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Presidency
Drug Control Headquarters

Report

Regional Seminar on "Reducing Harms of Drug Use in Middle East, West and Central Asia"

Shaghayegh Cultural Complex, Tehran, I.R. of Iran

27 – 29 October 2008

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ATS	Amphetamine Type Stimulants
CCTV	Closed-Circuit Television
CNTF	Counter Narcotic Trust Fund
CO	Country Office
COIRA	Country Office of I. R. of Office
DCHQ	Drug Control Headquarters
DDR	Drug Demand Reduction
DIC	Drop-In-Centre
DRAT	Drug Demand Reduction Action Team
DSR	Drug Supply Reduction
ECO	Economic Cooperation Organisation
FSW	Female Sex Workers
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GO	Governmental Organisation
HBV	Hepatitis B Virus
H.E	His Excellency
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
IEC	Information Education and Communication
IHRA	International Harm Reduction Association
INCAS	Iranian National Centre for Addiction Studies
IPO	Iranian Prisons Organisation
IRIB	Islamic Republic of Iran Broadcasting
LEA	Law Enforcement Agency
MBT	Methadone and Buprenorphine Maintenance Treatment
MHME	Ministry of Health and Medical Education
MMT	Methadone Maintenance Treatment
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NAS	Neonatal Abstinence Syndrome
NEP	Needle Exchange Programme
NGO	Non - Governmental Organisation
NSP	Needle & Syringe Programme
OST	Opioid Substitution Treatment
PHC	Primary Health Care
PNEP	Prison-based Needle Exchange Programme

PO	Project Office
RO	Regional Office
ROCA	Regional Office for Central Asia
ROMENA	Regional Office for Middle East and North Africa
RORBR	Regional Office for Russia and Belarus
Rx	Treatment
SAPTO	Substance Abuse Prevention and Treatment Office
SBDDS	Sukkur Blood and Drugs Donating Society
SIDC	Soins Infirmiers Developpment Communitaire
STI	Sexually Transmitted Infection
SWO	State Welfare Organisation
TB	Tuberculosis
TC	Therapeutic Community
TOT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

Background and Organisation

Countries in Middle East, West and Central Asia are confronted with an increasing drug use which is closely interrelated with HIV transmission in this region. In view of existing challenges and regional characteristics there is a mutual interest in the region to learn from successful good practises in the framework of south-south cooperation. Both programmes of the Iranian Government as well as United Nations Office on Drugs and Crime (UNODC) hold components vis-à-vis establishing and advancing regional cooperation and exchange in harm reduction measures. In this context, the Iranian Drug Control Headquarters (DCHQ) together with UNODC Iran organised jointly this regional seminar with the following objectives:

- Exposure of participants (national/regional) to International Best Practices in harm reduction
- Exposure of participants to Iranian expertise and Know-how as well as encountered challenges in harm reduction in this country
- Provision of opportunities for future collaboration amongst participating countries
- Setting practical grounds for regional networking in drug demand reduction and harm reduction;
- Provision of harm reduction trouble-shooting apparatus through experts' exchange of views.

Participants of the seminar consisted of authorities/senior experts from counties in the region, Drug Demand Reduction (DDR)/HIV officers from UNODC regional offices, relevant, internationally renowned experts and UNODC Headquarters along with Iranian experts. Regional participants were 22 officials representing following countries: The Islamic Republic of Afghanistan, Republic of Azerbaijan, Islamic Republic of Iran, Republic of Iraq, Hashemite Kingdom of Jordan, Republic of Kazakhstan, Kyrgyzstan Republic, Republic of Lebanon, Islamic Republic of Pakistan, Palestine, Federation of Russia, Syrian Arab Republic, Republic of Tajikistan, Turkmenistan, and The Republic of Uzbekistan.

The seminar commenced with the opening ceremony and continued by national reports delivered by relevant authorities of the Islamic Republic of Iran. The consultations carried with the four thematic areas of discussion: Harm Reduction in Prisons, Abstinence- based Treatment, Opioid Substitution Treatment (OST) and Needle/Syringe Programmes (NSP). Thematic areas were complemented by working groups discussing relevant issues on policy making, structures/infrastructure, human and financial resources management and practices/challenges.

Opening Ceremony: Welcoming and Introduction

The opening ceremony took place on 27 of October 2008 in the multipurpose theatre at Shaghayeh Cultural Complex, Tehran, Islamic Republic (I. R.) of Iran. In addition to the participants of the seminar, invitees to the opening ceremony included officials from the Embassies, Iranian Government, Civil society, United Nations System as well as journalists. The Regional Seminar was opened with a brief introduction of Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Head Quarters (DCHQ), I. R. of Iran, then Mr. Roberto Arbitrio, Representative of the United Nations Office on Drugs and Crime (UNODC), Country Office I.R of Iran, H. E. Dr. Esmaeil Ahmadi Moghadam, Secretary General of the DCHQ, , Dr. Gilberto Gerra, Chief of Health and Human Development Section at UNODC (Vienna) on behalf of Mr. Costa, Executive

Director of UNODC, H. E. Dr. Abdolreza Mesri, Minister of Social Welfare and Security, Dr. Hassan Emami Razavi, Health Deputy to the Ministry of Health, Medical Education and Treatment ,Mr. Mohammad Ali Zanjirehie, Representative of the Iranian Prison Organisation and Mr. Christian Jorge Volkmann Salazar, Chair of the United Nations Thematic Group on HIV/AIDS expressed a warm welcome to the distinguished guests, ambassadors and other participants to the seminar, arranged as a part of the campaign against illicit drugs in the region.

National Reports by Governmental Authorities of the I.R. of Iran

Role of Harm Reduction in National Drug Control Policies was presented by Dr. Saeed Sefatian Director General, Treatment, and Rehabilitation and Vocational Training Department of Drug Control Headquarters.

The National HIV/AIDS Programme was elaborated by Dr. Mohammad Mehdi Gouya, Director General, and Centre for Disease Control, Ministry of Health, Treatment and Medical Education.

Harm Reduction and Social Welfare was discussed by Dr. Farhad Aghtar, Director General of Prevention and Addiction Affairs, State Welfare Organisation.

Prison Programmes were presented by Dr. Marziyeh Farnia, Director General of the Health and Treatment Department, Iranian Prisons Organisation.

Health and Harm Reduction was explained by Dr. Mohammad Bagher Saberi Zafarghandi, Director General of Psychosocial Health and Addiction Department, Ministry of Health, Treatment and Medical Education.

Harm Reduction in Prison Settings

Chair: Professor Ambros Uchtenhagen, Vice Chairs: Dr. Marziyeh Farnia, Dr. Saeed Sefatian

Speakers from the Republic of Kyrgyzstan, Islamic Republic of Pakistan, Palestine and Hashemite Kingdom of Jordan presented the current situation of prisons regarding drug use, HIV/AIDS, challenges, prevention and harm reduction programmes and future plans. Harm reduction programmes in prisons in most countries were found to be in commencing steps and more of a pilot nature rather than routine component of prison programmes. Dr. Bahman Ebrahimi, Deputy to the Director General of Health and Treatment Department of State Prisons Organisation of Islamic Republic of Iran analysed the harm reduction programmes such as Methadone Maintenance Treatment (MMT) and Needle and Syringe Programmes (NSP) in Iranian prisons. Dr. Alex Wodak, Director of Alcohol and Drug Service, St. Vincent's Hospital, Australia delivered the international best practice on harm reduction in prison setting. He emphasised that the first important activity on reducing harms and preventing HIV in prison settings included reducing number of inmates where and whenever possible. He explained that the prisoners are a high risk group for transmission of HIV and explained the importance of OST, NSP and ARV to reduce harms in prisons. Following the presentations, participants discussed in working groups relevant issues and reported back to the plenary. Professor Uchtenhagen summarised the session and reflected on the results in terms of need on harm reduction programmes in prisons together with advocacy, data collection and continued regional exchange.

Abstinence – based Treatment

Chair: Professor Ambros Uchtenhagen, Vice Chairs: Dr. Farhad Aghtar, Dr. Saeed Sefatian

Islamic Republic of Afghanistan, Islamic Republic of Pakistan, Republic of Iraq, Kurdistan Province and Republic of Lebanon presented their country reports and explained about their situation regarding abstinence- based treatment programmes. Dr. Mehrdad Ehterami, Head of

Research and Development Office, and Head of Community Based Organisation Committee, State Welfare Organisation represented the Islamic Republic of Iran to present the country report in this issue. He elaborated the challenges, development and achievements in abstinence- based treatment in Iran. Dr. Gilberto Gerra, Chief of Health and Human Development Section UNODC Vienna, offered a very detailed and scientific presentation on addiction as a disease. He also highlighted the goals and advantages of drug dependence treatment and abstinence-based treatment as one of the programmes of harm reduction. Following the presentations, participants discussed in working groups relevant issues and reported back to the plenary. Beside achievements in abstinence-based treatment there seemed still to be serious challenges in need of systematic intervention in abstinence-based treatment it the countries of the region especially concerning evidence-based practices, improvement of psychological treatment, increasing accessibility and affordability of treatment for drug users.

Opioid Substitution Treatment (OST)

Chair: Dr. Alex Wodak, Vice Chairs: Dr. Parviz Afshar, Dr. Saeed Sefatian

The Republic of Uzbekistan and Republic of Lebanon delivered their country reports on OST. They showed that the OST programme is just developing in their countries and that there are significant challenges and problems on the way. The country report of Islamic Republic of Iran was presented by Dr. Kianoush Kamali, Senior Expert, Office of STIs and AIDS, Ministry of Health, Treatment and Medical Education, Dr. Azarakhsh Mokri, Training Deputy and Head of Treatment and Clinical Psychology Department at Iranian National Centre for Addiction Studies (INCAS) and Dr. Alireza Norouzi, Expert, Substance Abuse Prevention and Treatment Office, Ministry of Health, Treatment and Medical Education. The usefulness of OST as a major strategy for reducing demand of illegal drugs and adhering drug users into programmes resulting in drug and HIV control was emphasised in the country report of I. R. of Iran. In contrast to other countries in the region the number of individuals on OST in Iran both in the community as I prisons was found to be significant and included as a major element in the drug treatment system of the country. Efficient and cost effective modalities for service delivery are used in Iran, which could be considered as novel suiting the circumstances of a developmental country with very good results in successful reduction of drug harms in Iran. International best practices were elaborated by Professor Gabriele Fisher, Medizinische Universität Wien, Universitätsklinik für Psychiatrie und Psychotherapie and Dr. Alex Wodak, Director of Alcohol and Drug Service, St. Vincent's Hospital, Australia. The drug abuse, treatment differences between women and men and oral substitution treatment for women was explained by Professor Fischer. Dr. Wodak delivered the global overview on international best practices in oral substitution treatment. Following the presentations, participants discussed in working groups relevant issues and reported back to the plenary. The session revealed urgent need of countries in including OST among their services to drug users in their countries. It was observed that in many countries legal issues and regulations were in need of adjustment for more effective introduction and scaling of OST.

Needle and Syringe Programmes (NSP)

Chair: Dr. Jean Paul Grund, Senior Researcher, Addiction Research Centre, Netherlands, Vice Chair: Dr. Saeed Sefatian

The attendees from Islamic Republic of Pakistan, Republic of Uzbekistan, and Republic of Tajikistan elaborated their country reports and mentioned that this programme can reduce the prevalence rate of HIV/AIDS cases. In each report, the difficulties and gaps involved in the implementation of the programme were explained. Dr. Saeed Sefatian gave an overview of

Iranian strategies, including national workshops, information dissemination through media, briefing local authorities, appointment of key people in community, launching pilot activities, and further involvement of NGOs. The problems and the solutions also were presented. The International best practices were presented by Dr. Beatrice Stambul, President of French Harm Reduction Association. Relevant risks and harms of injecting drug use, required characteristics of NSP, the essential role of this programme, fixed and mobile NSPs in harm reduction were explained. Due to organisational issues working groups did not take place and the session moved directly towards wrap-up. Dr. Jean Paul Grund summed up that most countries suffer from a large number of IDUs who are infected to HIV and this programme is considered low although it has been increasing during recent years. He urged for increasing efforts in training, short term pilot programmes, monitoring and evaluation.

Background and Organisation

Context

Countries in the Middle East and Central Asian region are heavily affected by the problem of increasing opiate consumption, where drug use seems closely interrelated to HIV transmission. Effective and efficient measures in controlling the dual epidemic of drugs and HIV seem pertinent for containing further harm resulting from consumption of opiates in this region. Many countries in the region have already launched successful programmes since 2000. The existing challenges and limitations in drug demand reduction and harm reduction programme approaches calls for advancing regional cooperation and exchanges.

