responses. Some informants agree as long as the government convinces society to accept the idea. Other informants argue that if drugs are legalized, there will be an increase in drug use, and it will be harmful for the society, as happened with legalizing cigarettes. Other informants express the need to observe and learn from the experiences in countries where certain drugs are legalized or decriminalized.

Concl. 33: When one’s drug use becomes central in one’s lifestyle, many PUD experience stigmatisation, alienation and discrimination from different
sources, including parents, non-PUD friends, potential employers / caregivers, and community.

**Concl. 34:** With increasing dependency, PUD tend to remain in contact with PUD only. Self-stigmatization and self-marginalization reinforce stigmatization and alienation experienced from *mainstream society*.

**Concl. 35:** Drug use (often regardless the type of drug or mode of intake) is illegal and, as a result, PUD tend to be criminalised.

→ **Rec. 40:** Implement community building activities, including awareness raising and education that counter the exclusion of PUD from *mainstream society*. Re-strategize and scale up awareness and education programs with a focus to reduce stigma and discrimination through existing NGOs and GOs working in this field, at the local level with community members by including key leaders (religious and political).

→ **Rec. 41:** Introduce broad based strategies that aim to provide “in-depth” and appropriate knowledge so that it can create “comprehensive” awareness among educational institutions, (also aiming to reach out to parents) the general public (through media) and all levels of the legal sector including law enforcement agencies (through NGOs).

→ **Rec. 42:** Consider (further) shifting from the current focus on the penalisation of (certain) drug use to the provision of services that stress the facilitation of rehabilitation and reintegration.
Part III: Conclusions and recommendations

All the conclusions and recommendations that were developed in Part II are listed in the Executive summary. The scope of the research and the resulting wealth of information seriously impede the formulation of more general conclusions and recommendations that the ones offered there. They would become overly vague, too sweeping, or both. In order to do justice to the available data, the reader is encouraged to take note of the conclusions and recommendation that are offered in the core text and to verify to what extent they hold true for the site of her/his interest.

This chapter should therefore be seen as the story-line of this report: the factors covered in the conclusions section below contribute to—or fail to impede, let alone prevent—problematic health behaviour. As exemplified in the next section; prevailing scenarios, the resulting problems reach well beyond and outside the person’s health, including interpersonal, social, financial and judicial issues. The comprehensive nature and magnitude of these problems, require an urgent response in various fields and at all levels. In the recommendations section, such comprehensive solution in terms of programming and policy is called for.

Conclusions

Knowledge and attitudes
Many young people apply their happy go lucky attitude which typifies young people in general to drug use and other risk behaviours. At initiation into drug use, young people do not know what to expect and have little or no idea of possible adverse drug use related effects. Moreover, initially, drug use tends to be without serious problems, or the advantages easily outweigh the disadvantages, so there is no immediate need to change this attitude, or behaviour.

Most PUD—after having used for several years—link drug use with a variety of health related problems, yet many PID appear to be unaware of the health risks that are associated with injecting. Knowledge levels with regards to HIV/AIDS are low. The addictive nature of injecting is widely recognised amongst PID, yet PID remain optimistic about the possibility to be able to abstain.

Availability and price
Drugs are widely—and for PUD often easily—available. Availability and price play an important role in how drug careers start and develop. In particular, fluctuations of availability and price and differences in availability between types of drugs often act as a trigger for a crucial change in one’s drug use.

Most dependent PUD spend large proportions of their income on drugs which is clearly linked to financial issues and thus judicial problems.

Parents and school
Parents fail to play a significant role in primary prevention and are largely ignored by PUD once drug use is taking a more central stage. With ignorant or indifferent parents and teachers, drug use develops largely unchecked and unopposed until individual problems surface. At that point, PUD do not consider abstinence-based approaches viable or desirable, so parents’ and teachers’ negative reactions to drug use are ineffective in terms of accomplishing positive behaviour changes.

Polarization between young PUD and parents is common. When drug use becomes very problematic and undergoing treatment becomes an option, then the parents regain some credibility and usefulness, if anything because of the related expenses. However, treatment services do not actively involve parents, whereas many PUD would consider such involvement useful.

Schools fail to address drug use and other health related issues. Teachers, curricula and management systems are not effective in primary or secondary prevention of drug use. Some
Young people and drugs – Towards a comprehensive health promotion policy

...schools or campuses provide PUD a safe-haven where drug use freely develops unnoticed or ignored.

Peers and fellow-PUD
Peers or friends play a central role in young people’s drug careers. Initiation of drug use as well as its development are to a large extent facilitated by peers. Over time, contact with non-PUD friends decreases and consequently fellow-PUD become omni-present. Various types of drugs and modes of intake appear accessible within one’s circle of peers and within the sub-culture, little difference is made between them. In other words, such peer-groups provide an ideal environment for initiation as well as development of drug careers.

Services
Demand for services greatly exceeds supply and knowledge of available services is insufficient. NGOs offer demand and harm reduction services that typically target street-based PUD. These low-threshold services are generally evaluated positively, yet are limited in terms of coverage. Government or private treatment services are expensive and reach a particular, limited proportion of dependent PUD. Overall, relapse rates are high. Major issues include: lack of coordination, inadequate after care and insufficient attention to social economic aspects of drug dependency.

Prevailing scenarios
In the table below, an effort is made to summarize the conclusions from the sections above in the form of one fictitious case that describe the prevailing country specific drug careers in relation to the environmental factors, knowledge levels, attitudes, and drug use related problems that were investigated in the present study (see
Table 9). These cases portray the most common, average or modal scenario, based on the results of this research. The pictures that arise should be viewed as stereotypes, nothing more, nothing less. In terms of drug type and mode of intake, smokes opium was the stereotypic for PUD.

In order to provide a more complete picture, information on other drug use is sometimes included (in the third person).

In the table after that, some selected statistical data are compiled (see Table 10).
Table 9: Prevailing scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>I am a 28 year old, single male. I usually sleep out in the open. I was born here, but left my parents house several years ago. I never finished high school, but did go to school until I was 18. I’m doing odd jobs on the street, since I lost my job when my working abilities declined and there was a fear they would find out my drug use.</td>
</tr>
<tr>
<td><strong>Initiation</strong></td>
<td>Here, people usually start with smoking opium, marijuana or sometimes heroin, depending on what their friends are using. My first experience with drugs was when I was 18. I was having some personal problems. I smoked opium together with some friends that I had known for some time. We did it in a park, but we also smoked at home and at school. I felt calm, satisfied and at peace after first use. The regrets came later. My parents have enough problems themselves. Once they found out, it was taken very seriously, but whatever they tried, it didn’t really help.</td>
</tr>
<tr>
<td><strong>Development</strong> of drug use</td>
<td>Without my PUD friends, I wouldn’t have started, and I wouldn’t have continued using. We usually used in someone’s home, and at some stage, heroin hit the market, so we tried that. Sometimes, we used marijuana too. After several years of smoking, many of my friends switched to injecting heroin. Injecting is cheaper, easier, and stronger, but it’s also riskier and even more addictive, so I have decided to not inject drugs. But sometimes it is difficult, especially when there is a shortage and the price goes up.</td>
</tr>
<tr>
<td><strong>Overdose</strong></td>
<td>Overdose is quite common, but I have not experienced it myself.</td>
</tr>
<tr>
<td><strong>Efforts to reduce use or abstain</strong></td>
<td>Every now and then, I try to lower my intake, but I don’t know what to do. I think, the parents need to be involved, and professional help is needed, too.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Parents, relatives and my employer have talked me into treatment the first time, and the second time I was sent by the judge. Neither was very effective; I was back using within a couple of weeks both times. The treatment was too short to really become ready to stay clean.</td>
</tr>
<tr>
<td><strong>Onset of problems</strong></td>
<td>I didn’t really have any problems for quite some time. Distrust and arguments with the family started it all. The other problems came much later.</td>
</tr>
<tr>
<td><strong>Health problems</strong></td>
<td>I don’t eat properly and I’ve lost a lot of weight and look terrible. I am also starting to lose my memory, it seems. There is nothing much I can do, can’t really go anywhere for help. My injecting friends have even worse problems.</td>
</tr>
<tr>
<td><strong>Financial problems</strong></td>
<td>Money is always in the background. At the moment, I am not doing so badly, but that can change easily, especially if drug prices go up. I have sometimes sold things from home. Some of my friends have started dealing, others are involved in theft and robbery.</td>
</tr>
<tr>
<td>Judicial problems</td>
<td>I was arrested and sent to a treatment centre. This was a big deal, especially to my parents. I hear that those who can afford it can continue to use whatever they want in prison.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Knowledge, attitudes and practices</td>
<td>I heard from Radio/TV that you can get AIDS through injecting drugs, sex and blood transfusion but most people don’t know this. I usually don’t use syringes of others but if somebody asks me I share my syringe with him. I inject heroin with other friends. We boil heroin in one shared spoon, water and heroin but use our own syringes. We sometimes use our own syringes several times.</td>
</tr>
</tbody>
</table>
Table 10: Summary of key statistics