During previous years there have been several initiatives advancing regional cooperation and exchange on harm reduction measures. The Iranian government hosted the "Inter-Country Consultation on HIV Prevention among Injecting Drug Users" in 2004 organised by the World Bank and the UNODC Iran. Several regional meetings and activities have already been launched in the context of the Economic Cooperation Organisation (ECO) initiated by the Iranian government and other member countries. Moreover, the Centre for Harm Reduction of ECO countries is to be established shortly in Tehran. The Memorandum of Understanding on Sub-Regional Drug Control Cooperation (MOU) of the Central Asia Countries and Russia with UNODC is also extending to drug demand reduction and HIV/AIDS Control issues. Aligning with the Paris Pact initiative, UNODC is developing a regional framework called the "Rainbow Strategy" in drug control including Drug Demand Reduction and Harm Reduction components for concerted action in the West/Central Asian region. The UNODC Regional Office of Middle East and North Africa has launched the regional project XNAJ58 "Promoting good practices and networking for reducing demand for and harms from drugs" funded by the European Commission. The project aims to build capacity and expertise through utilisation of internationally recognised European expertise in the context of a regional network. The Middle East and North Africa Harm Reduction Network has been established with sub- regional knowledge hubs in Iran, Lebanon and Morocco supported by the World Health Organisation (WHO) and the International Harm Reduction Association (IHRA) and the financial support of the Drosos Foundation. Beside the already mentioned Inter-Country Consultation, UNODC Iran has been strongly promoting regional interaction. The project IRNI57- "Advocacy and Regional Cooperation in Drug Demand Reduction" is striving to encourage regional collaboration towards the materialisation of a regional network. In the context of South-South Cooperation, UNODC Iran has organised numerous study tours in direct cooperation with the Drug Control Headquarters (DCHQ) including the visit of health and prison officials from Afghanistan and Pakistan; as well as Egypt, Jordan, and Lebanon to Iran to exchange experiences and learn from good practices in harm reduction measures in communities and prisons.

Rational

There has been mutual interest in the region to use the existing harm reduction expertise and experiences in Iran for fruitful south-south cooperation and cross fertilisation as a practical strategy for addressing problems and challenges on harm reduction.

The Iranian government due to existing experience and expertise is very interested in establishing and advancing its regional cooperation in harm reduction matters. It welcomes practical cooperation with countries of the region including meetings, training and exchange of experiences.

The UNODC Country Office Iran programme gives high priority to south-south initiatives and regional cooperation as well as dissemination of sound practices in drug demand/harm reduction. Moreover, the project IRNI57 "Advocacy and Regional Cooperation in Drug Demand Reduction" envisages explicitly launching of regional cooperation initiatives in drug demand reduction including learning mutually from international and regional recognised best practices as one of its outputs.

In this context, the Iranian Drug Control Headquarters (DCHQ) together with UNODC Iran organised jointly this regional seminar with countries of the Middle East and Central Asia.

Objectives

- Exposure of participants (national/regional) to International Best Practices in harm reduction;
- Exposure of participants to Iranian expertise and Know-how as well as encountered challenges in harm reduction in this country;
- Provision of opportunities for future collaboration amongst participating countries;
- Setting practical grounds for regional networking in drug demand reduction and harm reduction;
- Provision of harm reduction trouble-shooting apparatus through experts' exchange of views.

Invitations

Together with the DCHQ top international experts in harm reduction were identified and invited for participation. The DCHQ and UNODC Iran developed the general structure of the agenda on the basis of the identified objectives of the seminar. The Iranian National Centre for Addiction studies provided valuable technical advice both on identification of top international experts as well as structuring the agenda.

UNODC field offices in the region: CO Afghanistan, CO Pakistan, RO Central Asia, RO Middle East and North Africa, as well as PO Azerbaijan, PO Turkmenistan kindly provided strong support in the preparations. Aside from some exceptions, preliminary letters were prepared and sent via UNODC offices to Line Ministries requesting for introduction of relevant officials, where-after invitation letters were sent out. UNODC Field offices facilitated both the introduction process as well as making necessary travel arrangements.

Participants

Non-Iranian participants were invited from following entities:

- National authorities/senior experts influential in DDR/HR programmes of each country, one from the Ministry of Health and one from the Prisons Organisation respectively;
- Relevant DDR/HIV Officers of UNODC field offices in the region;
- Internationally renowned harm reduction experts;
- UNODC Headquarters Vienna.

Regional participants were 22 officials representing following countries: The Islamic Republic of Afghanistan, Republic of Azerbaijan, Islamic Republic of Iran, Republic of Iraq, Hashemite Kingdom of Jordan, Republic of Kazakhstan, Kyrgyzstan Republic, Republic of

Lebanon, Islamic Republic of Pakistan, Palestine, Federation of Russia, Syrian Arab Republic, Republic of Tajikistan, Turkmenistan, and The Republic of Uzbekistan.

Beside the head of the Health and Human Section from UNODC Headquarters, Vienna and staff of UNODC Iran, 5 UNODC colleagues took part from field offices in the region.

Iranian participants consisted of relevant authorities, directors, senior experts and NGO activists. Not all Iranian participants were present in all sessions. The total number of the Iranian participants counted 80, with about a half present during every single session. The annex three reflects on participants in detail.

Programme description

Main axes of exchange were arranged around themes in separate sessions:

- Harm Reduction in Prisons;
- Abstinence- based Treatment;
- Opioid Substitution Treatment (OST);
- Needle/Syringe Programmes (NSP).

Each session opened with a plenary consisting of brief reports from countries, which have already commenced practical measures on the specified theme covering following components:

- Policy making;
- Structure/infra structure/coordination;
- Management of human and financial resources;
- Practice/challenges.

These reports were complemented by briefings on internationally recognised best practices delivered by international experts. Subsequent to the plenary working/discussions in small groups took place with consequent reporting back in the larger group with wrapping-up of outcomes including identification of potential areas for future collaboration in the region.

Participants were divided into four working groups:
Group 1- Policy making; facilitator: Mr. Geoffrey Monaghan, Regional Drug & HIV/AIDS Expert, UNODC-RORBR;
Group 2- Structure/infra structure/coordination; facilitator: Dr. Kamran Niaz, Regional Epidemiological Adviser, UNODC-ROCA;
Group 3- Management of human and financial resources; facilitator: Dr. Gelareh Mostashari, Drug Demand Reduction Expert, UNODC- COIRA;
Group 4- Practice/challenges; facilitator: Ms. Nina Kerimi, Regional Project Coordinator, UNODC- ROCA.

Working groups received specified questions for discussion and were instructed to report back to the plenary together with relevant recommendations on the single topics. Due to time limitations working groups could not be conducted under the needle syringe session. The tasks for all working groups are reflected under annex four.

On the second day site visits took place to provide a glance of practical aspects of implementation of introduced measures in Iran. As for organisational matters the participants were divided into two groups. The first group visited the Iranian National Centre for

Addiction Studies (INCAS) as well as a women's Drop In Centre (DIC) Pardis-e-Mehr and the second group visited the Ravan Pouya Drop In Centre (DIC) and the Rajaee Shahr Prison located in Karaj, nearby Tehran.

The agenda of the meeting is to be found under annex one.

Recommendations

Feed backs from all reporting working groups were recorded during the consultations. On the last day all recommendations were appraised and a summary of recommendations compiled in a draft document. Drafted recommendations were shared with participates during the last session. The document was amended and finalised incorporating feedback received from the participants.

Opening Ceremony: Welcoming and Introduction

The opening ceremony of the Regional Seminar on Reducing Harms of Drug Use in Middle East & Central Asia took place on 27 of October 2008 in the multipurpose theatre at the Shaghayeh Cultural Complex, Tehran, Islamic Republic (I. R.) of Iran. In addition to the participants of the seminar, invitees to the opening ceremony included officials from the Embassies, Iranian Government, Civil society, United Nations System as well as journalists.

The Regional Seminar was opened with a brief introduction of Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Head Quarters (DCHQ), I. R. of Iran, who warmly welcomed all the participants taking part in the regional seminar. He highlighted that in her efforts, the I. R. of Iran has made severe progress within the field of harm reduction by using the expertise from various experts, NGOs, the private sector as well as former drug users. National coordination between programmes has also been an important part of the successful harm reduction activities in the country. Dr. Sefatian continued by sharing the objectives of this important seminar, including optimising use of international experts, sharing and exchanging scientific information from various countries, and gaining collective wisdom. He further hoped that the seminar will open a window to additional plans and actions within harm reduction at the regional level.

Mr. Roberto Arbitrio, Representative of the United Nations Office on Drugs and Crime (UNODC), Country Office I.R of Iran, thanked the Iranian government and the DCHQ for co-organising this important seminar. He also expressed his thanks to the international experts, and Dr. Gilberto Gerra, participating in the seminar. Mr. Arbitrio continued by mentioning the long partnership that has been established between the UNODC and the DCHQ, and the implementation of a number of UNODC harm reduction projects, carried out in cooperation with the I. R. of Iran. He added that Iran is considered as an advanced country when it comes to activities within harm reduction and he stressed the importance of regional cooperation within the drug demand reduction field. Mr. Arbitrio also pointed out the successful South-South cooperation, where there has been a large commitment among participating countries. He finished by expressing his hopes that the seminar will be a first step in the progress of regional cooperation, bringing together ideas and recommendations from various stakeholders involved.

H. E. Dr. Esmaeil Ahmadi Moghadam, Secretary General of the DCHQ, expressed a warm welcome to the distinguished guests, ambassadors and other participants to the seminar, arranged as a part of the campaign against illicit drugs in the region. He expressed concern for the political situation in Afghanistan, which has consequently left Iran with sustained costs for blocking drugs entering the country as well as the dismantling of established drug networks. He added that the international efforts of fighting the drug production in Afghanistan has failed, and created a severe situation, not only for the region but the whole world. H. E. Dr. Moghadam continued by sharing some statistics of the Iranian seizures of drugs in the last two years. Despite increased efforts in 2007, 560 tons of illicit drugs were seized in 2007. So far in 2008, 440 tons of various drugs have been confiscated, which is an increase by 25% compared to previous year. He added that Iran spends about $60 million each year in the fight against illicit drugs. Recent supply reduction activities include strengthening channels (628 km), concrete walls, electric devices, CCTV surveillance as well as sniffing dogs. On the demand reduction side, H. E. Dr. Moghadam emphasised the new approach taken by the DCHQ in 2006, confronting drug addicts as patients and not criminals, providing they are in treatment. Iranian harm reduction activities comprise, *inter alia*,

increasing access to treatment centres (including DIC, outreach centres and treatment centres), implementing needle syringe programmes, and raising social awareness. He added that in the next five years, one of Iran's highest priorities is to increase access to treatment, covering 80% of the estimated need.

Dr. Gilberto Gerra, Chief of Health and Human Development Section at UNODC (Vienna), thanked the organisers of the seminar and on behalf of Mr. Costa, Executive Director of UNODC, congratulated Iran for its efforts in harm reduction, opening a new way for cooperation in the region. Dr. Gerra emphasised the importance of the new approach among various international organisations and countries in including harm reduction in drug control programmes. Yet, there are still many countries that do not recognise drug addiction as a disease. He explained that drug dependence is a multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease. Various factors related to bio-psychosocial background cause substance abuse, resulting in turn in clinical dependence. Scientific surveys clearly show that increasing coverage of drug treatment programmes has been the approach most useful rather than mandatory drug treatment of drug dependents. A variety of science-based methods for prevention and treatment have been found effective and cost-effective, proving that Drug dependence is both preventable and treatable. Dr. Gerra further mentioned that a Global Action Plan, a joint initiative of the UNODC and the WHO intends to look into drug demand reduction issues across five continents at specified regional categories[1]. Dr. Gerra continued by emphasising that the ongoing discussion about the balanced approach between Drug Supply Reduction (DSR) and Drug Demand Reduction (DDR) needs to be taken into real action. At current date, DSR is given 91% of the funding within drug control activities, while DDR receives merely 9% of funding, a limitation to efforts in DDR and harm reduction activities. Dr. Gerra further informed about an upcoming event the "Technical Seminar on Drug Addiction Prevention and Treatment: From Research to Practice Seminar" taking place in Vienna in December 2008. He further stressed the importance of mainstreaming drug demand reduction in the public health system and concluded his remark by encouraging donors to fund further DDR and harm reduction activities.

As the next speaker, H. E. Dr. Abdolreza Mesri, Minister of Social Welfare and Security, expressed his gratefulness for the organisers of the regional seminar. He further emphasised that in recent years harm reduction has been accepted as a vital component within DDR. He added that the approach has is now well accepted within various national agencies including the police and a range of health agencies. H. E. Dr. Abdolreza Mesri further expressed his concern over the large addict community in Iran, making substantial programmes necessary. He announced that drug use is the fourth ranking disorder resulting in causalities in the country after Road accidents, cardiovascular disorders and depression. He emphasised the significance of reintegrating drug users back into the society, stressing the major role that harm reduction measures play in this regard. He called for increasing efforts to avoid leaving drug users alone with the drug trafficking mafia. H.E. concluded his remarks by quoting the late Imam Khomeini: "Rescuing each addict saves society at large".

[1] Joint UNODC-WHO large-scale initiative on Drug Demand Reduction: Prevention, Treatment and Reduction of Health and Social Consequences of Drug Use and Dependence

The word was handed over to Dr. Hassan Emami Razavi, Health Deputy to the Ministry of Health, Medical Education and Treatment, who welcomed all participants to the seminar on harm reduction in this region. He pointed out that drug use is today seen as a severe disorder and a public health concern. Its consequences leaves great costs for the Iranian government, being the fourth highest cost for the Iranian society, but also for the society, including decrease of family income, increase in crime and the threat of HIV/AIDS. Dr. Razavi also emphasised that drug use in Iran is today seen as a multifactor disease, which has in turn led to advanced research on addiction and treatment for drug users, including evidence-based methods. He pointed out the implementation of needle and syringe programmes, which are free of charge, and the successful methadone treatment programme, available to a low cost in the governmental sector. Dr. Razavi further added that Iranian drug addicts need improved accessibility to treatment services, where both national and private organisations, as well as NGOs, can play a major role. Iranian strategies are now focusing on increasing downstream services; outreach groups, and improve access for specific groups in society, such as women. Finalising his remark, he summarised the successful Iranian approach within harm reduction, and hoped to see the I. R. of Iran as a leader for developing country to prevent HIV/AIDS among drug addicts.

Mr. Mohammad Ali Zanjirehie, Representative of the Iranian Prison Organisation, warmly welcomed all the participants in the name of God. The organisation works with the rehabilitation of inmates, and currently has 260 prisons, 25 compulsory drug rehabilitation centres, 16 temporary detention centres and a number of corrective centres for juveniles. In addition to this, the organisation has 30 after release centres, including vocational training, in order to support individuals after their release from prison. Mr. Zanjirehie informed the participants that around 135,000 people are incarcerated at every given time and the turnover of inmates is about 500,000 annually. Around 45% of the inmates are sentenced for drug-related crimes, but it was stressed that this number needs to be reduced. He further mentioned that inmates sentenced for drug crimes have special programmes, including life skills trainings and personal hygiene. Other activities for inmates include athletic, sport programmes, and education, with the aim to change attitude and control behaviour. Mr. Zanjirehie also highlighted the importance for stopping the drugs finding its way in to the prison, and shared some examples of interventions that the organisation has made in order to stop this: CCTV cameras, sniffing dogs, and body searches. He concluded his remark by stressing the crucial value of rehabilitation of prisoners.

The Concluding speaker of the opening ceremony, Mr. Christian Jorge Volkmann Salazar, Chair of the United Nations Thematic Group on HIV/AIDS, congratulated the Government of I. R. of Iran and the UNODC for their efforts in arranging this seminar, an important effort in the fight against HIV/AIDS. Mr. Salazar presented three main recommendations that he stressed should be in line with other prevention work; comprehensive surveys to be carried out in order to gain valid data; healthy living life skills among adolescents; multi-sector mobilisation including various Ministries, NGOs, journalists and religious leaders. Rounding up, Mr. Salazar once again thanked the I. R. of Iran, a leader within harm reduction in the region, for their initiative and support for the seminar.

Notes from the Seminar

I. National Reports by Governmental Authorities of the I.R. of Iran

Role of Harm Reduction in National Drug Control Policies

Dr. Saeed Sefatian, Director General of the Treatment, Rehabilitation and Vocational Training Department, Drug Control Head Quarters (DCHQ)

DCHQ is governed under the Presidential Office and consists of seven organisations: Ministry of Health, Ministry of Intelligence, Ministry of Education, IRIB, Office of the Prosecutor General, Ministry of Interior and I.R.I. Police. The Headquarter has three missions, consisting of policy making, supervision, and coordination. The missions are further aimed to support the following objectives: supply control, demand reduction, treatment and rehabilitation, prevention, as well as promotion of international cooperation. In addition to this, the overall policies, approved by State Expediency Council, are: Criminalisation of use of narcotics, psychotropic substances, and precursors; Establishment and development of public services with regards to treatment and rehabilitation; Adaptation of necessary social measures after treatment. Referring to the article 15 of the Iranian Anti-Narcotic Law, Dr. Sefatian pointed out that although addiction is a crime, each addict is entitled to refer to licensed centres identified by Ministry of Health for treatment and rehabilitation. The article further recognises that all addicts are exempted from penalty of addiction for two years during their treatment and rehabilitation process. Since one year, police and law enforcement can refer an arrested addict to a private, public or community based organisation instead of referring him to judicial system. This procedure has been implemented for 20,000 injecting and high risk addicts. During 2007, 16 million USD has been spent on treatment and rehabilitation out of which 60% of the budget has been allocated to harm reduction.

Within the DCHQ, there are four organs for recommendations and approvals in drug treatment and harm reduction issues consisting of the Treatment Committee, the "Drug Treatment Think Tank" (including 15-20 individuals), the High Council of Research (nationwide), and the Research Centre (for DCHQ research).

Five vending Machines for provision of syringes and condoms are under pilot in Tehran. So far, 570,000 individuals have been covered by treatment and harm reduction programmes. Services have been provided by relevant organisations: Ministry of Health, State Welfare Organisation, Prison Organisation, NGOs, private centres and vocational training organisations, which have been providing a wide range of service:

Drop in Centres (DICs)	48416
Outreach	60085
MMT and detoxification with Methadone	115296
In-patient drug treatment	11944
Detoxification with Clonidine	250429
Therapeutic Communities	2649
Shelter	3500
Camp	86000
Vocational training	8885
Mobile services	1450
Total	576269

Concluding his presentation, Dr. Sefatian pointed out that harm reduction activities in the country are relatively new, initiated four years ago, but are today wide spread throughout the Islamic Republic.

The National HIV/AIDS Programme

Dr. Mohammad Mehdi Gouya, Director General, Centre for Disease Control, Ministry of Health, Treatment and Medical Education

Dr. Gouya stressed that as most of the HIV positives are infected through injecting drug use (IDU), harm reduction programmes are of great importance. As a response to the alarming HIV epidemic, I. R. of Iran has in recent years implemented intensive harm reduction programmes, which have further resulted in a decrease of HIV infected among IDUs. He described the HIV/AIDS situation in Iran as follows:

AIDS patients	1,592 individuals
AIDS deaths	2,800 individuals (have died since the beginning of the epidemic)
Total reported cases of HIV/AIDS	18,320 individuals (identified cases since the beginning of the epidemic)

Although the identified number of HIV/AIDS cases in the country today is 18,320, estimates show that the number is probably as high as 70 000- 80 000 infected. Between 65-70% of the HIV infected are IDUs. Dr. Gouya also mentioned that the country is still in the phase of concentrated epidemic among the IDUs and there has been no evidence for rapid rising of the HIV prevalence in the IDUs up to 2007 in the country.

Harm reduction programmes have been carried out in different parts of the country and have been scaled up since two years ago. The programmes might have prevented the rapid increase such as the one in Ukraine, which had a rapid increase of HIV among IDUs.

HIV control and prevention programmes are now seen as a high priority for the country, and various Ministries works in collaboration with governmental and non-governmental organisations on this issue. The second National Strategic Plan on HIV/AIDS has been drafted with 10 strategies and has been approved in the National Supreme Health Council.

The strategies include harm reduction, universal access and positive prevention of HIV. A behavioural surveillance system is already established. Beside harm reduction programmes offered under drug control programmes, drug treatment including methadone maintenance and antiretroviral therapy is offered in Counselling Centres for Behavioural Disorders (also known as triangular clinics).

Harm Reduction and Social Welfare

Dr. Farhad Aghtar, Director General of Prevention and Addiction Affairs, State Welfare Organisation

After the Islamic Revolution in 1979, production, distribution, trafficking and use of drugs was prohibited. Also drug Addiction was criminalised. In 1983, the State Welfare Organisation (SWO) was handed over the responsibility of camps established for detention of drug dependents. Following the amendment under the article 15 of the Iranian Anti narcotic Law in 1997, the first drug treatment centre was established in Welfare Organisation. Drug treatment facilities expanded within the State Welfare Organisation ever since and harm reduction was included in the offered services. Dr. Aghtar pointed out that currently 90% of the services are provided by the private and non- governmental sectors and 10% through governmental institutions. There are currently 50 drug treatments centres out of which 39 are also providing methadone maintenance treatment in the governmental sector under the State Welfare Organisation (SWO).

Drug Treatment Centres operating under the Iranian State Welfare Organisation, 2007

Centre	**Outpatient**		**MMT Unit**		**Inpatient**	
Type of centres	Governmental	Private	Governmental	Private	Governmental	Private
No. of centres	50	568	39	430	0	35
No. of clients	28693	190464	10424	51929	0	11944
subtotal	219157		62353+4697= 67050		11944	
Total			298151			

The SWO entertains 26 Therapeutic Communities (TCs) in the country and supports 83 Drop-in Centres (DICs), 128 outreach services and 25 shelters ran by NGOs providing services to over 50,000 drug users.

Therapeutic Communities operating under the Iranian State Welfare Organisation, 2007

Therapeutic Communities		
Number of centres	**No. of admissions**	**No. of graduated**
26	2,649	1,319

Harm Reduction Services operating under the Iranian State Welfare Organisation, 2007

Service	**Drop-in Centre (DIC)**	**Out reach**	**Shelter**
Number of centres	83	128	25
No. of clients	35034	23926	2258

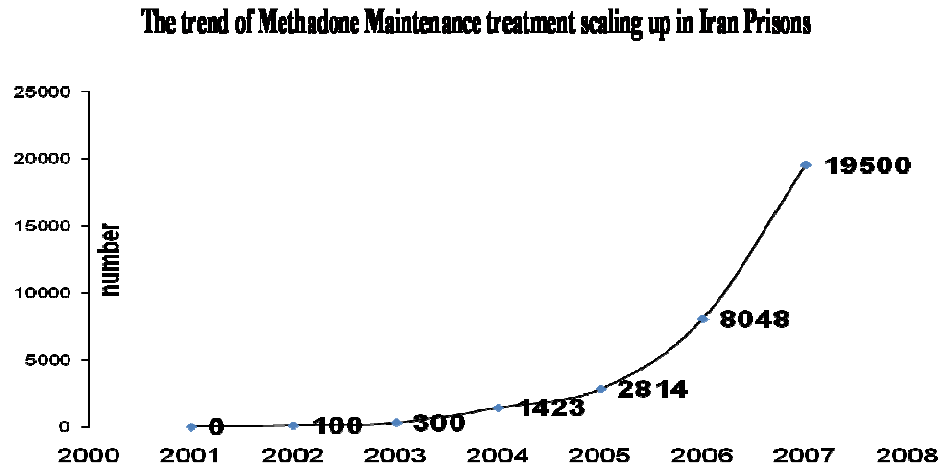
Syringe and Condom distribution under the Iranian State Welfare Organisation, 2007

Service	**No. of distributed syringes**	**No. of distributed condoms**
Drop-in Centres	2,061,000	398,723
Outreach Services	2,604,512	365,641
Total	4,665,512	764,364

Prison Programmes

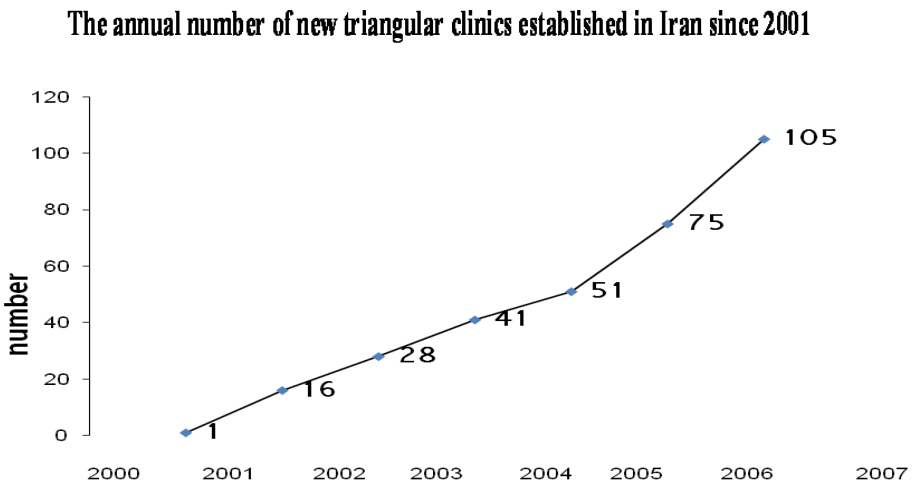
Dr. Marziyeh Farnia, Director General of the Health and Treatment Department, Iranian Prisons Organisation

Dr. Farnia exclaimed that the country has nearly 145,000 prisoners, of which 48% are charged for drug related crimes. There are a total of 230 detention centres including prisons, rehabilitation camps and juvenile correctional centres in Iran. Some of the problems encountered in prisons include overcrowding, violence and high risk behaviours such as drug use, unsafe tattooing and unsafe sex. Drug treatment programmes in prisons include Detoxification with clonidine and tranquilisers, and maintenance therapies with methadone and Naltrexone. Methadone maintenance treatment commenced 2003 as a pilot project and has extended continuously and has provided services to over 19,000 inmates. Additionally, non-medical interventions in the form of counselling and education are offered in many prisons throughout the country. The Iranian Prisons entertain 76 Voluntary Counselling and Testing Centres as well as 29 After (Release) Care Centres.



The prohibition of distributing syringes and needles was removed for the first time by the order of the Iranian Head of the judiciary two years ago. Current programmes on Harm Reduction/HIV prevention in Iranian prisons include:

- Education and Awareness raising;
- HIV voluntary counselling and testing;
- Provision of bleach;
- Needle syringe exchange programmes;
- Condom distribution;
- Conjugal Meeting rooms for private meeting of inmates with their spouses;
- Distribution of disposable shavers;
- Serving as sentinel sites within the established HIV surveillance system of the Centres for Behavioural Disorders (also known as Triangular Clinics) in prisons provide services such as Voluntary Counselling and Testing (VCT) harm reduction counselling, training and clinical care, and treatment for HIV and prevent HIV among drug users.