<table>
<thead>
<tr>
<th>Key data</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age of respondents</td>
<td>28 yrs</td>
</tr>
<tr>
<td>Age of initiation</td>
<td>18 yrs</td>
</tr>
<tr>
<td>Residence: living with parents*</td>
<td>50-25%</td>
</tr>
<tr>
<td>Residence: street / park / open area*</td>
<td>17-43%</td>
</tr>
<tr>
<td>Age of initiation (Q30): &lt;15 years</td>
<td>22%</td>
</tr>
<tr>
<td>Drug of initiation: cannabis</td>
<td>32%</td>
</tr>
<tr>
<td>Drug of initiation: opium</td>
<td>37%</td>
</tr>
<tr>
<td>Drug of initiation: heroin</td>
<td>24%</td>
</tr>
<tr>
<td>Drug of initiation: brown sugar</td>
<td>1%</td>
</tr>
<tr>
<td>Age of initiation (Q30): &gt;15 years</td>
<td></td>
</tr>
<tr>
<td>Drug of initiation: cocaine</td>
<td></td>
</tr>
<tr>
<td>Drug of initiation: methamphetamine</td>
<td></td>
</tr>
<tr>
<td>Drug of initiation: amphetamine</td>
<td></td>
</tr>
<tr>
<td>Drug of initiation: other</td>
<td></td>
</tr>
<tr>
<td>Opiate use at initiation (Q30) / total opiate users</td>
<td>71%</td>
</tr>
<tr>
<td>People injecting drugs (PID)</td>
<td>66%</td>
</tr>
<tr>
<td>Injecting at initiation (Q30) / total PID</td>
<td>23%</td>
</tr>
<tr>
<td>Switched towards injecting / total PUD</td>
<td>50%</td>
</tr>
<tr>
<td>Period until switch towards injecting: &gt;3 years</td>
<td>57%</td>
</tr>
<tr>
<td>Switched away from injecting</td>
<td>1%</td>
</tr>
<tr>
<td>Switched towards opiate</td>
<td>26%</td>
</tr>
<tr>
<td>Switched away from opiate</td>
<td>5%</td>
</tr>
<tr>
<td>Needle sharing: active-passive; often / always*</td>
<td>26-46%</td>
</tr>
<tr>
<td>Syringe sharing: active-passive; often / always*</td>
<td>27-45%</td>
</tr>
<tr>
<td>Unsafe injecting practices; ever</td>
<td>89%</td>
</tr>
<tr>
<td>Currently using</td>
<td>66%</td>
</tr>
<tr>
<td>Intensive use; more than once/week: cannabis</td>
<td>23%</td>
</tr>
<tr>
<td>Intensive use; more than once/week: heroin</td>
<td>57%</td>
</tr>
<tr>
<td>Intensive use; more than once/week: brown sugar</td>
<td>4%</td>
</tr>
<tr>
<td>Intensive use; more than once/week: opium</td>
<td>30%</td>
</tr>
<tr>
<td>Intensive use; more than once/week: cocktails</td>
<td>0%</td>
</tr>
</tbody>
</table>

* non-PID - PID respectively.
Recommendations

The recommendations in the Executive summary are based on the conviction that one has to learn from research experience relating to drug prevention that shows that drug abuse is a complex psychosocial issue that cannot be fixed by simple solutions. In general, it is “imperative to improve the link between research and practice: base policy and funding decisions on the research evidence we already have; monitor and evaluate policies and programs; and continually adjust policies and programs to reflect new information as it becomes available”. 47

As the sub-title of this report suggests, the recommendations are the embodiment of a comprehensive approach towards health promotion policy. The combined issues of drug use and HIV/AIDS require programmes and policies that combine primary and secondary prevention as well as harm reduction. It is necessary to take a broad view of drug prevention and to acknowledge that drug use is one of a range of problem behaviours that should not be seen in isolation. Those people and organizations concerned with problem behaviours should work collaboratively to address the shared careers to these outcomes. This includes the areas of health, crime, suicide, education, community building, among others. Single, one-shot strategies or programmes that target an issue in isolation are likely to be ineffective. Coordination and streamlining of national policies and local interventions in the area of health promotion is required to maximize impact.

With the above in mind, we can now turn to the recommendations that were formulated in the core text, and organized in the Executive summary, according to area of work. The appropriate government and non-government agencies are urged to further develop and implement these recommendations, in collaboration with PUD and other people that have inside knowledge and experience with the complicated issues of drug use and HIV/AIDS prevention.

Annexes

Annex 1: List of tables ............................................................................................................... 115
Annex 2: Overview: availability, mode of intake, prevalence and price ................................. 141
Annex 3: Implementing partners ............................................................................................. 142
Annex 4: Human Development Report ................................................................................... 143
Annex 5: India: (additional) drugs used (as provided by the SRM)

Error! Bookmark not defined.
### List of tables

| Table 1: | Comprehensive health promotion intervention for people using drugs ........................................... 262 |
| Table 2: | Interviews with key informants and focus group discussions ....................................................... 520 |
| Table 3: | Number of informants (open interviews) and respondents (questionnaire) ....................................... 531 |
| Table 4: | Prevalence of sharing of injecting materials (often or always) (Q46 & Q47) ................................... 620 |
| Table 5: | Unsafe injecting practices (Q46-Q48) ......................................................................................... 631 |
| Table 6: | Reasons / Factors mentioned for start of drug use (Q39) .............................................................. 7169 |
| Table 7: | Crucial switches (Q31) .............................................................................................................. 7875 |
| Table 8: | Frequency of overdose (Q52) and by non-PID vs. PID (Q37) .......................................................... 85 |
| Table 9: | Prevailing scenarios .................................................................................................................... 11007 |
| Table 10: | Summary of key statistics .......................................................................................................... 11209 |
| Table 11: | Age groups (Q3) ......................................................................................................................... 11714 |
| Table 12: | Duration of domicile in city of interview (Q2) .............................................................................. 11714 |
| Table 13: | Residence (Q7) .......................................................................................................................... 11714 |
| Table 14: | Educational background (Q6) ..................................................................................................... 11714 |
| Table 15: | Main source of income (Q10) ...................................................................................................... 11815 |
| Table 16: | Most important source of HIV/AIDS knowledge (Q19) ............................................................... 11815 |
| Table 17: | Knowledge on transmission of HIV/AIDS (Q19) ............................................................................. 11916 |
| Table 18: | Knowledge on prevention of HIV/AIDS (Q21) ............................................................................... 11916 |
| Table 19: | Very knowledgeable in regards to HIV/AIDS (Q19-21) and Hep C (Q24-26) ............................... 12017 |
| Table 20: | Largely positive image of selected drugs (Q15) ........................................................................ 12017 |
| Table 21: | Perceived health risks by non-PID/PID and (Q16) ..................................................................... 12118 |
| Table 22: | Dislike of PID among non-PID (Q29::14) ................................................................................... 12118 |
| Table 23: | Prevalence of unsafe injecting practices (how often do/did you...) (Q48) ................................. 12219 |
| Table 24: | Reasons for using a used needle and/or syringe (Q45) ............................................................... 12219 |
| Table 25: | Acquire syringes/needles from...... (Q50) ............................................................................ 12219 |
| Table 26: | Constraints to access to new syringes (Q45) .............................................................................. 12320 |
| Table 27: | Prevalence of unprotected sex (Q59) ......................................................................................... 12320 |
| Table 28: | Reasons for not using a condom among sexually active PUD (Q60) ........................................... 12421 |
| Table 29: | (Perceived) availability of selected drugs (Q15) ..................................................................... 12522 |
| Table 30: | Life-Time Prevalence (LTP) and Last Quarter Prevalence (LQP) (Q30) ....................................... 12522 |
| Table 31: | Mode of intake of heroin (LTP) (Q37) ......................................................................................... 12623 |
| Table 32: | Number of years since initiation to drug use (Q30) ...................................................................... 12623 |
| Table 33: | Age adjusted number of years since initiation to drug use (Q30) .............................................. 12623 |
| Table 34: | Intensive drug use- (Q30), (compared with LQP) ..................................................................... 12724 |
| Table 35: | Age at initiation (Q30) .............................................................................................................. 12724 |
| Table 36: | Drug of initiation (Q30) ............................................................................................................. 12724 |
| Table 37: | Contributing factors of drug use (Q29) ..................................................................................... 12825 |
| Table 38: | Person PUD talks with most on drug use and drug related problems (Q62) ............................ 12825 |
| Table 39: | Closest non-PUD (Q63) ............................................................................................................. 12825 |
| Table 40: | Closest person’s reaction / behaviour (Q66- Q68) .................................................................. 12926 |
| Table 41: | Parents initial, current and desired reaction / behaviour (Q66- Q68) .......................................... 12926 |
| Table 42: | Friends’ initial, current and desired reaction/behaviour (Q66-Q68) ........................................... 12926 |
| Table 43: | Partner/spouse initial, current and desired reaction / behaviour (Q66- Q68) ......................... 13027 |
| Table 44: | Prevalence of drug use in school (Q64) ................................................................................... 13027 |
| Table 45: | Gradual versus clarity of switch (Q31) ...................................................................................... 13027 |
| Table 46: | Period until switch towards injecting (Q32) ............................................................................... 13027 |
| Table 47: | Very much a factor for Switch 2 by bite (Q32) (Compared with Switch 1) ............................... 13128 |
| Table 48: | Intention of overdose (Q53) ..................................................................................................... 13128 |
| Table 49: | Carer after overdose (Q54) ....................................................................................................... 13229 |
Table 50: Effect of overdose experience (Q56) ................................................................. 1329
Table 51: Self-estimation of chance of abstinence (Q57) .................................................... 1329
Table 52: Frequency of “self-treatment” (Q42).................................................................... 1330
Table 53: Ways to stay away from drugs (Q43)................................................................ 1330
Table 54: Who should be / have been involved to help you to stop? (Q44) ...................... 1341
Table 55: Treatment (Q33)............................................................................................... 1341
Table 56: (Knowledge of) availability of drug use related services (Q69)........................... 13532
Table 57: Use of drug use related services (Q70).............................................................. 13532
Table 58: Constraints to access or complete drug use related services (Q73)................. 13633
Table 59: Drug use related services that helped most physically Q71)............................ 13633
Table 60: Drug use related services that helped most in staying off drugs (Q72)............ 13734
Table 61: Frequency of relapse (Q35)............................................................................... 13734
Table 62: Factors for relapse (Q36).................................................................................. 13835
Table 63: Income / expenditure per day (Q11).................................................................. 13835
Table 64: Average daily expenses on drugs (Q12)............................................................ 13835
Table 65: Contact with police (Q75)................................................................................ 13936
Table 66: Drug use related offence (Q76)........................................................................ 13936
Table 67: Prevalence of drug use in prison (Q68)............................................................... 13936
Table 68: Development of drug use in prison (Q79)........................................................ 14037
Table 69: Way to get drugs while in prison (Q80)............................................................ 14037
Table 70: Characteristics of PUD -according to PUD- (Q27)............................................. 14037
### Tables