Condoms distribution is widely available in Iranian prisons in case of private meetings and/or inmates going on leave. In 2006, 2,000,000 condoms were received from the Ministry of Health and distributed in prisons over the country.

In terms of policy making the Iranian Prisons Organisation is striving through various strategies to decrease the prisons population both through liaising with relevant entities in the judiciary for exerting amnesty as well as averting incarceration in cases where not absolutely necessary.

The Iranian Prisons Organisation (IPO) enjoys good working relations with the Ministry of Health in addressing health issues of prisoners especially issues of drug use, HIV and TB. The Council for Prison Health Enhancement and Addiction in prison established in the 2003/4 is headed by the Undersecretary of Health from the ministry with membership of relevant directors and experts from both the prison and the ministry. A joint agreement with the Ministry of Health, Treatment and Medical Education on high- risk diseases and harm reduction resulting from addiction in prison has been signed. The Iranian Prisons Organisation is one of the important stakeholders in the HIV surveillance system and identified sentinel sites are held by the IPO throughout the country.

The IPO has been one of the active sub recipients to the National Project of Global Fund for Prevention and control HIV/AIDS in Iran since the first project was launched in 2004. Many harm reduction and HIV control activities have been carried out in prisons under this project.

Health and Harm Reduction

Dr. Mohammad Bagher Saberi Zafarghandi, Director General of Psychosocial Health and Addiction Department, Ministry of Health, Treatment and Medical Education

Dr. Saberi expressed his concern regarding the large number of young people in the country at high risk of drug abuse. An epidemiological study carried out in 2007, showed that the number of drug addicts in the country is 1,200,000. The usual drugs of abuse are opium, purified heroin sold under the name and branding of "crack" (heroin) as well as brown heroin. The mean age of drug use identified in the mentioned study was 32.7 years and 9.4% of drug users were women. 47.3% of drug users in the country are married, 41.2% single, 5.2% divorced and 4.2% separated. The main drug of abuse among substance dependents is opium (32.8%) which is followed by purified heroin, retailed under the name of "crack" in the illegal drug market (25.7%) and brown heroin (18.8%) respectively. 18.7% of all substance dependents report injecting as main route of drug administration.

The HIV virus is mainly transmitted through unsafe injection. The situation of HIV epidemic among IDUs has convinced the Public Health authorities and drug control officials to adopt the harm reduction policy as one of the main components of the comprehensive drug policies in Iran. This has been reflected in different official documents and plans, including:

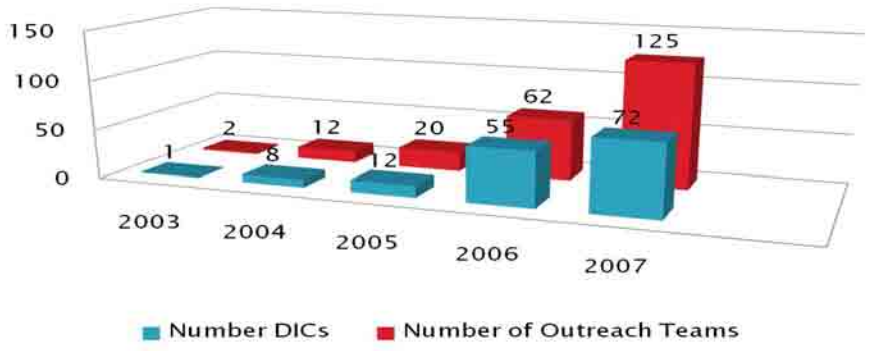
- The "I.R Iran Anti-Drug Macro Policies" document. This is the first important legal document that officially mentioned harm reduction approaches as an approach for drug demand reduction;
- The recent draft of amendments to the "Anti-Narcotic Law";
- The "Second National Strategic Plan on HIV/AIDS 2007-2009".

Although drug addiction among women is less severe than among men, women are still at high risk. Dr. Saberi further pointed out that the Anti-narcotic Law in Iran is endorsed by the Expediency Council in 1997, unlikely to be prone to parliamentary related alterations. The Ministry of Health and Medical Education (MHME) plays an important role in Iran's demand reduction endeavours. The Substance Abuse Prevention and Treatment Office (SAPTO) is the focal point of the Iranian Ministry of Health in the DCHQ. The National Harm Reduction Committee has also been active since 2002. He further emphasised the importance of governmental support for harm reduction programmes, and expressed hope that this kind of activities can be integrated into prevention and treatment programmes. He also highlighted the significance of monitoring and evaluation in implementation of harm reduction programmes.

The Iranian Ministry of Health, Treatment and medical Education exerts its functions throughout the country by means of its 41 Medical Universities. Harm Reduction Programmes in Iran are implemented via Drop-in Centres (DIC) and Outreach Teams and Methadone Maintenance Programme.

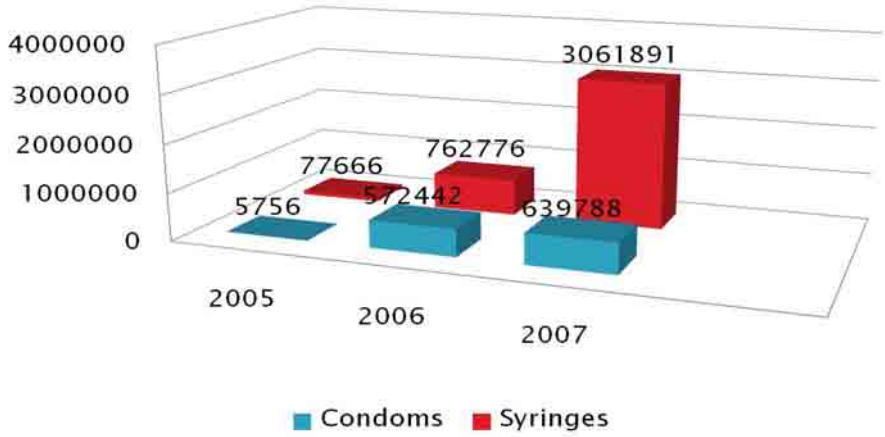
The first DIC has been established in October 2003. DICs undertake activities such as education and harm reduction counselling, first aid and wound management, syringe and needle distribution and condom distribution. In 2005, 12 DICs and 20 outreach teams worked under the supervision of 9 universities of medical sciences in 6 metropolitan areas. During the second half of the 2006, in response to clear need for expansion of harm reduction programmes, with financial support of DCHQ, SAPTO planned to establish 60 DICs and 100 outreach teams.

Number of DICs and Outreach Teams under the Iranian Ministry of Health

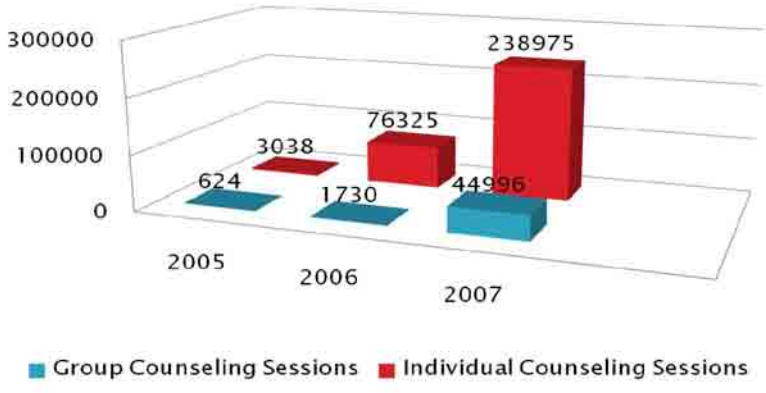


Number of clients contacted under Programmes of the **Iranian Ministry of Health**
DIC Coverage: Number of Clients

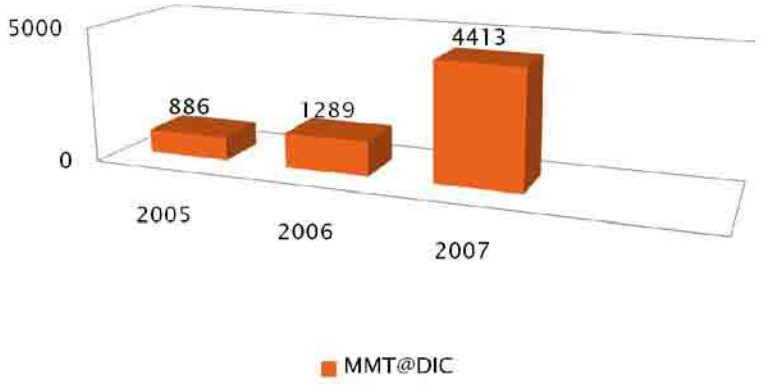
Syringes and condoms distribution by DICs under programmes of the Iranian Ministry of Health



Counselling services provided by DICs under programmes of the Iranian Ministry of Health



Low-threshold Methadone Maintenance Treatment provided by DICs under programmes of the Iranian Ministry of Health



In October 2002 the first methadone maintenance treatment pilot programme was launched at Rouzbeh Psychiatric Hospital, an affiliate hospital of the Tehran University of Medical Sciences. The second MMT pilot programme was launched in March 2003 in the Behavioural Disease Counselling Centre (Triangular Clinic) at West Tehran Health Centre (affiliated with the Iran University of Medical Sciences). Thereafter, with the technical support of SAPTO five more centres were launched for methadone maintenance treatment in 5 cities, mainly in Drop-in Centres. With financial support of the DCHQ, SAPTO planned to establish 133 new public-owned methadone clinics in general hospitals of medical universities during second half of 2006. Currently more than 133 public owned methadone programmes are available across the country.

Several factors helped catalyse change and explain Iran's achievements in harm reduction programmes: First, there is widespread appreciation, including at very senior levels, of the seriousness of harms related to substance use disorders. Attempting to convince the senior policymakers paving the way for adoption of harm reduction measures took place in early 2000. An interesting example is the role of religious leaders in promoting harm reduction. In 2005 the head of the Iranian Judiciary officially recommended to apply a harm reduction oriented interpretation of the article 15 of the Iranian Antinarcotics law, which exempts drug users under treatment from prosecution. Second, there is a serious commitment among all stakeholders in harm reduction activities including MHME, Prison Organisation, SWO and NGOs to evidence-based harm reduction programmes. Third, the important role that non-governmental organisations and civil society played in advocacy and the implementation of successful programmes that reached high risk groups. Forth, there is a strong base for drug research in Iran.

The current level of implementation of all harm reduction activities are at only a fraction of that required to achieve control. The future plans are: rapidly expanding the scale of implementation of HIV prevention strategies for IDUs to reach a level commensurate with control of HIV/AIDS. This must be the major priority in Iran for the next decade. In addition to expanding current drug treatment efforts (especially opioid substitution), the merits of rapidly expanding needle-syringe programmes and outreach education to IDUs and those

opium users likely to begin injecting need to be more fully and widely understood. Capacity building of a large group of professionals and other staff will be required from national to provincial and local levels. The quality control aspects of harm reduction programmes in Iran also need to be improved. The provision of a "National Drug Abuse Services Information System" is a real necessity. No doubt that presentation of I.R Iran activities in the area of harm reduction programmes in this prestigious meeting includes warm welcoming to sharing of experiences and mutual collaboration with other countries.

II. Harm Reduction in Prison Settings

Chair: Professor Ambros Uchtenhagen
Vice Chairs: Dr. Marziyeh Farnia, Dr. Saeed Sefatian

A. Plenary Session Presentations

The Republic of Kyrgyzstan

Mr. Kalybek Nazbekov, Head of General Directorate, Executive Punishment of Ministry of Justice in the Republic of Kyrgyzstan

Mr. Nazbekov gave a report on the drug use situation in Prison settings and stated that there are 33 prisons in Kyrgyzstan. He stated that there has been a remarkable decrease in deaths caused by overdose. He referred to HIV cases in Kyrgyzstan and said that the number of HIV cases in the first 6 months of 2008 was 180 cases. He stated that there has been an increase in the number of individuals kept in the some prisons.

On prison settings in Kyrgyzstan, Mr. Nazbekov reiterated that 3% of the prison population are addicted to opiates, 35% to alcohol. He stated that an HIV epidemic exists among drug users in prison.

He specified some of the problems that drug users face in Kyrgyzstan:

- Social deprivation;
- Nutrition;
- Prevention programmes;
- Medical services.

He stated that the drug use and HIV prevention programmes in Kyrgyzstan are as follows:

- Free of charge needle & syringe distribution programme;
- Condom, syringe and needle distribution in prison;
- ART Therapy;
- Government scheme: skills and on-the-work training;
- Information for prisoners: east-west programme / educational programmes on safe sexual behaviour and injection.

Mr. Nazbekov stated that since 2002 the Government of Kyrgyzstan has increased the allocated budget and therefore harm reduction programmes were advanced in recent years.

Islamic Republic of Pakistan:

Mr. Mohammed Yameen Khan, Inspector General of Prisons in the Sindh Province

Mr. Khan stated that for the time being there are 90 prisons in Pakistan with around 90,000 prisoners, 7500 of which are drug users (12% of the whole prison population). There are 355 female drug users in prisons, which makes 5% of the drug user population in prisons.

According to the report Government, Pakistan encounters the problem of overcrowded prisons since current population of prisons in Pakistan is 86209, whereas authorized capacity of the prisons is 37019.

Mr. Khan continued that the control of Narcotics is a federal subject under the control of Narcotics Substances Act 1997. The Ministry of Narcotics and Anti Narcotics Force are responsible to take action under this Act. Furthermore, the Provincial Government as well as the Police is taking action under Islamic Laws and Pakistan Penal Code.

He referred to the contribution of UNODC Country Office Pakistan and stated that UNODC has recently launched 4 pilot projects in 4 prisons in Pakistan on drug addiction treatment and HIV/AIDS awareness amongst inmates:

- Central Prisons Karachi (Sindh Province);
- District Jail Lahore (Punjab Province);
- Central Prison Haripur (NWFP Province);
- District Jail Quetta (Balochistan Province).

Each intervention team consists of a psychologist who is responsible for interviewing the inmates and suggesting psychiatric treatment, an HIV/AIDS counsellor who provides awareness to inmates regarding sexually transmitted diseases and is responsible for voluntary counselling and blood test (VCT) and a drug use counsellor who provides programmes on the rehabilitation of the inmates. In Karachi, there is also one NGO (SAHEE) that has been assigned for providing psychological training to selected inmates through "CRIMNON" training programme. It is also responsible for after care programmes and family counselling.

In 2003 in Larkana District Prison in Sindh Province, of 210 randomly tested inmates, 29 injecting drug users (IDUs) were identified as HIV positive. The injecting equipments were often non-sterile and sharing of equipments was common among the IDUs. In 2004, Provincial AIDS Control Programme of the Government of Sindh identified 203 as HIV positive in a random check of 1357 individuals on the street. The project on "Enhanced HIV/AIDS Control Programme, Health Department of the Government of Sindh" was launched in 2004. It was funded by the World Bank and Government of Sindh, supported by the Inspector General Prisons Sindh and Prison Department of Sindh and has been implemented by Sukkur Blood and Drugs Donating Society / SBDDS Organisation with a target population around 14,000 inmates. The structure and methodology included advocacy, training of staff and peer educators, collection of baseline data, establishment of VCT and STI clinics.

The package of services provided to prison inmates included:

- Harm Reduction:
  - Syringe Needle Exchange, Social Services & Wound Management.
- Peer Education:
  - On HIV/AIDS, STI's (Sexually Transmitted Infections);
  - Voluntary Counselling and Testing (VCT);
  - Behavioural Change Communication, Condom Education;
  - Skill Enhancement (Vocational Trainings);
  - Referral Services for treatment of Opportunistic infections, Sensitive lab: tests & Anti-Retroviral Treatment (ART).

Palestine

Colonel Mahmoud Rahhal, Director of the Rehabilitation and Administration Reform, West Bank

Colonel Rahhal explained that drug control activities started in Palestine at the time of the establishment of the Palestinian Police in 1994. The strategy drugs control included drug demand reduction, drug supply reduction (trafficking and distribution), information dissemination, education and prevention. In Palestine different NGOs cooperate with the government in reducing drug and substance abuse and drug users are treated as patients.

Opium and cannabis are being used most. The highest number of drug users is between 24-34 years of age. There are 8000 cases of drug use in courts, 3000 cases of trafficking and distribution. Most drug crimes are committed by men. There are about 40,000 drug users in Gaza. There are usually more drug users in places where police is absent. The drug-related problems that the country faces are:

- Palestine police cannot control its borders so more drugs can be entered the country through Israel;
- Lack of resources and equipments is troublesome;
- Lack of K-9 units for drug control;
- Lack of technical support from the community;
- Lack of enough forensic laboratories;
- Lack of a unified strategy for drug control in the country;
- Lack of financial support to families of substance abusers;
- Diseases such as HIV/AIDS are mostly transmitted in prison.

The Hashemite Kingdom of Jordan

Major Ahmad Elayyan Meqbel Abu Zaid, Head of Forgery Crimes, Control and Credit Cards Section, Anti Narcotic Department, Ministry of Interior

Major Abu Zaid exclaimed that Jordan is strategically located among countries where narcotics are trafficked. There are 10 rehabilitation centres in Jordan in which many individuals are being educated on drug-related issues. These centres provide training and education as well as training of trainers (TOT) on HIV/AIDS prevention and care. The target groups for trainings are social workers, prison staff and police officers.

More coordination effort and collaboration with other countries is needed for campaigning for HIV/AIDS control since the risk of HIV/AIDS prevalence is higher in prison.

The purpose of assessing drug use and HIV/AIDS in rehabilitation centres (prisons) was to:

- Rapidly assess the amount of drugs being used in prison and transmission of HIV and health services inside correctional and rehabilitation centres (prisons);
- Identifying the rate of narcotic distribution in prisons;
- Identifying behaviours that cause transmission of HIV in prisons;
- Determining different types and tendencies that cause in drug use and high risk behaviours that result in the transmission of HIV/AIDS inside the rehabilitation centres that are being assessed;
- Assessing accessibility and production of HIV/AIDS medication and using it in the correctional centres (prisons);
- Access to recommendations and methods for drug use and HIV/AIDS prevention in rehabilitation centres and frequency of access to necessary services;
- Access to facts that would assist in developing strategies and national programmes to prevent HIV/AIDS and present prevention and treatment services through qualitative health services;
- Access the knowledge, approach and behaviour of social workers towards juvenile delinquents in correctional and rehabilitation centres (prison);
- Generalising the obtained data through organising a workshop for policy makers and relevant authorities so that it can be decided what needs to done.

The Islamic Republic of Iran

Dr. Bahman Ebrahimi, Deputy to the Director General of Health and Treatment Department of State Prisons Organisation

Dr. Ebrahimi gave an analytic presentation of the harm reduction activities in prisons in the Islamic Republic of Iran. HIV infection in prisons is 10-12 times higher than in the society. 75% of the inmates are in 19-39 age range. Drug treatment in prisons is implemented mainly through maintenance therapies. There are two types of clinical maintenance therapies: Agonist and Antagonist treatments. Some years ago, prison authorities in Iran were reluctant to opioid maintenance treatment because of concerns on abuse of methadone itself in the prison. Major barriers for agonist maintenance treatment were:

- Complicated regulations on receiving opioid drugs supplied by Ministry of Health;
- Lack of national therapeutic protocols, especially the ones which are adjusted the prison settings;
- Insufficiently established mechanisms of inter-agency coordination.

Methadone maintenance treatment can be considered as an effective harm reduction activity in prisons only if methadone coverage reaches about 60-80%. The problem is that drug use treatment is not covered by insurance. There are methadone and staff shortage and there is not enough budget allocated to the different types of drug treatment. Opportunities for developing maintenance treatment in prisons are:

- Unanimity and coordination among health and treatment officials on the necessity of the initiation of harm reduction activities;
- Drawing on the high potentials of religious and political figures' influence on people;

- Relying on the prisons officials' positive attitudes towards the initiation of harm reduction activities;
- Visiting other countries' harm reduction successful practices.

The effectiveness of methadone maintenance treatment has been shown under two points of view: the security/enforcement point of view and the health point of view.

From an enforcement point of view MMT results in:

- Decrease in illicit drug demand in prisons;
- Decrease in illicit drug-related crimes;
- Decrease in death rate resulting from drug use;
- Decrease in fight rates;
- Decrease in self-imposed injuries;
- Relaxing financial burden on families.

From a health and treatment point of view:

- A very positive impact on controlling and preventing HIV/AIDS (from 3.8% to 1.8% last year);
- Reduction in the rate of concomitant diseases;
- Reduction in high-risk behaviours, i.e. shared injection in prison;
- Reduction in the treatment costs;
- Safer atmosphere in prison.

The use of antagonistic maintenance treatment like Naltrexone is eased by following factors:

- General acceptance by authorities and the society;
- Acceptable response among drug addicted mothers and the individuals who have still preserved their social dignity and are supported by their families and the public;
- Lack of legal procedures and easier regulations to provide them, like other medication.

The use of the antagonistic treatment is impeded by following factors:

- Very high price;
- Low retention rates among drug users, especially intravenous drug users;
- Rumours against them made by drug dealers inside prisons;
- Their antagonistic effects.

There are also other measures to control high risk behaviours in prisons:

- Triangular clinics;
- Education;
- Syringe and needle exchange;
- Establishing hotlines;
- Conjugate rooms;
- Condom provision;
- Safe razors provision;
- Implementing comprehensive security measures;
- Tattooing relevant measures.

Needle exchange programme was developed in prisons in Iran for two initial reasons: a) Injecting drug users are susceptible to severe social problems and physical disorders and thus may not be able to abstain from drug use altogether, b) HIV spread among injecting drug users is one of the fastest transmission routes. The prisons officials and staff had a number of concerns before the initiation of the prison-based needle exchange programme (PNEP):

- Needles used to threaten the prison staff;
- Needles and syringes used as weapons against other inmates;
- An increase in injecting drug users and in number of injections in prisons;
- An increase in needle stick accidents;
- New HIV+ cases among intravenous drug users who participate in the programme.

There were also concerns on the side of inmates:

- Closer supervision by security personnel;
- A decrease in number of leaves granted;
- A decrease in privileges and an increase in punitive measures;
- As a subject of threat used by other prisoners.

Benefits of PNEP for the society as a whole:

- Prevention of AIDS prevalence among intravenous drug users;
- Reduction in high-risk behaviours;
- A decrease in Hepatitis B and C prevalence;
- A substantial reduction in society's health costs.

Field studies show that in cities where PNEP was conducted there was a decrease of 18.6% HIV prevalence, whereas in cities where no PNEP was implemented there was an increase of 8.1% in HIV prevalence. PNEP results in different countries' prisons:

- A significant reduction in sharing needle and syringes among inmates;
- A decrease in death and intoxication rate resulted from overdosing;
- Increased participation of drug users in addiction treatment programmes (MMT, etc);
- An increase in inmates' knowledge about high-risk behaviours and infection transmission routes;
- A reduction in injection-related abscesses among prisoners.

However the negative consequences anticipated by prison staff were not noticed after the introduction of PNEP. The studies show that in the course of implementing the programme in prison, the initial resistance of prisons staff against the programme implementation decreases and disappears and both intravenous and other drug users in prisons accept the benefits of the programme.

International Best Practices

Dr. Alex Wodak, Director of Alcohol and Drug Service, St. Vincent's Hospital, Australia

The most important harm reduction measure related to prisons is to:

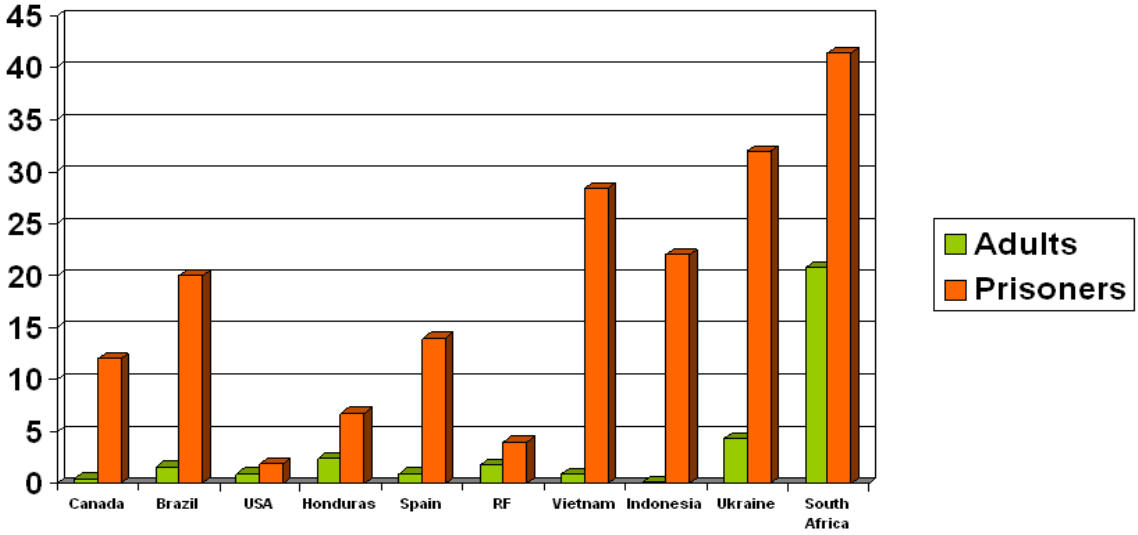
Reduce the prison population

There are many HIV cases in prisons but unfortunately few are detected. The following factors resulted in introducing harm reduction in prisons:

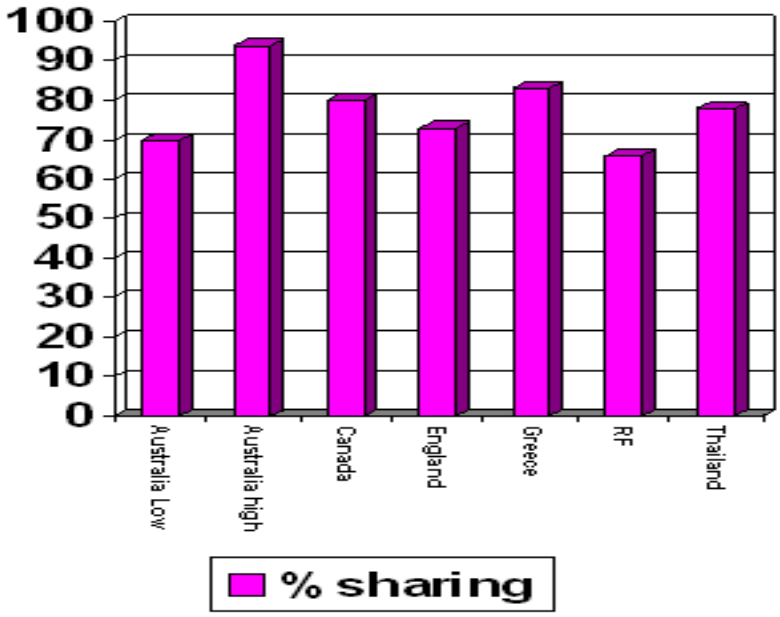
- High prevalence of injecting drug use (10-15%);