**Table 11: Age groups (Q3)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Q</th>
<th>OI</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 yrs</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>15-18 yrs</td>
<td>2%</td>
<td>39%</td>
</tr>
<tr>
<td>18-21 yrs</td>
<td>5%</td>
<td>35%</td>
</tr>
<tr>
<td>21-25 yrs</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>25-30 yrs</td>
<td>34%</td>
<td>7%</td>
</tr>
<tr>
<td>30-35 yrs</td>
<td>42%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>281</td>
<td>46</td>
</tr>
</tbody>
</table>

Mean age: 28 yrs, 16 yrs.

Source: Q3: How old are you? ____ years. *Because of the big difference in Tehran in age between the respondents (Q) and the informants (OI), both are displayed here.

**Table 8: Duration of domicile in city of interview (n=280) (Q2)**

<table>
<thead>
<tr>
<th>Duration of domicile</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All my life / born here</td>
<td>65%</td>
</tr>
<tr>
<td>Moved here at age 0-6</td>
<td>3%</td>
</tr>
<tr>
<td>Moved here at 7-12</td>
<td>5%</td>
</tr>
<tr>
<td>Moved here at 13-18</td>
<td>8%</td>
</tr>
<tr>
<td>Moved here at 19-24</td>
<td>6%</td>
</tr>
<tr>
<td>Moved here at &gt;24</td>
<td>5%</td>
</tr>
<tr>
<td>Living here on and off</td>
<td>5%</td>
</tr>
<tr>
<td>Passing through</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q12: How long have been living in this city?

**Table 13: Residence (n=270) (Q7)**

<table>
<thead>
<tr>
<th>Residence</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with parents*</td>
<td>50 - 25%</td>
</tr>
<tr>
<td>Street / Park / Open area*</td>
<td>17 - 43%</td>
</tr>
<tr>
<td>With siblings</td>
<td>4%</td>
</tr>
<tr>
<td>Living alone</td>
<td>11%</td>
</tr>
<tr>
<td>With spouse / partner</td>
<td>8%</td>
</tr>
<tr>
<td>Treatment centre</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

Sum of percentages: 103%

Source: Q7: Where do you usually spend the night? (More answers possible)

* Non PID, PID respectively. Only those options that have a score higher than 5% at at least one site

**Table 94: Educational background (n=278) (Q6)**

<table>
<thead>
<tr>
<th>Education</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No schooling / unfinished primary</td>
<td>10%</td>
</tr>
<tr>
<td>Primary / unfinished secondary</td>
<td>28%</td>
</tr>
<tr>
<td>Secondary / unfinished high</td>
<td>35%</td>
</tr>
<tr>
<td>Finished high school / higher</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: Q6: What is your highest educational level? (One answer only)
Table 15: Main source of income (n=280) (Q10)

<table>
<thead>
<tr>
<th>Source of income</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odd jobs on the street</td>
<td>46%</td>
</tr>
<tr>
<td>Steady income (legal)</td>
<td>36-17%</td>
</tr>
<tr>
<td>From family / partner</td>
<td>12%</td>
</tr>
<tr>
<td>Stealing, pick pocketing</td>
<td>1%</td>
</tr>
<tr>
<td>Begging</td>
<td>3%</td>
</tr>
<tr>
<td>Selling drugs</td>
<td>5%</td>
</tr>
<tr>
<td>From friends</td>
<td>1%</td>
</tr>
<tr>
<td>Sex work</td>
<td>1%</td>
</tr>
<tr>
<td>No income</td>
<td>21%</td>
</tr>
<tr>
<td>No answer</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Q10: What is/was your main source of income? (DO NOT READ THE OPTIONS. More answers possible) *Non-PID, PID respectively

Table 16: Most important source of HIV/AIDS knowledge (n=211) (Q19)

<table>
<thead>
<tr>
<th>Source</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass media</td>
<td>64%</td>
</tr>
<tr>
<td>Service provider (NGO)</td>
<td>8%</td>
</tr>
<tr>
<td>Fellow PUD</td>
<td>5%</td>
</tr>
<tr>
<td>Service provider (GO)</td>
<td>14%</td>
</tr>
<tr>
<td>Friend (non PUD)</td>
<td>2%</td>
</tr>
<tr>
<td>School</td>
<td>1%</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>4%</td>
</tr>
<tr>
<td>Partner</td>
<td>2%</td>
</tr>
<tr>
<td>Parents</td>
<td>1%</td>
</tr>
<tr>
<td>Sibling(s)</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q18: Who/What was the most important source of this knowledge? (One answer only)
Table 17: Knowledge on transmission of HIV/AIDS (n=281) (Q19)

<table>
<thead>
<tr>
<th>Assumed mode of transmission</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected sex⁴⁸</td>
<td>45%</td>
</tr>
<tr>
<td>Sharing injecting equipment</td>
<td>46%</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>36%</td>
</tr>
<tr>
<td>Mother to child</td>
<td>1%</td>
</tr>
<tr>
<td>Unsterilised medical instruments</td>
<td>2%</td>
</tr>
<tr>
<td>Sharing razor blade</td>
<td>15%</td>
</tr>
<tr>
<td>Sex with boys / males</td>
<td>3%</td>
</tr>
<tr>
<td>Kissing</td>
<td>2%</td>
</tr>
<tr>
<td>Sharing toothbrush</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Q19: How is HIV/AIDS transmitted? (DO NOT READ THE OPTIONS. More answers possible) (Percentages indicate proportion of all respondents, regardless the answer to Q17)

Table 18: Knowledge on prevention of HIV/AIDS (n=281) (Q21)

<table>
<thead>
<tr>
<th>Assumed way of prevention</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected sex (condom) (+)</td>
<td>34%</td>
</tr>
<tr>
<td>Use own inj. equipment (0)</td>
<td>32%</td>
</tr>
<tr>
<td>New sterile injecting equipment (+)</td>
<td>20%</td>
</tr>
<tr>
<td>No sharing inj. equipment (0)</td>
<td>16%</td>
</tr>
<tr>
<td>No sex (+)</td>
<td>2%</td>
</tr>
<tr>
<td>Monogamy (0)</td>
<td>1%</td>
</tr>
<tr>
<td>Personal hygiene (-)</td>
<td>10%</td>
</tr>
<tr>
<td>Healthy lifestyle (-)</td>
<td>2%</td>
</tr>
<tr>
<td>No injecting drugs (+)</td>
<td>1%</td>
</tr>
<tr>
<td>No drugs (+)</td>
<td>2%</td>
</tr>
<tr>
<td>Vaccination (-)</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>121%</td>
</tr>
</tbody>
</table>

Source: Q21: What are ways to prevent acquiring HIV/AIDS? (DO NOT READ THE OPTIONS. More answers possible) (Percentages indicate proportion of all respondents, regardless the answer to Q17). Behind options: (+)means correct; (-) incorrect; (0) neutral.

⁴⁸ The top five answers were considered "correct"
Table 19: **Very knowledgeable** in regards to HIV/AIDS (Q19-21) and Hep C (Q24-26) (n=281)

<table>
<thead>
<tr>
<th>Aspects</th>
<th>HIV/AIDS</th>
<th>HEP C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission</td>
<td>49%</td>
<td>5%</td>
</tr>
<tr>
<td>Cure</td>
<td>63%</td>
<td>17%</td>
</tr>
<tr>
<td>Prevention</td>
<td>11%</td>
<td>2%</td>
</tr>
<tr>
<td>Overall</td>
<td>10%</td>
<td>1%</td>
</tr>
</tbody>
</table>


Table 20: **Largely positive** image of selected drugs (Q15)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designer drugs</td>
<td>74%</td>
</tr>
<tr>
<td>ATS</td>
<td>14%</td>
</tr>
<tr>
<td>Opium</td>
<td>54%</td>
</tr>
<tr>
<td>Heroin</td>
<td>31%</td>
</tr>
<tr>
<td>Marijuana / hash</td>
<td>68%</td>
</tr>
<tr>
<td>Cocktails</td>
<td>24%</td>
</tr>
<tr>
<td>Opiate pharmac</td>
<td>23%</td>
</tr>
<tr>
<td>Brown sugar</td>
<td>23%</td>
</tr>
<tr>
<td>Non-opiate pharmac</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source Q15: What is the effect on your mind after the drug takes effect? Proportion that mentions largely positive effects (‘Don’t know’ ignored). NA: Not applicable, sample too small

---

49 Respondents were deemed “very knowledgeable” when they scored 3 points or more; 1 point for each correct mode of transmission, one minus point for each incorrect mode of transmission

50 Respondents were deemed “very knowledgeable” when they answered that there is no cure

51 Respondents were deemed “very knowledgeable” when they scored 2 points or more; 1 point for each correct way to prevent transmission, one minus point for each incorrect way, no points for neutral answers.