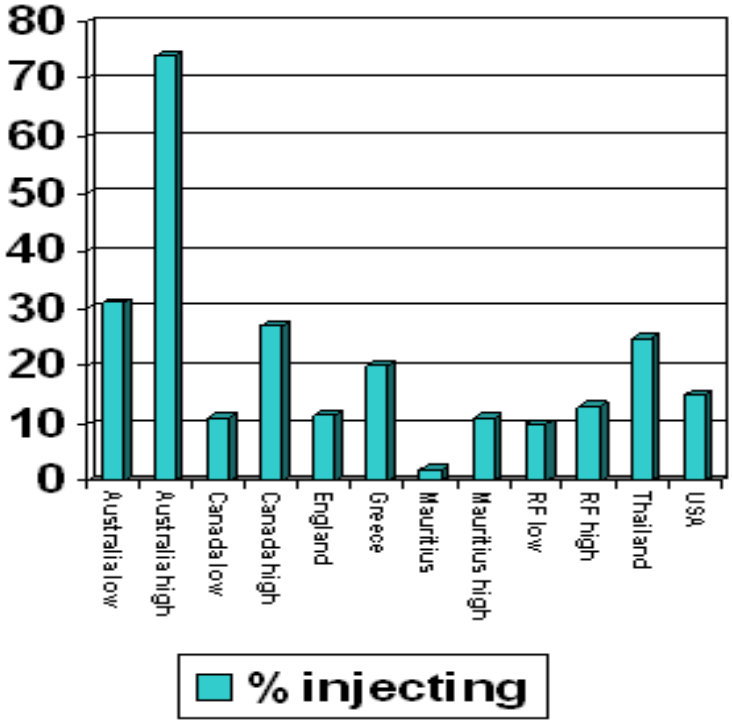
- Low frequency of injecting drug use (5%);
- Very high rate of partner change among injecting drug users;
- Needles, syringes conducive HIV spread.

Therefore, it is better to reduce the prisons' population through expanding non-prison sentencing options for drug offences. The following table illustrates the HIV prevalence (percentage) among individuals in the society and among prison inmates. Studying this table shows that prevalence of HIV is much higher in the prison than in the society in different countries.



Studying the following two tables show higher rate of shared injection in prisons in different countries.





Prison needle syringe programme is now provided in 12 countries and more countries are starting to implement this programme. Its benefits in prison are the same as in community and there has been no evidence of significant harms in prisons, i.e. no violence against staff and inmates.

The following tables show the status of prison needle syringe programme in different countries and the result of implementing the programme in different prisons.

Switzerland	Pilot in 1992/3	PSEP now in 7 prisons
Germany	Pilot in 1996	PSEP now in 1 prisons (down from 7 following political decision)
Spain	Pilot in 1997	PSEP now approved for all 69 prisons, programmes in over 30
Moldova	Pilot in 1999	PSEP now in 7 prisons
Kyrgyzstan	Pilot in 2002	PSEP now in all 11 prisons
Belarus	Pilot in 2003	Now in 1 prison
Armenia	Pilot in 2004	Now in 3 prisons
I. R. of Iran	Pilot in 2005	Under review
Luxembourg	Pilot in 2007	Under review
Ukraine	Pilot in 2007	Under review
Scotland	Pilot in 2007	Under review
Belgium	In development	Under review
Portugal	In development	Under review
Poland	In development	Under review

Prison	Incidence HIV&HCV	Needle sharing	Drug use	Injecting
Am Hasenburg (D)		↓	No increase	No increase
Basauri (Es)	No HIV	↓	No increase	No increase
Hannoversand (D)		↓	No increase	No increase
Hindelbank (CH)	No HIV	↓	Decrease	No increase
Lehrter Strasse & Lichtenburg (D)	No HIV but HCV	↓	No increase	No increase
Linger 1 (D)	No HIV	↓	No increase	No increase
Realta (CH)	No HIV	Single cases	Decrease	No increase
Vechta (D)	No HIV	↓	No increase	No increase
Vierlande (D)	No HIV	Little change or reduction	No increase	No increase

Prison Opiate Substitution Therapy (OST) is now being implemented in 29 countries and more countries are starting to implement it. Its benefits in prison are the same as in community and it may reduce prison violence and the rate of re-imprisonment by 80%. The most effective substitution therapy in prison is methadone.

Educating inmates on HIV can be carried out by inmates for inmates. Cartoons and different simple narrations and graphics can be used due to low literacy among inmates to show how HIV spreads through injecting drug use and sexual behaviour.

Anti Retroviral Therapy (ARV) is being implemented by more countries in prison settings. It reduces the viral load and may reduce HIV infection as well. Good results can be obtained from combining ARV and OST. It can also be used in Tuberculosis treatment.

Continuity prison-community:

- All treatment to/from:
  - Community;
  - Hospital;
  - Prison.
- Continuous care especially with OST, ARV;
- Health care is provided to all families in Iran one year after release from prison.

Sexual transmission prevention is another important component of programmes in prisons. Condoms are now being provided in prisons in 28 countries. Private visits are also provided for wives of inmates to stay a few hours or overnight.

HIV infection can also be reduced through controlled tattooing.

Keep re-offending low:

- Use prison time improve education - literacy, numeracy, vocational training;
- Post- release follow up;
- Keep family intact during prison sentence;
  Providing OST in prison and in community.

Conclusions:

- Critical role of prisons in HIV control in community must be overlooked;
- There are many more HIV infections in prisons than reported;
- HIV transmission is mainly from injecting drug use;
- HIV can also transmitted through some sexual behaviour and tattooing.

B. Feedback from Working Groups

Group 1: Policy Making

Dr. Mohammad Sadegh Shirazi presented the second working group.

Check list

1. Is drug use in prisons recognised as a special concern in your country?

Pakistan – no
Lebanon – no
Iran, Russia, Azerbaijan, Iraq – yes

2. Is the link between drug use, HIV and prisons considered as concerning in your country?

Pakistan, Iraq – no
Iran, Russia Azerbaijan, Lebanon – yes

3. Is the reduction of the number of inmates entering prisons recognised as an important strategy to address the two mentioned problems above in your country?

Russia, Azerbaijan, Lebanon – no
Iran, Afghanistan, Iraq – yes

4. Are harm reduction measures in prisons recognised as an important strategy to address the two mentioned problems above in your country?

Russia, Lebanon – no
Iran, Afghanistan, Iraq, Azerbaijan – yes

Challenges

- No legal framework exists for harm reduction in some countries;
- Lack of training;
- Implementation quality and quantity should increase;
- After care and rehabilitation supports should be increased;
- There is resistance in some countries for example for syringe distribution by the public;

- In some other countries such as Iraq the problem is that the law is in the hands of the occupying country;
- Lack of superior methods in some countries;
- Lack of capacity and superior methods.

Recommendations

- Countries in the region can establish a network to exchange positive and negative experiences and have common projects through technical and financial support of organisations;
- NGOs should be more active. In many countries NGOs are more active but in others GOs are the main implementers;
- An Epidemiologic research should be carried to prove the problem;
- Stigmatization specially in Islamic countries;
- Advocacy and capacity building – for example, in Islamic countries religious people can be effective on this matter. There are also trainings for individuals below 14 years of age particularly through media;
- Advocacy and capacity building between different levels of the society;
- Increase quality and quantity of the current programmes.

Group 2: Structure, Coordination

Mr. Ernest Robello presented the second working group.

Check list

1. Is there a defined coordination body/forum existing to link drug treatment in prison to the Ministry of Health (MOH)?

Iran – there is a high council of Prison Health operating with both members of Prison Organisation and the MOH. There is a Referral process.
Pakistan – there is no linkage between prison and MOH.
Jordan – national Task Force MOH, MOI, NGOs (Coordinating body on drug abuse and HIV) is established based on Government and UNODC agreement. There are representative from both Government and UNODC in this Secretariat.

2. Are HIV positive inmates segregated in prisons in your country?

Iran – no
Pakistan – if somebody is tested HIV positive, he/she will be isolated.
Jordan – the same as Pakistan

3. Are specialised after release services provided to drug users and HIV positive inmates?

Iran – yes, through Triangular Clinics – Full range of services outside including ARV and OST
Pakistan – HIV positive will receive ARV treatment outside the prison system and drug counselling and HIV counselling.
Jordan – After release, prisoners are referred to primary health services or NGOs are available. Also the HIV positive are referred to national programme.

4. Are NGOs/peer groups active and involved in programmes in prisons in your country?

Iran – NGOs are not allowed in prison setting. Peer groups have programmes in prisons.
Pakistan - Peer groups and NGOs are active.
Jordan – Self help groups and NGOs are not currently working but their involved is part of strategy. They are not active but this issue has been reflected to be considered in the national strategy for adaptation.

Challenges

- HIV Positive and Drug user prisoners do not have a specific programme after release;
- Lack of social support for drug users;
- Stigmatization exists for the HIV groups;
- Need to establish a coordinating body for both drug users and HIV;
- Linkage between programmes for both groups;
- A citizen board to supervise Drug and HIV prevention activities in prison;
- More commitment;
- Advocacy;
- De-centralize the services;
- Establishment of a Board of Trustee in order to involve NGOs in prison setting activities in order to compile precise information on prisoners.

Recommendations

- National roundtables and workshops at the national and regional level to strengthen;
- Well coordinated National policy/programme;
- Discuss issues at national and regional level;
- A monitoring and evaluation system for ongoing programmes;
- Forum for exchange of views/ best practices at national and regional level.

Group 3: Management of Human and Financial Resources

Dr. Hamed Ekhtiari presented the third working group.

Check list

1. Is there a regular budget line for programmes on HIV and drug treatment programmes in prisons?

Iraq - no
Syria - no
Jordan - no
Afghanistan - no
Palestine - no
Iran – no precise information on this matter exists but annually has been allocated from different articles/resources.

2. Are drug treatment/HIV prevention staff parts of the prisons human resources chart?

No country mentioned that they have it.

3. Do you consider the turnover of drug treatment/HIV prevention staff in prisons as high?

Each country mentioned that their turn over is very high.
In Jordan it was mentioned that it has been very high for the past one to two years.
Palestine mentioned high turnover due to military situation.

4. Is regular training on drug treatment/HIV prevention/education part of routine managerial measures in prisons?

Iraq – No. but the group were originally from Kurdistan and had information about that area specifically and this information could not cover the whole country.
Syria – not sure
Jordan – yes, multiple
Afghanistan – it is available but not regular (separated)
Palestine - no
Iran - primary education for many prisoners exists

Challenges

- There is not enough space and equipment in prisons for such programmes;
- There is no possibility for evaluation and intervention;
- Trained human resources available;
- Not enough training/education.

Recommendations

- NGOs to be utilised in training programmes for prisons. Therefore their presence in prisons should be allowed;
- Considering the fact that INCAS has been recognized as the knowledge hub of region by WHO EMRO, therefore there is the possibility of training facilities in the region particularly for countries such as Afghanistan, Pakistan and Iraq;
- Training courses by ROMENA in Cairo for specialised individuals and also for officers and clinicians.

Group 4: Practice/challenges

Dr. Luisa Baymirova presented this working group:

Check list

1. Do any protocols and/or guidelines exist on the regulation of harm reduction measures in prisons in your country?
2. Is Opioid Substitution treatment such as methadone maintenance treatment offered in prisons in your country?
3. Are Needle Syringe programmes offered in prisons in your country?
4. Are condoms offered in prisons in your country?
5. Are there voluntary Counselling and testing programmes existing in prisons in your country?

The group answered the above four questions as following:

- The most broad spectrum of services (all of listed in the group work outline) is provided in Iran and to the less extent in Kyrgyzstan. Provision of all interventions in these two countries is regulated by national normative documents, national protocols and manuals;
- In other three countries (Uzbekistan, Azerbaijan, and Turkmenistan) only elements of the WHO recommended package for HIV prevention and treatment among drug users are provided (i.e. VCT, condom distribution, TB prevention and treatment, information provision). However, the coverage by and scale of these interventions remain low.

Challenges

- Often decisions on which types of interventions to implement are driven by political motives and evidence-based conclusions are ignored;
- Not rare cases when there is a lack of reliable data needed to take the decision and the decisions eventually taken are based on a subjective perception of the problem in question, or on individual opinions; sometimes the problem of drug use in prisons and the necessity of interventions to mitigate its consequences are denied;
- There may be problems with available cadres of services providers and lack of financial means.

Recommendations

- Since countries are at different stages of the implementation of harm reduction in prisons, it was difficult to make universal recommendations on scaling up of the access to harm reduction services in prisons in this group of countries.