52 Respondents were deemed “very knowledgeable” when they were deemed “very knowledgeable” on at least two of the three aspects above

53 The figure for designer drugs and ATS are heavily dominated by the Jakarta sample

54 The figure for non-opiate and opiate pharmaceuticals are heavily dominated by the New Delhi sample

Back to main text
### Table 21: Perceived health risks by non-PID/PID (Q16)

<table>
<thead>
<tr>
<th>Health risk</th>
<th>Non PID</th>
<th>PID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worse general health</td>
<td>42%</td>
<td>46%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Death</td>
<td>13%</td>
<td>38%</td>
</tr>
<tr>
<td>Addiction</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Brain damage</td>
<td>11%</td>
<td>3%</td>
</tr>
<tr>
<td>Overdose</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>28%</td>
<td>8%</td>
</tr>
<tr>
<td>Loss of concentration</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Decreased motivation</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Osteoporosis (bones)</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Abscess</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Thrombosis</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Decreased sex drive</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Loss of eyesight</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Loss of teeth</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>No related risks</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Respondents</td>
<td>95</td>
<td>175</td>
</tr>
</tbody>
</table>

Source: Q16: What are physical / health risks related problems to regular use of your current or latest drug, if any? (DO NOT READ THE OPTIONS. More answers possible  
Back to main text: Chapter 3b. Attitudes  
Back to main text: Chapter 6b. Problems

### Table 22: Dislike of PID among non-PID (Q29;:14)

<table>
<thead>
<tr>
<th>Dislike of PID</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>7%</td>
</tr>
<tr>
<td>Somewhat agree</td>
<td>5%</td>
</tr>
<tr>
<td>Agree</td>
<td>87%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q29: To what extent to you agree with the following statement? (14) People injecting drugs are generally disliked by non injecting PUD. 3 point-scale: Disagree - Somewhat agree - Agree. Those that agreed  
Back to main text
Table 23: **Prevalence of unsafe injecting practices** (how often do/did you…) (n=182) (Q48)

<table>
<thead>
<tr>
<th>Unsafe practice</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-inject your blood (jerking or booting)</td>
<td>57%</td>
</tr>
<tr>
<td>Flush: Inject, remove blood and re-inject</td>
<td>34%</td>
</tr>
<tr>
<td>Use “street doctor” / professional injector</td>
<td>35%</td>
</tr>
<tr>
<td>Share needle and/or syringe</td>
<td>25%</td>
</tr>
<tr>
<td>Inject after squirting drugs into syringe</td>
<td>23%</td>
</tr>
<tr>
<td>Use make-shift equipment (pens, straws)</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: Q48: see above. Percentage of respondents that answered “**Often”/”**Always” on 5-point scale: Never – Rarely – Sometimes – Often - Always.

Table 24: **Reasons for using a used needle and/or syringe** (n=179) (Q45)

<table>
<thead>
<tr>
<th>Reason / Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t have his/her own syringe.</td>
<td>77%</td>
</tr>
<tr>
<td>Desperate because of withdrawal symptoms.</td>
<td>30%</td>
</tr>
<tr>
<td>No money to buy or get a syringe.</td>
<td>36%</td>
</tr>
<tr>
<td>Wanted to save money to buy more drugs.</td>
<td>2%</td>
</tr>
<tr>
<td>Own needle was broken or dull.</td>
<td>2%</td>
</tr>
<tr>
<td>Syringe had been cleaned.</td>
<td>5%</td>
</tr>
<tr>
<td>Don’t really care.</td>
<td>5%</td>
</tr>
<tr>
<td>Someone else got or paid for the drugs.</td>
<td>1%</td>
</tr>
<tr>
<td>Injecting with people one trusts.</td>
<td>1%</td>
</tr>
<tr>
<td>Own needle was clogged.</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q45: What are some of the reasons for using a needle and / or syringe someone else had used before? DO NOT READ OPTIONS. (More answers possible)

Table 25: **Acquire syringes/needles from…..** (n=176) (Q50)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemist</td>
<td>97%</td>
</tr>
<tr>
<td>NSEP</td>
<td>3%</td>
</tr>
<tr>
<td>Friends (PUD)</td>
<td>6%</td>
</tr>
<tr>
<td>Drug dealer</td>
<td>2%</td>
</tr>
<tr>
<td>Street doctor</td>
<td>1%</td>
</tr>
<tr>
<td>Find on the street</td>
<td>4%</td>
</tr>
<tr>
<td>Friend (non PUD)</td>
<td>2%</td>
</tr>
<tr>
<td>Outreach worker</td>
<td>1%</td>
</tr>
<tr>
<td>Spouse</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q50: Where do /did you usually get your syringes or needles? (DO NOT READ THE OPTIONS. More answers possible)
Table 26: Constraints to access to new syringes (n=167) (Q45)

<table>
<thead>
<tr>
<th>Reason / Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price</td>
<td>54%</td>
</tr>
<tr>
<td>Too desperate to fix</td>
<td>18%</td>
</tr>
<tr>
<td>Not applicable: No barriers</td>
<td>5%</td>
</tr>
<tr>
<td>Lazy</td>
<td>11%</td>
</tr>
<tr>
<td>Distance</td>
<td>21%</td>
</tr>
<tr>
<td>Other obligations (work/study)</td>
<td>8%</td>
</tr>
<tr>
<td>Discrimination / Stigma</td>
<td>1%</td>
</tr>
<tr>
<td>Law</td>
<td>2%</td>
</tr>
<tr>
<td>No knowledge of services</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Q51: What are / were constraints to access new syringes? (DO NOT READ THE OPTIONS. More answers possible)

Table 27: Prevalence of unprotected sex (n=92) (Q59)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>All</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Rarely</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Often</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>Always</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>No answer, etc</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Q59: Do you ever have unprotected sex? If yes, how often? (One answer only)
* Act: Sexually active: those that answered Yes to Q58, see above.
Table 28: Reasons for not using a condom among *sexually active* PUD (n=92) (Q60)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't like using it</td>
<td>33%</td>
</tr>
<tr>
<td>Don't really care</td>
<td>10%</td>
</tr>
<tr>
<td>Trust sex partner</td>
<td>20%</td>
</tr>
<tr>
<td>Not available / difficult to get</td>
<td>13%</td>
</tr>
<tr>
<td>Partner doesn’t want to use one</td>
<td>15%</td>
</tr>
<tr>
<td>Don’t know how to use it</td>
<td>23%</td>
</tr>
<tr>
<td>Sex within marriage only</td>
<td>12%</td>
</tr>
<tr>
<td>In monogamous relationship</td>
<td>5%</td>
</tr>
<tr>
<td>Shame / Embarrassed</td>
<td>8%</td>
</tr>
<tr>
<td>Want to procreate</td>
<td>4%</td>
</tr>
<tr>
<td>What's a condom?</td>
<td>2%</td>
</tr>
<tr>
<td>Expensive</td>
<td>2%</td>
</tr>
<tr>
<td>Afraid to suggest use</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q60: What are reasons for someone NOT using a condom while having sex? (DO NOT READ OPTIONS. More answers possible.) Only those who were considered ‘sexually active’ (Q58).
### Table 29: (Perceived) availability of selected drugs (n=281) (Q15)\(^{55}\)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana / hash</td>
<td>58%</td>
</tr>
<tr>
<td>Heroin</td>
<td>70%</td>
</tr>
<tr>
<td>Opium</td>
<td>76%</td>
</tr>
<tr>
<td>Brown sugar</td>
<td>61%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>20%</td>
</tr>
<tr>
<td>Amphetamine (ATS)</td>
<td>4%</td>
</tr>
<tr>
<td>Designer drugs (Ecstasy)</td>
<td>24%</td>
</tr>
<tr>
<td>Methadone(^{56})</td>
<td>27%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>6%</td>
</tr>
<tr>
<td>Hallucigenics</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Q15: Have you ever heard of this drug being available in your city? (Y / N)  

### Table 30: Life-Time Prevalence (LTP) and Last Quarter Prevalence (LQP) (n=281) (Q30)

<table>
<thead>
<tr>
<th>Drug used</th>
<th>LTP</th>
<th>LQP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana / hash</td>
<td>45%</td>
<td>29%</td>
</tr>
<tr>
<td>Heroin</td>
<td>71%</td>
<td>59%</td>
</tr>
<tr>
<td>Brown sugar</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Opium</td>
<td>62%</td>
<td>37%</td>
</tr>
<tr>
<td>Cocktails</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>ATS(^{57})</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Non-opiate pharmac.’s</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Opiate pharmaceuticals</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Sleeping pills(^{58})</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Hallucigenics</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Methadone</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Total: 221% | 142%

Source: Q30: LTP: column A: Which drugs have you ever used? WRITE DOWN IN CHRONOLOGICAL ORDER. Write down local names if in doubt. LQP: column E: Frequency (last 3 months); those that did not say “never”. 

---

\(^{55}\) To improve readability, throughout this report, percentages are usually presented with no decimal.

\(^{56}\) From these data, it is unclear whether Methadone and Buprenorphine were available in pharmacotherapy interventions or otherwise. Elsewhere, it will appear that Methadone is largely taken orally and Buprenorphine is largely injected.

\(^{57}\) In Indonesia, a drug called *shabu shabu* is the prevalent ATS drug.

\(^{58}\) At the request of the research team in Jakarta, sleeping pills were considered a separate drug rather than included in the non-opiate pharmaceuticals. The pharmaceuticals in the list are those pharmaceuticals that are injected in New Delhi and Pakistan.
Table 31: Mode of intake of heroin (n=199) (LTP) (Q37)

<table>
<thead>
<tr>
<th>Mode of intake heroin</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inject</td>
<td>79%</td>
</tr>
<tr>
<td>Fellow PID injects</td>
<td>2%</td>
</tr>
<tr>
<td>Professional injector</td>
<td>1%</td>
</tr>
<tr>
<td>Smoke</td>
<td>26%</td>
</tr>
<tr>
<td>Chase</td>
<td>1%</td>
</tr>
<tr>
<td>Inhale</td>
<td>5%</td>
</tr>
<tr>
<td>Sniff</td>
<td>10%</td>
</tr>
<tr>
<td>Eat</td>
<td>1%</td>
</tr>
<tr>
<td>Proportion of total</td>
<td>71%</td>
</tr>
</tbody>
</table>

Source: Q30: Fill out the table on the next page (Go through column 1 first, then fill out the rest)

Column 1: Which drugs have you ever used? WRITE DOWN IN CHRONOLOGICAL ORDER Write down local names if in doubt. Column 2: How have you taken it? (DO NOT READ OPTIONS. More than one answer possible. USE DIFFERENT ROW FOR EACH mode of intake)

Table 32: Number of years since initiation to drug use (n=279, Mean ± SD= 8.8±5.4) (Q30)

<table>
<thead>
<tr>
<th>Period until initiation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>1%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>9%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>5%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>6%</td>
</tr>
<tr>
<td>4-5 years</td>
<td>4%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>38%</td>
</tr>
<tr>
<td>10-15 years</td>
<td>27%</td>
</tr>
<tr>
<td>≥15 years</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Q30: Fill out the table on the next page (Go through column 1 first, then fill out the rest)

Table 33: Age adjusted number of years since initiation to drug use (n=279, Mean ± SD= 6.0±4.2) (Q30)

<table>
<thead>
<tr>
<th>Period until initiation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>10%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>3%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>5%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>9%</td>
</tr>
<tr>
<td>4-5 years</td>
<td>7%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>55%</td>
</tr>
<tr>
<td>10-15 years</td>
<td>12%</td>
</tr>
<tr>
<td>≥15 years</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q30: Fill out the table on the next page (Go through column 1 first, then fill out the rest)
Table 34: Intensive drug use (n=281) (Q30), (compared with LQP)

<table>
<thead>
<tr>
<th>Drug used</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana / hash</td>
<td>23%</td>
</tr>
<tr>
<td>Heroin</td>
<td>57%</td>
</tr>
<tr>
<td>Brown sugar</td>
<td>4%</td>
</tr>
<tr>
<td>Opium</td>
<td>30%</td>
</tr>
<tr>
<td>Amphetamine Type Stimulant</td>
<td>1%</td>
</tr>
<tr>
<td>Sleeping pills&lt;br&gt;59</td>
<td>1%</td>
</tr>
<tr>
<td>Ecstasy / Designer drugs</td>
<td>2%</td>
</tr>
<tr>
<td>Non-opiate pharmac. ’s</td>
<td>1%</td>
</tr>
<tr>
<td>Opiate pharmaceuticals</td>
<td>3%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>1%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1%</td>
</tr>
<tr>
<td>Methadone</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q30: Column E: Frequency (last 3 months); those that answered ““>once a week”, “Once a day”, or “>once a day”

Table 35: Age at initiation (n=279, Mean = 19) (Q30)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 13 years</td>
<td>5%</td>
</tr>
<tr>
<td>13-15 years</td>
<td>17%</td>
</tr>
<tr>
<td>16-18 years</td>
<td>27%</td>
</tr>
<tr>
<td>19-21 years</td>
<td>29%</td>
</tr>
<tr>
<td>22-25 years</td>
<td>14%</td>
</tr>
<tr>
<td>&gt; 25 years</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Q30: Column 1: Which drugs have you ever used? WRITE DOWN IN CHRONOLOGICAL ORDER. Column C: How old were you when you first used it?

Table 36: Drug of initiation (n=279) (Q30)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana / Hash</td>
<td>32%</td>
</tr>
<tr>
<td>Opium</td>
<td>37%</td>
</tr>
<tr>
<td>Heroin</td>
<td>24%</td>
</tr>
<tr>
<td>Brown sugar</td>
<td>1%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1%</td>
</tr>
<tr>
<td>Opiate pharmaceuticals</td>
<td>2%</td>
</tr>
<tr>
<td>Other (&lt;1% each)</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q30: Column A: Which drugs have you ever used? WRITE DOWN IN CHRONOLOGICAL ORDER. Write down local names if in doubt

At the request of the research team in Jakarta, sleeping pills were considered a separate drug rather than included in the non-opiate pharmaceuticals. The pharmaceuticals in the list are those pharmaceuticals that are injected in New Delhi and Pakistan.
### Table 37: Contributing factors of drug use (n=280) (Q29)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>The large majority of PUD starts using drugs when they have personal problems.</td>
<td>70%</td>
</tr>
<tr>
<td>The large majority of PUD is persuaded (or talked) into it by peers.</td>
<td>60%</td>
</tr>
<tr>
<td>People start using drugs out of boredom or loneliness.</td>
<td>65%</td>
</tr>
<tr>
<td>The large majority of PUD try to persuade people around them to start using drugs</td>
<td>51%</td>
</tr>
<tr>
<td>A drug career usually goes hand in hand with a dysfunctional family.</td>
<td>43%</td>
</tr>
</tbody>
</table>

Source: Q29: To what extent to you agree with the following statements? (GO THROUGH LIST ONE BY ONE) 3 point-scale: Disagree - Somewhat agree –Agree

### Table 38: Person PUD talks with most on drug use and drug related problems (n=279) (Q62)

<table>
<thead>
<tr>
<th>Contact person</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellow PUD</td>
<td>35%</td>
</tr>
<tr>
<td>Nobody</td>
<td>34%</td>
</tr>
<tr>
<td>Friend (non PUD)</td>
<td>2%</td>
</tr>
<tr>
<td>Partner / Spouse</td>
<td>6%</td>
</tr>
<tr>
<td>Mother</td>
<td>6%</td>
</tr>
<tr>
<td>Sibling</td>
<td>5%</td>
</tr>
<tr>
<td>Parents</td>
<td>1%</td>
</tr>
<tr>
<td>Doctor / Hospital</td>
<td>6%</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>1%</td>
</tr>
<tr>
<td>Father</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q62: Who do you talk with MOST about your drug use or drug-related problems? (One answer only)

### Table 39: Closest non-PUD (n=279) (Q63)

<table>
<thead>
<tr>
<th>Closest person</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>5%</td>
</tr>
<tr>
<td>Friend / Peer</td>
<td>1%</td>
</tr>
<tr>
<td>Relative</td>
<td>74%</td>
</tr>
<tr>
<td>Sibling</td>
<td>8%</td>
</tr>
<tr>
<td>Partner / Spouse</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Q63: Who is closest to you that does NOT use drugs? (One answer only)
Table 40: Closest person’s reaction / behaviour (n=281) (Q66- Q68)

<table>
<thead>
<tr>
<th>Closest person’s reaction</th>
<th>Initial</th>
<th>Current</th>
<th>Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t know of drug use</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Urged me to stop</td>
<td>++</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Angry</td>
<td>+++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Stricter</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Broke relationship</td>
<td>+++</td>
<td>+++</td>
<td></td>
</tr>
<tr>
<td>Indifferent</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>General positive support</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Love, affection</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Respect</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Moral support</td>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

Source: Q66: What was the initial reaction / behaviour towards your drug use of the person closest to you? Q67: What is his/her current behaviour? Q68: What would you like this person’s behaviour to be? Do not read the options. More answers possible; maximum 3) and corresponding questions in the open interviews. +rare, ++occasional, +++somewhat common, ++++ common.

Table 41: Parents initial, current and desired reaction / behaviour (n=281) (Q66- Q68)

<table>
<thead>
<tr>
<th>Parents’ reactions</th>
<th>Initial</th>
<th>Current</th>
<th>Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t know of drug use</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Angry</td>
<td>+++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Urged me to stop</td>
<td>++</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Stricter</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Broke relationship</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Indifferent</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>General positive support</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Love, affection</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Moral support</td>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

Source: Q66: What was the initial reaction / behaviour towards your drug use of your parents? Q67: What is their current behaviour? Q68: What would you like your parent’s behaviour to be? Do not read the options. More answers possible; maximum 3). (In order of frequency of initial reaction). +rare, ++occasional, +++somewhat common, ++++ common.