With regards to regional collaboration the following recommendations were suggested:

- To create a regional database containing information on national and international research/studies, legislation, norms/standards and regulatory mechanisms related to harm reduction implementation (in general and in prisons) for countries' perusal [UNODC as a custodian of the database was proposed as one of the options);
- To initiate and maintain information exchange among countries in the region through conducting joint seminars, organizing study tours, providing technical assistance, establishing a network of collaboration research centres/knowledge hubs existing in countries.

Working Group Wrap up Session & Identifying Follow up Actions

Professor Uchtenhagen explained that due to advanced time a discussion shall not be opened. Summarising the session he made following statements:

- This seminar is not considered to be a non-repetitive experience but it is conceived to be the start of a process of cooperation in the region and listening to your working group reports it is highly evident that there is a willingness and need for continued cooperation in the region;
- Harm reduction standards are needed;
- Advocacy needs to be emphasised;
- Regional data base are required;
- Exchange of regional programmes is important to ensure harm reduction programmes;
- Harm reduction as an integrated element of drug policy;

- Creating regional network at different levels including training exchange, site visits, exchange of experiences are considered needed and useful.

At the end, he mentioned that it was very encouraging and it is his privilege as the chair to thank all for this very engaged and fruitful cooperation start.

III. Abstinence-based Treatment

Chair: Professor Ambros Uchtenhagen
Vice Chairs: Dr. Farhad Aghtar, Dr. Saeed Sefatian

A. Plenary Session Presentations

Islamic Republic of Afghanistan

Dr. Abdullah Wardak, Director, Drug Demand Reduction, Ministry of Public Health

Drug Demand Reduction Department was established in Afghanistan in October 2005. For the time being, there are two going projects (DRAT and CNTF) in this department. 14 provinces are covered by these projects and 16 health facilities have been established for drug users. In case of the availability of budget, more provinces in Afghanistan will be covered by this department.

There are different types of treatment services in Afghanistan: 17 governmental and NGO services that provide demand reduction services through 23 different facilities.

There are 6 Drug Demand Reduction Action Teams (DRAT) programmes in 6 regions of Afghanistan. UNODC supported these programmes until April 2008. Counter Narcotic Trust Fund (CNTF) has supported two 20-bed hospitals in two Balkh and Nengrahar Provinces as well as eight community-based centres in eight provinces.

The goal is to reduce morbidity and mortality through drug demand reduction activities nationwide and objectives are to establish demand reduction activities in all provinces by the end of 2010 and to improve the capacity of the staffs in treatment facilities and deliver quality services for drug users according to national guidelines and best practices.

There are different types of drug users in Afghanistan:

- Traditional opium users who are mostly carpet weavers, people from rural areas in Afghanistan. The approach for treating this group of drug users would be through community-based, home-based and camp detoxification with community support in aftercare and relapse prevention;
- War-related traumatised people who usually suffer mental health distresses and the majority use psychotropic injecting drugs, which can put them at risk of HIV/AIDS and other blood born diseases. The approach for treating this group of people would be through mental health programmes to strengthen life skills, provision of community support, good aftercare and relapse prevention programmes;
- Refugees who have returned from Pakistan and Iran and unemployed young generation in urban centres. The approach towards treating this group of people would be harm reduction, demand reduction and HIV prevention programmes and awareness

as well as referral to drug use treatment programmes and their re-integration into communities.

Current situation of drug use treatment in Afghanistan is not very welcoming since there are limited drug treatment and rehabilitation centres; there is a need for expansion, upgrading and building of the capacity of existing treatment facilities all over the country; there is insufficient treatment facilities despite high number of drug users and lack of proper treatment centres for drug users in prisons.

Achievements:

- Development and introduction of national treatment guideline (already signed with Ministry of Public Health and Ministry of Counter Narcotics);
- Registration of NGOs, who are working in treatment of drug users, with Ministry of Public Health;
- Collection and aggregation of NGOs report and their submission to PHC/PM General directorate on quarterly bases;
- Supervision, Monitoring and Evaluation of DRAT, CNTF and NGOs' programmes;
- Participation in drug demand reduction working group monthly meetings at Ministry of Counter Narcotics;
- Participation in international workshops and seminars;
- Establishment of 10-bed treatment centre for drug users in Pulcharkhi PRISON by UNODC/Afghanistan;
- Distribution of harm reduction kits to inject bale drug users in Afghanistan**.**

Challenges:

- Security problem;
- Shortage of resources;
- Migration;
- High Unemployment rate;
- Easy access to drugs in community;
- High illiteracy rate;
- Shortage of professional staff for addicts treatment;
- Need for international assistance in the fields of harm reduction and supply reduction;
- Lack of drug use prevention and treatment trainings in school syllabuses.

Recommendations:

- Technical & Financial Support;
- Capacity Building to institutionalise drug abuse prevention and treatment for sustainable interventions;
- Sharing experiences and exchanging knowledge with other countries for identification of best practices;
- Supporting imprisoned drug users' treatment programme.

Islamic Republic of Pakistan

Mr. Iftikhar Ahmed, Deputy Director General, Anti Narcotics Force

Although Pakistan was declared as a poppy free country in 2001, the country is still facing a severe problem with the wide spread drug abuse, estimated at 625,000 opioid users which of 125,000 are believed to be IDUs. In 2004, WHO/UNAIDS declared Pakistan as the HIV concentrated epidemic country. According to the National HIV Second Generation Surveillance, carried out by National HIV/AIDS Control programme in 2007, the HIV prevalence among injecting drug users is 15.8%, 11% are Hepatitis C positive, and 18% are infected with tuberculosis. The survey also showed that 45% of IDUs are married and the condom use is 16.5%. The average age of opioid addicts is around 30, while the age of initiation of drug is around 19 years. Due to well established link between IDUs, FSW & MSW, Mr. Ahmed expressed a concern about the risk for HIV to spread among general population. The following seizures were made in Pakistan during 2007:

- Heroin-13,736 kg.;
- Cannabis- 101,069 kg.;
- Opium- 15,362

The legal framework on drug control in Pakistan consists of the Ministry of Narcotics Control, which is responsible for policymaking and planning within this area. The Government of Pakistan has further developed a national drug control master plan from 2008-2013, that sets out the country's strategy for drug demand reduction. Following activities are included within this plan:

- Up gradation of drug treatment centres;
- Establishment of National Task Force;
- Training of drug treatment staff;
- Establishment of drug treatment services in prison settings;
- Specifically designed programme for children with drug abuse problems;
- Women drug treatment services;
- Multi-sectoral coordination;
- Establishment of treatment data collection system.

At current day, only 10% of the addict population in Pakistan has access to treatment and the total number of drug treatment and rehabilitation centres are 76, a majority run by NGOs. In addition to this, 20% of the prison population in Pakistan has been incarcerated because of drug use. Mr. Ahmed stressed the need for training of treatment staff, enhanced capacity of service providers, and establishment of a scientific based system in order to monitor and assess delivery, quality and coverage of drug treatment services.

Republic of Iraq, Kurdistan Province:

Dr. Sirwan K Ali, Consultant and Psychiatrist, Head of Psychiatric Department, Hawler Medical University Iraq

Iraq is as a country situated in an area with severe drug abuse problems, weak controls and relatively open borders, seriously affected by a high number of drug users. In addition to this, international conflicts, violence, unemployment, poverty, and the breakdown of health services, makes the country even more vulnerable. Dr. K Ali also pointed out the large

increase of alcohol consumption in Iraq, and the lack of services needed for this issue. The age of first drug use of the majority seems to be 12-18 years. Following substances are most common in Kurdistan:

- Benzhexol (artane) 31%
- Benzodiazepines 29%
- Codeine contains medication 19%
- Cocaine 14%
- Cannabis 5%
- Theriac (opium) 2%

Experts from Kurdistan have attended in the last few years a number of international training sessions on abstinence-based treatment, and a special unit for addiction treatment has been established at the Hawler Teaching Hospital in the Kurdistan province. Another response to the drug addiction is the multisectoral committee for the control and strategic planning, established in 2006. Dr. K Ali also pointed out the challenges facing Iraq on this issue, including stigmatisation, discrimination. Also the rule of Law needs to reign in the province. He stressed that media and NGOs can play a great role in prevention activities, and emphasised an urgent response to the increasing drug addiction population in the country.

Republic of Lebanon

Mr. Elias Al Aaraj, Director of Soins Infirmiers Developpment Communitaire

Assessments carried out in cooperation with UNODC in 1993 and 2001, showed that there were scarce services supporting drug addicts. 90% of drug users did not know of their rights, and no awareness campaigns existed. Yet today, Mr. Aaraj pointed out that there is no operational working plan for drug abuse and no budget allocated for these needs, which consequently has led to increased vulnerability among drug users.

NGOs operating in the country only have capacities to care for around 600 patients. The country has about 200 prisoners with drug problems but no services are provided for them except for counselling on legal assistance. Apart from the need of treatment and rehabilitation programmes, Mr. Aaraj called for additional prevention activities including awareness campaigns through media and education in schools.

Islamic Republic of Iran

Dr. Mehrdad Ehterami, Head of Research and Development office, and Head of Community Based Organisation Committee, State Welfare Organisation

Dr. Ehterami delivered an analytical overview presentation on the development of Iranian abstinence-based treatment in the last 15 years. The Iranian State Welfare Organisation is one of the DCHQ member organisations. Dr. Ehterami expressed his concern about the stigma and discrimination towards drug users, which influence prevention and treatment process negatively in the country. He elaborated that drug users in treatment move on the three axes of: criminality-social integration, best health-death and human rights. A number of factors enable services involved in drug treatment to enable the process of moving towards requirements of the 21st century: social responsibility, expanding partnerships, increasing investments and securing infrastructure for health promotion.

He highlighted the organisation's policies towards drug abuse treatment: avoiding labelling of drug users, seeking alternatives to incarceration, and encouraging drug users to live without drugs. He further pointed out the organisations goals of treatment:

- Maximising motivation for abstinence;
- Rebuilding a drug –free life style;
- Helping to maximise aspects of life function;
- Optimising medical function;
- Identifying and treating psychiatric symptoms and disorders;
- Dealing with marital and other family issues;
- Enriching job functioning and financial management;
- Addressing relevant spiritual issues;
- Dealing with homelessness;
- Relapse prevention.

Dr. Ehterami gave also a brief overview on abstinence–based treatment. Drug treatment centres were operating in Iran until the Islamic revolution in 1979. After the revolution drug use as well as addition were declared for illegal and drug treatment centres closed. With increasing numbers of drug users boot camps were established by 1983. Around 1996 the need for voluntary treatment was gradually recognised and the Welfare Organisation was allowed to establish an outpatient abstinence-based drug treatment centre providing medical drug treatment with clonidine together with non-medical interventions and social work support. In 1997 after the amendment of the Anti Narcotic Law, the first meeting of relevant experts, implementers and authorities was convened to discuss drug demand reduction issues in this country, the same year prevention activities started to be launched in Iran. After 1998 compulsory rehabilitation boot camps were started being closed gradually. In the year 2000 the first pilot activity on medical relapse prevention with Naltrexone was launched[2]. In the same year several Therapeutic Communities (TCs) were opened by the State Welfare Organisation in the country. Staring with 2002 private clinics could request and receive license to provided drug (abstinence-based) treatment under specified conditions, also community-based interventions began being implemented. In 2003 methadone treatment started in context of two pilot activities[3] in the community and one further in the prison[4]. Also other harm reduction programmes started in the community in the same year[5]. In 2004 a number of rehabilitation centres according to 12 steps programmes started to expand offering short-term drug free residential treatment. A pilot on Buprenorphine maintenance treatment was conducted[6]. The year 2005 witnessed significant expansion of private and community-based services. Treatment of Amphetamine type Stimulants (ATS) started same year[7]. The effectiveness of many of the modalities mentioned above has already been demonstrated through relevant research.

[2] Conducted by the State Welfare organisation, with the Iranian National Centre for Addiction Studies (INCAS) as on of the main pilot sites, supported by the E52- DARIUS project of UNODC- Iran

[3] Conducted by the Iranian National Centre for Addiction Studies (INCAS), supported by the E52- DARIUS project of UNODC- Iran

[4] In the Ghezel Hessar Prison in Karaj, by the Tehran Psychiatric Institute and supported by the E52- DARIUS project of UNODC- Iran

[5] Supported by the E52- DARIUS project of UNODC- Iran and the Gesellschaft für Technische Zusammenarbeit (GTZ)

[6] By the Iranian National Centre for Addiction Studies (INCAS) together with the Yale University

[7] In and by the Iranian National Centre for Addiction Studies (INCAS)

Still many people in Iran believe that addiction should be considered as a crime. The law and trends in its enforcement have been moving in recent years towards recognising addiction more and more as a disease. According to the existing Anti-narcotic Law (amended in 1997), the addicted person is a criminal unless under drug treatment.

Drug use policies should include encouraging abstinence, non-punitive approaches towards addiction, design of relevant interventions for substances untreatable through maintenance treatment, establishment of specialised training for intervening in the social problem of drugs. The psychopathology of drug use should be assessed and treated, and destigmatisation needs to take place. The strategies to achieve the above should include training, capacity building, advocacy, observing human rights as well as awareness raising.