Table 42: Friends’ initial, current and desired reaction/behaviour (n=281) (Q66-Q68)

<table>
<thead>
<tr>
<th>Friends (non-PUD) reactions</th>
<th>Initial</th>
<th>Current</th>
<th>Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t know of drug use</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love, affection</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broke relationship</td>
<td>++</td>
<td>+++</td>
<td></td>
</tr>
<tr>
<td>Gave up hope</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General positive support</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Respect</td>
<td></td>
<td></td>
<td>++</td>
</tr>
</tbody>
</table>

Source: Q66: What was the initial reaction / behaviour towards your drug use of your parents? Q67: What is their current behaviour? Q68: What would you like your parent’s behaviour to be? Do not read the options. More answers possible; maximum 3). +rare, ++occasional, +++somewhat common, ++++ common.
Table 43: Partner/spouse initial, current and desired reaction / behaviour (Q66- Q68)

<table>
<thead>
<tr>
<th>Partner’s reactions</th>
<th>Initial</th>
<th>Current</th>
<th>Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t know of drug use</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Broken relationship</td>
<td></td>
<td></td>
<td>+++</td>
</tr>
<tr>
<td>Urged me to stop</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Angry</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Indifferent</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love, affection</td>
<td></td>
<td></td>
<td>++</td>
</tr>
<tr>
<td>Respondents</td>
<td>281</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Q66: What was the initial reaction / behaviour towards your drug use of your Boyfriend / Girlfriend / Partner / Spouse? Do not read the options. More answers possible; maximum 3). +rare, ++occasional, +++somewhat common, ++++ common.

Table 44: Prevalence of drug use in school (n=272) (Q64)

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not at all</td>
<td>77%</td>
</tr>
<tr>
<td>Rare</td>
<td>13%</td>
</tr>
<tr>
<td>Somewhat common</td>
<td>5%</td>
</tr>
<tr>
<td>Common</td>
<td>3%</td>
</tr>
<tr>
<td>Very common</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q 64: When you were going to school, was there any drug use in school? If yes, how common was it? (One answer only. Only those that went to school)

Table 45: Gradual versus clarity of switch (Q31)

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Switch 1</th>
<th>Switch 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear</td>
<td>63%</td>
<td>76%</td>
</tr>
<tr>
<td>Gradual</td>
<td>38%</td>
<td>24%</td>
</tr>
<tr>
<td>Respondent</td>
<td>192</td>
<td>86</td>
</tr>
</tbody>
</table>

Source: Q31: Was is a clear or a gradual switch?

Table 46: Period until switch towards injecting (n=80) (Q32)

<table>
<thead>
<tr>
<th>Period</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>13%</td>
</tr>
<tr>
<td>1-3 years</td>
<td>31%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>14%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>38%</td>
</tr>
<tr>
<td>10 years or more</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Q31: Two most crucial switches. Identify switches towards / away from injecting or towards / away from “harder” drug, and fill out table below.
Table 47:  Very much a factor for Switch 2 by bite (n=86) (Q32) (Compared with Switch 1)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength of drug (quicker high)</td>
<td>80%</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>43%</td>
</tr>
<tr>
<td>Curiosity</td>
<td>52%</td>
</tr>
<tr>
<td>Relaxation / Sleep</td>
<td>76%</td>
</tr>
<tr>
<td>Easier availability new drug</td>
<td>62%</td>
</tr>
<tr>
<td>Suppression of feelings</td>
<td>45%</td>
</tr>
<tr>
<td>Fashionable</td>
<td>33%</td>
</tr>
<tr>
<td>To be different</td>
<td>36%</td>
</tr>
<tr>
<td>To enhance confidence</td>
<td>33%</td>
</tr>
<tr>
<td>Performance at work / school</td>
<td>40%</td>
</tr>
<tr>
<td>Lack of availability new drug</td>
<td>59%</td>
</tr>
<tr>
<td>Price</td>
<td>-</td>
</tr>
<tr>
<td>Easier to use in public</td>
<td>47%</td>
</tr>
<tr>
<td>Bored with previous high</td>
<td>63%</td>
</tr>
<tr>
<td>Lack availability previous drug</td>
<td>45%</td>
</tr>
<tr>
<td>Tried to give up previous drug</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Q32: To what extent have the items below been a factor in your Switch 2? GO THROUGH THE LIST ONE BY ONE. Those scores that were rated "Very much" a factor by >33% of the respondents are included

Table 48:  Intention of overdose (n=87) (Q53)

<table>
<thead>
<tr>
<th>Intention</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>47%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>29%</td>
</tr>
<tr>
<td>Totally</td>
<td>20%</td>
</tr>
<tr>
<td>NA/ Don't know</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Q53: How intentional was it? (The overdose; One answer only)
Table 49: Carer after overdose (n=87) (Q54)

<table>
<thead>
<tr>
<th>Carer</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends (PUD)</td>
<td>32%</td>
</tr>
<tr>
<td>No one</td>
<td>32%</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>6%</td>
</tr>
<tr>
<td>Friends (non PUD)</td>
<td>5%</td>
</tr>
<tr>
<td>Partner / Spouse</td>
<td>8%</td>
</tr>
<tr>
<td>Sibling(s)</td>
<td>3%</td>
</tr>
<tr>
<td>Relative(s)</td>
<td>1%</td>
</tr>
<tr>
<td>Doctor</td>
<td>7%</td>
</tr>
<tr>
<td>Other (NGO worker, Outreach worker, Peers support group, Religious leader, Counsellor, School / Teacher(s), Community leaders, Police, Government Officer, NA/Don’t know)</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Q54: Who looked after you when you OD’d? (One answer only)  
Back to main text

Table 50: Effect of overdose experience (n=187) (Q56)

<table>
<thead>
<tr>
<th>Effect</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No effect</td>
<td>72%</td>
</tr>
<tr>
<td>Became more careful</td>
<td>6%</td>
</tr>
<tr>
<td>Decreased drug use</td>
<td>15%</td>
</tr>
<tr>
<td>Went into treatment</td>
<td>4%</td>
</tr>
<tr>
<td>Switched to other drug(s)</td>
<td>2%</td>
</tr>
<tr>
<td>Switched to other mode</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Q56: How did this /these OD experience(s) influence your attitude towards your drug use, if at all? (DO NOT READ OPTIONS. One answer only)  
Back to main text

Table 51: Self-estimation of chance of abstinence (Q57)

<table>
<thead>
<tr>
<th>Chance of abstinence</th>
<th>Non PID</th>
<th>PID</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>No, probably not</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Yes, possibly</td>
<td>55%</td>
<td>54%</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Don’t care</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Respondents</td>
<td>121</td>
<td>57</td>
</tr>
</tbody>
</table>

Source: Q57: What are the chances of you ever being able to stop using drugs? (One answer only) (Only active users as per Q34)  
Back to main text

---

60 NGO worker, Outreach worker, Peers support group, Religious leader, Counsellor, School / Teacher(s), Community leaders, Police, Government Officer, NA/Don’t know, were mentioned fewer than 5 times.
### Table 52: Frequency of “self-treatment” (n=279) (Q42)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>27%</td>
</tr>
<tr>
<td>Once</td>
<td>15%</td>
</tr>
<tr>
<td>A couple of times</td>
<td>35%</td>
</tr>
<tr>
<td>Several times (4-7)</td>
<td>8%</td>
</tr>
<tr>
<td>Many times (&gt;7)</td>
<td>10%</td>
</tr>
<tr>
<td>All the time</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Q42: Do / Did you ever consciously reduce your intake by yourself? If so, how often? (One answer only)

### Table 53: Ways to stay away from drugs (Q43)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid drug using friends</td>
<td>22%</td>
</tr>
<tr>
<td>Occupy oneself</td>
<td>43%</td>
</tr>
<tr>
<td>Avoid going to certain places</td>
<td>15%</td>
</tr>
<tr>
<td>Stay home</td>
<td>0%</td>
</tr>
<tr>
<td>Start or shift to alcohol</td>
<td>9%</td>
</tr>
<tr>
<td>Move</td>
<td>10%</td>
</tr>
<tr>
<td>Change lifestyle</td>
<td>12%</td>
</tr>
<tr>
<td>Spiritual / religious focus</td>
<td>3%</td>
</tr>
<tr>
<td>Pursue hobbies</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Q43: What do/did you do to stay away from drugs? (DO NOT READ THE OPTIONS. More answers possible).
Table 54: Who should be / have been involved to help you to stop? (n=142)(Q44)

<table>
<thead>
<tr>
<th>Desired supporter</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s)</td>
<td>50%</td>
</tr>
<tr>
<td>Friends (non PUD)</td>
<td>10%</td>
</tr>
<tr>
<td>Partner / Spouse</td>
<td>12%</td>
</tr>
<tr>
<td>Sibling(s)</td>
<td>14%</td>
</tr>
<tr>
<td>Friends (PUD)</td>
<td>6%</td>
</tr>
<tr>
<td>No one</td>
<td>0%</td>
</tr>
<tr>
<td>Relative(s)</td>
<td>6%</td>
</tr>
<tr>
<td>Doctor</td>
<td>4%</td>
</tr>
<tr>
<td>NGO worker</td>
<td>5%</td>
</tr>
<tr>
<td>Outreach worker</td>
<td>0%</td>
</tr>
<tr>
<td>Peers support group</td>
<td>1%</td>
</tr>
<tr>
<td>Religious leader</td>
<td>0%</td>
</tr>
<tr>
<td>Counsellor</td>
<td>1%</td>
</tr>
<tr>
<td>School / Teacher(s)</td>
<td>0%</td>
</tr>
<tr>
<td>Community leaders</td>
<td>0%</td>
</tr>
<tr>
<td>Police</td>
<td>0%</td>
</tr>
<tr>
<td>Government Officer</td>
<td>1%</td>
</tr>
<tr>
<td>NA/Don't know</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Q44: As above (DO NOT READ THE OPTIONS. More answers possible).

Table 55: Treatment (n=281) (Q33)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never treated</td>
<td>57%</td>
</tr>
<tr>
<td>Ever treated</td>
<td>43%</td>
</tr>
</tbody>
</table>

Of those who received treatment (n=122):

| One successful            | 2%      |
| One unsuccessful          | 8%      |
| More than one treatment   | 90%     |

Source: Q33: Have you ever been treated? How long did your least and most successful treatment last?

61 In case of one treatment, it was deemed “successful” if the respondent was not using at the time of the interview and “unsuccessful” if the person was using. The period of abstinence after these treatments will be covered elsewhere.
62 The (perceived) success of these treatments will be cover in the sections below.
Table 56: (Knowledge of) availability of drug use related services (Q69)

<table>
<thead>
<tr>
<th>Drug use related service</th>
<th>Source</th>
<th>Non- PID</th>
<th>PID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Medical Services</td>
<td>PUD</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Somewhat*</td>
<td></td>
</tr>
<tr>
<td>Detoxification centres</td>
<td>PUD</td>
<td>25%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Widely</td>
<td></td>
</tr>
<tr>
<td>Residential rehab centres</td>
<td>PUD</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Limited</td>
<td></td>
</tr>
<tr>
<td>Day care</td>
<td>PUD</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>Drop-in centres</td>
<td>PUD</td>
<td>23%</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Limited</td>
<td></td>
</tr>
<tr>
<td>Street-based / Outreach</td>
<td>PUD</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Limited</td>
<td></td>
</tr>
<tr>
<td>Peer groups / Self-support</td>
<td>PUD</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Somewhat</td>
<td></td>
</tr>
<tr>
<td>NSEP</td>
<td>PUD</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Limited</td>
<td></td>
</tr>
<tr>
<td>MMT / BMT</td>
<td>PUD</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>SRM</td>
<td>Limited</td>
<td></td>
</tr>
</tbody>
</table>

Respondents (average): 94 184

Sources: Each first row: Q69: Which of the following drug related services are available? Each second row: As filled out by the SRM based on analysis of existing data, August 2004: To what extent are the following drug related services available? *Limited availability (covering a small part of the target group) **Available to some degree (covering a sizable part of the target group) ***Widely available

Back to main text (Chapter 1) Back to main text (Chapter 4)

Table 57: Use of drug use related services (n=278-279) (Q70)

<table>
<thead>
<tr>
<th>Drug use related service</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Medical Services</td>
<td>5%</td>
</tr>
<tr>
<td>Detoxification centres</td>
<td>10%</td>
</tr>
<tr>
<td>Residential rehab centres</td>
<td>7%</td>
</tr>
<tr>
<td>Day care</td>
<td>1%</td>
</tr>
<tr>
<td>Drop-in centres</td>
<td>26%</td>
</tr>
<tr>
<td>Street-based / Outreach</td>
<td>2%</td>
</tr>
<tr>
<td>Peer groups / Self-support</td>
<td>4%</td>
</tr>
<tr>
<td>NSEP</td>
<td>7%</td>
</tr>
<tr>
<td>MMT / BMT</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Q70: What kind of services have you received? GO THROUGH LIST ONE BY ONE. (Proportions of the total group, regardless of knowledge of availability (Q69).)

Back to main text
Table 58: Constraints to access or complete drug use related services (n=271) (Q73)

<table>
<thead>
<tr>
<th>Constraints</th>
<th>Tehran</th>
</tr>
</thead>
<tbody>
<tr>
<td>No knowledge of services</td>
<td>58%</td>
</tr>
<tr>
<td>Lengthy / time-consuming</td>
<td>21%</td>
</tr>
<tr>
<td>Lack of available services</td>
<td>51%</td>
</tr>
<tr>
<td>Price</td>
<td>24%</td>
</tr>
<tr>
<td>Distance</td>
<td>22%</td>
</tr>
<tr>
<td>Lack of space in centre</td>
<td>23%</td>
</tr>
<tr>
<td>Other obligations</td>
<td>16%</td>
</tr>
<tr>
<td>Bad reputation of centre</td>
<td>8%</td>
</tr>
<tr>
<td>Fear of exposing addiction</td>
<td>21%</td>
</tr>
<tr>
<td>Discrimination/stigma</td>
<td>9%</td>
</tr>
<tr>
<td>Fear of residing with HIV/AIDS infected clients</td>
<td>28%</td>
</tr>
<tr>
<td>Law</td>
<td>14%</td>
</tr>
<tr>
<td>Fear of residing with PUDs</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: Q73: What are the constraints to access or complete these services (GO THROUGH THE LIST ONE BY ONE. Ask if there are any other constraints.) Those that answered “Very much” on a three point scale: “Not at all” – “Some extent” – “Very much”. (“No answer”, “Not applicable”, “Don’t know” are discarded)

Table 59: Drug use related services that helped most physically (Q71)

<table>
<thead>
<tr>
<th>Drug use related service</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential rehabilitation centres</td>
<td>90%</td>
</tr>
<tr>
<td>Drop-in centres</td>
<td>57%</td>
</tr>
<tr>
<td>Detoxification centres</td>
<td>76%</td>
</tr>
<tr>
<td>Needle and Syringe Exchange Programme</td>
<td>61%</td>
</tr>
<tr>
<td>MMT / BMT(Pharmacotherapy)</td>
<td>75%</td>
</tr>
<tr>
<td>Peer groups / Self-support peer groups</td>
<td>42%</td>
</tr>
<tr>
<td>Day care</td>
<td>-</td>
</tr>
<tr>
<td>Hospital / Medical Services</td>
<td>15%</td>
</tr>
<tr>
<td>Street-based/Outreach /Community-based</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Q71: Which of these services helped you most physically? (Only when total is at least 10 respondents per service at the site) More answers possible.
Table 60: Drug use related services that helped most in staying off drugs (Q72)

<table>
<thead>
<tr>
<th>Drug use related service</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential rehabilitation centres</td>
<td>85%</td>
</tr>
<tr>
<td>Drop-in centres</td>
<td>56%</td>
</tr>
<tr>
<td>Detoxification centres</td>
<td>79%</td>
</tr>
<tr>
<td>Needle and syringe exchange programme</td>
<td>44%</td>
</tr>
<tr>
<td>MMT / BMT</td>
<td>75%</td>
</tr>
<tr>
<td>Peer groups / Self-support peer groups</td>
<td>42%</td>
</tr>
<tr>
<td>Day care</td>
<td>-</td>
</tr>
<tr>
<td>Hospital / Medical services</td>
<td>15%</td>
</tr>
<tr>
<td>Street-based/Outreach /Community-based</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Q72: Which of these services helped you most to stay off drugs? (Only when the total is at least 10 respondents per service) More answers possible.

Table 61: Frequency of relapse (n=119) (Q35)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>11%</td>
</tr>
<tr>
<td>Once</td>
<td>21%</td>
</tr>
<tr>
<td>A couple of times</td>
<td>47%</td>
</tr>
<tr>
<td>Many times</td>
<td>17%</td>
</tr>
<tr>
<td>On and off all the time</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Q35: Have you ever relapsed? If “No, never” go to Q37
Table 62: Factors for relapse (n=106) (Q36)

<table>
<thead>
<tr>
<th>Reason / Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant exposure to PUD friends</td>
<td>17%</td>
</tr>
<tr>
<td>Emotional/mental state</td>
<td>36%</td>
</tr>
<tr>
<td>Family problem(s)</td>
<td>23%</td>
</tr>
<tr>
<td>Persuasion from PUD friends</td>
<td>22%</td>
</tr>
<tr>
<td>Irresistible urge to use</td>
<td>31%</td>
</tr>
<tr>
<td>Wanted to use</td>
<td>11%</td>
</tr>
<tr>
<td>Unemployment /Financial reasons</td>
<td>20%</td>
</tr>
<tr>
<td>Lack of moral support</td>
<td>5%</td>
</tr>
<tr>
<td>Underestimated power of drug</td>
<td>3%</td>
</tr>
<tr>
<td>Rejection/discrimination/stigma</td>
<td>4%</td>
</tr>
<tr>
<td>Overconfidence</td>
<td>1%</td>
</tr>
<tr>
<td>Sex-related reason</td>
<td>3%</td>
</tr>
<tr>
<td>Work pressure</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Q36: What are the factors that made / make you relapse? (DO NOT READ THE OPTIONS. More answers possible). Only those respondents that had been in treatment.

Table 63: Income / expenditure per day (Q11)

<table>
<thead>
<tr>
<th>“Expenditure”</th>
<th>Non PID</th>
<th>PID</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>70,777</td>
<td>47,445</td>
<td>55,391</td>
</tr>
<tr>
<td>In US$</td>
<td>$7.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75%</td>
<td>85,000</td>
<td>60,000</td>
<td>70,000</td>
</tr>
<tr>
<td>Resp.</td>
<td>94</td>
<td>182</td>
<td>276</td>
</tr>
</tbody>
</table>

Source: Q11: How much do /did you make in a day / month? (Monthly income /30). FOR NON-ACTIVE USERS; INCOME DURING THE LAST MONTHS OF USE

*This includes some reported incomes of more than Rs. 5,000 / day, which are probably exaggerations or ‘lucky breaks’, rather than a reflection of one’s average income over a longer period.

Table 64: Average daily expenses on drugs (Q12)

<table>
<thead>
<tr>
<th>Expenditure on drugs</th>
<th>Non PID</th>
<th>PID</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>56,406</td>
<td>51,995</td>
<td>53,507</td>
</tr>
<tr>
<td>in US$</td>
<td>$6.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75%</td>
<td>60,000</td>
<td>70,000</td>
<td>70,000</td>
</tr>
<tr>
<td>% on drugs</td>
<td>80%</td>
<td>110%</td>
<td>97%</td>
</tr>
<tr>
<td>Resp.</td>
<td>96</td>
<td>184</td>
<td>280</td>
</tr>
</tbody>
</table>

Source: Q12: How much are / were your average daily expenses on drugs?
### Table 65: Contact with police (n=193) (Q75)

<table>
<thead>
<tr>
<th>Contact</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, never</td>
<td>29%</td>
</tr>
<tr>
<td>Respondents</td>
<td>272</td>
</tr>
<tr>
<td>Imprisoned</td>
<td>74%</td>
</tr>
<tr>
<td>Physically abused</td>
<td>52%</td>
</tr>
<tr>
<td>Money taken away</td>
<td>3%</td>
</tr>
<tr>
<td>Drug(s) taken away</td>
<td>9%</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>9%</td>
</tr>
<tr>
<td>Police custody</td>
<td>20%</td>
</tr>
<tr>
<td>Arrested</td>
<td>14%</td>
</tr>
<tr>
<td>Valuables taken away</td>
<td>2%</td>
</tr>
<tr>
<td>Forced to rat on PUD</td>
<td>3%</td>
</tr>
<tr>
<td>Sexually abused</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q75: Have you ever been in contact with the police in relation to your drug use? If Yes, what did they do? (DO NOT READ OPTIONS. More than one answer possible)

### Table 66: Drug use related offence (n=145) (Q76)

<table>
<thead>
<tr>
<th>Contact</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possession</td>
<td>42%</td>
</tr>
<tr>
<td>Using drugs / Intoxicated</td>
<td>60%</td>
</tr>
<tr>
<td>Fighting / Violence</td>
<td>3%</td>
</tr>
<tr>
<td>Theft / Robbery</td>
<td>4%</td>
</tr>
<tr>
<td>Selling of drugs</td>
<td>21%</td>
</tr>
<tr>
<td>Drug trafficking</td>
<td>1%</td>
</tr>
<tr>
<td>Murder</td>
<td>0%</td>
</tr>
<tr>
<td>Fraud</td>
<td>1%</td>
</tr>
<tr>
<td>Sex work</td>
<td>1%</td>
</tr>
<tr>
<td>Other:</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q76: Under which offence(s) were you sent to jail or prison? (DO NOT READ OPTIONS. More than one answer possible). Only those who had been jailed or imprisoned in relation to their drug use

### Table 67: Prevalence of drug use in prison (n=145) (Q68)

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not at all</td>
<td>7%</td>
</tr>
<tr>
<td>Rare</td>
<td>6%</td>
</tr>
<tr>
<td>Somewhat common</td>
<td>7%</td>
</tr>
<tr>
<td>Common</td>
<td>2%</td>
</tr>
<tr>
<td>Very common</td>
<td>78%</td>
</tr>
</tbody>
</table>

Source: Q78: Was there any drug use in prison? If yes, how common was it? (One answer only)
Table 68: Development of drug use in prison (n=144) (Q79)

<table>
<thead>
<tr>
<th>Development</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stopped using</td>
<td>35%</td>
</tr>
<tr>
<td>Decreased</td>
<td>42%</td>
</tr>
<tr>
<td>Remained the same</td>
<td>12%</td>
</tr>
<tr>
<td>Increased</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Q79: How is / was your drug use in prison, compared to previous? (One answer only)

Table 69: Way to get drugs while in prison (n=83) (Q80)

<table>
<thead>
<tr>
<th>Method</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay fellow inmates</td>
<td>81%</td>
</tr>
<tr>
<td>Bribe official(s)</td>
<td>2%</td>
</tr>
<tr>
<td>Other favours</td>
<td>8%</td>
</tr>
<tr>
<td>Smuggled in</td>
<td>5%</td>
</tr>
<tr>
<td>Nothing / Presented</td>
<td>2%</td>
</tr>
<tr>
<td>Sex</td>
<td>8%</td>
</tr>
<tr>
<td>Forced to rat on PUD</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Q80: What did you have to do to get drugs while in prison? (DO NOT READ OPTIONS. More answers possible).

Table 70: Characteristics of PUD -according to PUD (n=281) (Q27)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confident</td>
<td>28%</td>
</tr>
<tr>
<td>Happy</td>
<td>19%</td>
</tr>
<tr>
<td>Trustworthy</td>
<td>13%</td>
</tr>
<tr>
<td>Reliable</td>
<td>22%</td>
</tr>
<tr>
<td>Pleasure-seeking</td>
<td>34%</td>
</tr>
<tr>
<td>Manipulative</td>
<td>42%</td>
</tr>
<tr>
<td>Emotional</td>
<td>62%</td>
</tr>
<tr>
<td>Self-centered</td>
<td>50%</td>
</tr>
<tr>
<td>Dishonest</td>
<td>53%</td>
</tr>
<tr>
<td>Lazy</td>
<td>64%</td>
</tr>
<tr>
<td>Kleptomaniac</td>
<td>52%</td>
</tr>
<tr>
<td>Dependent</td>
<td>62%</td>
</tr>
<tr>
<td>Grumpy</td>
<td>58%</td>
</tr>
<tr>
<td>Critical</td>
<td>43%</td>
</tr>
</tbody>
</table>

Source: Q27: To what extent would you describe people using drugs as: (GO THROUGH LIST ONE BY ONE) “Yes” answers (3-point scale: No – Somewhat – Yes).
Annex 2: Overview: availability, mode of intake, prevalence and price

<table>
<thead>
<tr>
<th></th>
<th>Availability</th>
<th>Mode of intake</th>
<th>Prevalence</th>
<th>Price</th>
<th>Local name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brown Sugar</strong></td>
<td>1</td>
<td>4 / 1</td>
<td>2</td>
<td>40.000 to 50.000 Rials/gr</td>
<td>dava (drug)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>gard (powder)</td>
</tr>
<tr>
<td><strong>Heroin</strong></td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>60.000-70.000 Rials/gr</td>
<td>dava (drug)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em>crystal</em>: 90.000-100.000 Rials/gr</td>
<td>sefidi/*spid (white), gard (powder), Crystal (very pure heroine)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opium</strong></td>
<td>1</td>
<td>4 / 8 / 1</td>
<td>2</td>
<td>80.000 Rials/gr</td>
<td>Teryak</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Taryak</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tal</td>
</tr>
<tr>
<td><strong>Opiate Pharmaceuticals</strong></td>
<td>1</td>
<td>8 / 1</td>
<td>1</td>
<td></td>
<td>Codein, Surbutext</td>
</tr>
<tr>
<td><strong>Non opiate pharmaceuticals</strong></td>
<td>1</td>
<td>8 / 1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cocktails</strong></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>Speed Ball: 500.000 Rials/gr</td>
<td>Speed Ball (cocaine+heroin)</td>
</tr>
<tr>
<td><strong>ATS</strong></td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>45.000 Rials</td>
<td>Ghors (pill), kristal (crystal), yakh (ice)</td>
</tr>
<tr>
<td><strong>Designer drugs</strong></td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>30.000-50.000 Rials/pill</td>
<td>iks/eks/ ekstesy (Ecstasy), ghors-e-shadi (happiness pill)</td>
</tr>
<tr>
<td><strong>Hallucigenics</strong></td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>300.000 to 400.000 Rials/pack</td>
<td>acid</td>
</tr>
<tr>
<td><strong>Marijuana / Hash</strong></td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>Hash: 40.000 Rials/gr</td>
<td>bang, hashish, sigari, join, alaf (grass), grass, elich, dishlame</td>
</tr>
<tr>
<td><strong>Bruprenorphine</strong></td>
<td>1</td>
<td>1 / 8</td>
<td>1</td>
<td>Injectable buprenorphine 10.000 Rials/vial</td>
<td>Tamjizak (Temjesic: buprenorphine)</td>
</tr>
<tr>
<td><strong>Methadone</strong></td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>Official clinics: 90 Rials/5 mg</td>
<td>1</td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td>3</td>
<td>4 / 1</td>
<td>3</td>
<td>1.000.000 Rials/gr</td>
<td></td>
</tr>
<tr>
<td><strong>Solvents</strong></td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1.000.000 Rials/gr</td>
<td></td>
</tr>
<tr>
<td><strong>Sleeping pills</strong></td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>1.000.000 Rials/gr</td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>Beer: 35.000 Rials/can</td>
<td>mashroob, aragh (liquor), vodka, aabjo (beer)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Whisky: 150.000 Rials/bottle</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Home made liquor: 20.000 Rials/bottle</td>
<td></td>
</tr>
</tbody>
</table>


Annex 3: Implementing partners

**Persepolis, Tehran, Iran**

Persepolis is an NGO with 5 years history of activity in harm reduction areas such as NSEP, MMT, and safe sex & safe injection practices. It incorporates community based, low threshold services -based on a peer driven model- for people using drugs with services like drop-in-centres and outreach services in the Iran public health sector.

**Iranian National Center for Addiction Studies (INCAS)**

INCAS is a research center affiliated to Tehran University of Medical Sciences (TUMS) working on

*Back to main text*
Annex 4: Human Development Report

Iran: Human Development Indicators, 2003: Annexes\HDR\Iran\HDR Iran.htm
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