Relevant structures of drug treatment in the governmental sector in Iran are coordinated by the DCHQ and include: The Health Undersecretary of the Ministry of Health, Treatment and Medical Education, the Deputy of Prevention and Cultural Affairs of the State Welfare Organisation and the Iranian Prisons Organisation.

Dr. Ehterami further emphasised that in the management of human and financial resources special emphasis should be given to ensuring sufficient scientific knowledge, financial resources and addressing of malpractices, which seem increasing in the private sector. Instruments suitable for supervision of the private sector include: coordination and close supervision, awareness raising on scientific drug treatment modalities and obvious malpractices, payment of subsidies and provision of general health care.

He pointed out some of the Iranian challenges in drug treatment:

- Opportunity for deviation/malpractices;
- Changes which have been made in different cooperative organisations cause some problems in planning;
- Lack of resources;
- Lack of synergies in treatment centres;
- Lack of attention in future events which cause several problems in research and planning;
- Lack of sufficient attention to relapse prevention.

Dr. Ehterami finalised his speech with mentioning some explanations for the created challenges such as: differences in definitions and priority setting of relevant authorities, not utilising prior experiences, lacking of a written national strategic programme, insufficient participation of the general population, tending towards reaching quick and complete results, cultural issues of affected and unaffected populations.

International Best Practises - Treatment of Drug Dependence, Abstinence-based programmes

Dr. Gilberto Gerra, Chief of Health and Human Development Section UNODC Vienna

Dr. Gerra gave a detailed scientific presentation on the issue of addiction. He particularly emphasised that drug addiction is not a choice. It is a disease justified by both genetic and environmental scientifically evidence. He stressed that the ignorance towards drug addicts needs to come to an end. Addiction cannot be considered as a self-acquired disease, the simple consequence of a guilty-free choice. Furthermore, the genetic and environmental

factors create a large vulnerability for some individuals, who consequently risk falling into drug addiction. These include unrecognised issues during the prenatal period, the early parental attachment, family education style, peer pressure and drugs supply. These result in evident changes in brain functioning. According to a study there is a significant difference between heroin addicts and the control population regarding the activity level of some neurotransmitters in the brain. Another study illustrated that among children grown up in low socioeconomic status families had poorer cardiovascular health, lower dental health measures higher substance abuse resulting in clinical dependence.

Dr. Gerra continued with pointing out the goals of drug dependence treatment, including:

- Control withdrawal symptoms;
- Reduce craving and control compulsive behaviour;
- Prevent relapse;
- Improve life quality;
- Reactivate motivation;
- Reduce psychiatric symptoms;
- Facilitate reintegration.

The EU drug strategy guides towards improvement of access to targeted and diversified treatment programmes including integrated psychosocial and pharmacological care. There are many detoxification methodologies including rapid detoxification methodologies using clonidine/lofexidine and Naloxone and Naltrexone. Medical relapse prevention with naltrexone maintenance treatment has proven to be one of the effective methods in abstinence-based drug treatment. The coherent database systemic review has observed a trend in favour of treatment with Naltrexone for certain highly motivated target groups.

He urged that the society need to provide the right treatment for drug addicts, combining both psychosocial interventions and pharmacological treatment. Considering 50% of all addicts also suffer from a psychological disorder, such interventions are particularly important. Also the role of vocational training in the reintegration of recovered drug users in to the society and preventing of relapse into drug sue should not be underestimated. Peer support groups and 12 step programmes have proven very useful for certain groups of drug users in recovery.

Concluding his presentation, Dr. Gerra pointed out that development within the area will take time, and although not being able to provide the highest quality and range of services initially, there is a need to start somewhere.

B. Feedback from Working Groups

Group 1: Policy Making

Mr. Abbas Deilamizadeh presented the first working group.

Check list

1. Do you have a written policy on drug treatment in your country?

The colleagues from Russia and Azerbaijan were not with the group.
Iran - yes
Pakistan - yes
Iraq - no
Lebanon - no

2. Is psychological treatment /counselling considered as one of the most important pillar in drug treatment in your country?

All countries replied yes however Lebanon said that it is done by NGOs and private sectors.

3. Do you have compulsory drug treatment programmes in your country, like mandatory residence of drug users in prison-like closed settings (except for drug court treatment)?

All present countries gave positive answer. Iran mentioned that for hard reach drug users there are two options: either prison or compulsory residential places.

Challenges

In Lebanon, the approach and attitude is moving from criminalisation to health approach. For Pakistan the infra structure is very little and limited. The facilities are very limited for implementation of programmes. NGOs are very limited. The expenses of treatment in private sectors are very high.

Recommendations

- Pakistan recommended the increase in the number of rehabilitation centres;
- Iraq believes that there is need for UN intervention and neighbouring countries assistance and it is necessary to conduct epidemiological studies and also training for service providers;
- Iranian colleagues believed that number of centres need to increase. The budget for treatment should increase in order to expand the treatment and medication programmes to expand abstinence based treatment and medication. Since Iran has various programmes, these centres should be integrated.

Group 2: Structure/Coordination

Mr. Iftekhar Ahmed presented the second working group.

Check list

1. Which structures are involved in provision of abstinence- based treatment?

Jordan - Ministry of Health (outreach centres and in-patient national AIDS programme), Ministry of Interior, Police and NGOs have the task to find the patients and refer.
Pakistan – Federal government exists who is responsible for policy making. Ministry of Narcotics Control also exists along with Ministry of Health who give psychological services. Also the private sector and NGOs are involved.
Iran – Governmental organisations, Ministry of Health, Ministry of Welfare and prisons Organisation, DCHQ, NGOs and private sector are active.
Afghanistan – Ministry of Health, Ministry of Education, Youth groups and spiritual and religious groups.

2. Coordination with other sectors ensured (Health, social, welfare, criminal justice)

Jordan - has a working group with the task of implementation and operation and consists of Ministry of Interior, MOH, Judiciary, UNODC and NGOs and is governed by Judiciary.
Pakistan – cooperation between Ministry of Health and Ministry of Welfare is weak.
Iran – has a treatment committee in DCHQ. This committee is with the cooperation of Ministry of Health and Ministry of Welfare and Prisons Organisation.

Afghanistan - MOH with cooperation of Judiciary, Ministry of Welfare, UNODC, Red Cross and NGOs and DDR sections and prison organisation are involved as well.

3. Are Relapse prevention/psychological treatment mandatory parts of drug treatment?

Pakistan - these services are not mandatory but in some cases services are given.
Iran - the service providers give services but it depends on the referrals to accept or refuse these services.
Afghanistan - it is mandatory especially in prisons but not outside.

4. How far are NGOs/Peer groups involved in provision of drug treatment in your country?

Jordan - it is very high.
Pakistan - most of job is done through NGOs.
Iran - more than 70 is done through NGOs and private sectors.
Afghanistan - NGOs have just been involved.

Challenges

- improvement in accessing and developing services rendered and capacity building for service providers;
- lack of resources;
- Free of charge services are not much and cause decrease in the number of referrals. In some countries a national policy should be established and a coordination committee should be established in the region. Coordination of policies of the regional countries should be done;
- In many cases, the managements change and parallel projects are running or remain incomplete;
- Lack of coordination between different structures of governmental and private sectors.

Recommendations

- A standardized regional protocol should be established in order to integrate the services;
- More regional cooperation and coordination against narcotics cultivation, production and trafficking should exist;
- Common activities among countries. For example, if a country is weak in combating trafficking, other countries can assist;
- Integration among regional countries;
- An alarm system (EWS) to detect new trends in addiction;
- Advocacy among authorities and policy makers since the governments change rapidly in some countries;
- We have to prevent relapse. For those individuals coming out of prisons, there should be outreach rehabilitation facilities;
- Linkage between service providers;
- Access to services.

Group 3: Management of Human and Financial Resources

Dr. Mojtaba Shojaei presented the third group.

Check list

1. Are there written criteria for staff standardizing qualification for provision of drug treatment?

Jordan – done only by 3 psychiatrists who have received special training and General Practitioners do referrals and training.
Syria – done only by Addiction Treatment Specialist.
Afghanistan - they have designed a specific guideline and physicians and psychologists who can comply with this guideline can render drug treatment services.
Iran – Psychiatrists directly treat addiction but other physicians, social workers and psychologists should first take certain courses before they can provide those services.
Palestine – Psychologists and specialised individuals.

2. Is drug treatment integrated in the curricula of medical and nursing schools?

Jordan – There is theoretical and practical training for physicians in medical schools. For psychologists and sociologists have only theoretical courses.
Syria – They have only theoretical courses in medical schools on how to behave with patients for referral. Psychiatrists have theoretical and practical courses.
Afghanistan – There is practical courses for nurses but in near future training will be considered for General Practitioners.
Palestine – There is only one general training for physicians and nurses to recognize the addiction.
Iran – There is no training courses in medical and nursing schools but for psychiatrists there are theoretical and practical courses.

3. Is there a regular budget line for programmes on HIV and drug treatment programmes in prisons?

Jordan – this training exists but not mandatory
Afghanistan – it is mandatory at the beginning but later it is optional.
Palestine – exists but is not mandatory
Syria – same as Palestine
Iran – in order to take primary license it is mandatory but later it is optional.

4. Is regular training on drug treatment/HIV prevention/education part of mandatory qualification criteria in drug treatment centres in your country?

In the beginning training is mandatory, however not on a regular basis.

Challenges

Jordan and Syria claimed that in this context they have lack of budget and human resources. There is difficulty in working in treatment centres due to negative approach of society and Low wages.
Palestine – lack of resources and facilities
Afghanistan – long term programmes for treatment do not exist and they lack programme, instructors and facilities.
Iran – There is no mandatory re-training for those involved. Training courses are only for physicians but not for psychologists and social workers.

Recommendations

- A country for training should volunteer and other countries should introduce individuals to go there and receive training;
- MOH should allocate budget for treatment;
- Research in treatment and training should be carried out;
- Training for university courses should be created;
- There should be training courses in universities.

Group 4: Practice/challenges

Mr. Ashghabat Nohurov presented the forth group.

Check list

1. Do you consider waiting times for drug treatment rather as appropriate in your country?

Central Asia and Azerbaijan - do not have waiting list and they can receive patients immediately.
Iran for hospitalization and governmental hospital one or two week in waiting list but for outpatient centres and private sectors no problem exists.

2. Are drug treatment centres highly accessible in your country?

Following criteria:

- Geographical access;
- Prices and expenses;
- Lack of sexual, age, belief discrimination;
- Confidentiality of information.

In most cities of Central Asia treatment is accessible according to geographical view
In Iran there is a problem for far areas and far geographical areas but in central Asia and Azerbaijan no problem for far areas exists.
A little discrimination about women exists due to a cultural issue such as being shy to refer to treatment centres.
Discrimination due to cultural beliefs exists in Iran, Central Asia and Azerbaijan.
Confidentiality is observed in all countries.

3. Is the private sector involved in provision of drug treatment supervised according to a standardised written protocol?

In all countries other than Turkmenistan who does not have private sector all have standards by government for both governmental and private sectors.

4. Is free of charge drug/low cost treatment feasible for most drug users in need in your country?

In Iran there are subsidies so that people can receive treatment in private sectors but in other countries patients have to pay. The price depends on the type of services and number of services. In governmental places the costs are quite low.
In all countries other than Turkmenistan treatment for addiction is not covered by insurance.

Challenges

- Lack of prevention and treatment services after treatment;
- human resources and lack of it and lack of specialized forces;
- Stigmatisation exists everywhere – mostly in the society in which they live. It is very hard to see the patient as a member of the society and they are often blamed and their primary rights are not observed;
- Training of human resources in Central Asia and Azerbaijan is old;
- Budget for the service centres. Financing is not enough in many cases. It is necessary to receive the fund without mediator for equipment and medication;
- In central Asia and Azerbaijan this is one of the issues being paid attention. The services in these countries are detoxification and psychological services are very few.

Recommendations

- necessary base for training should be increased;
- number of treatment services particularly in rural areas should increase;
- modernisation and up-to-dating of programmes in training centres;
- Use of update and modern international methods;
- Constant information exchange;
- Joint regional researches;
- International cooperation;
- Research on more scientific treatments.

IV. Opioid Substitution Treatment

Chair: Dr. Alex Wodak
Vice Chairs: Dr. Parviz Afshar, Dr. Saeed Sefatian

A. Plenary Session Presentations

The Republic of Uzbekistan

Dr. Luiza Baymirova, Head Expert of Treatment and Care Central Department

Dr. Baymirova gave a detailed presentation of the development of OST in the country. The Ministry of Health in Uzbekistan developed guidelines and regulations of OST in 2001, and in 2003 and 2005, experts in the country piloted the first MMT. Following this, the Minister of Interior then modified the rules and drafted guidelines for OST, which was piloted in Tashkent in 2006. Uzbekistan earlier used an Indian manufacturer of methadone tablets but in 2005, the country independently started dispensing methadone tablets. Methadone for medical purposes is now used legally in Uzbekistan since 2006 and detoxification is used for individuals under 18 years of age. Although Ms. Baymirova highlighted some achievement for recent OST in Uzbekistan, she expressed concern regarding the OST that results in failure. There is a need for further evaluation of current substitute treatment in the country, as well as epidemiological surveys of drug addiction. In addition to this, Ms. Baymirova called for further studies on psycho tropical substances, as well as studies on drug related crime offences. Evaluations have been carried out regarding the quality of doctors and the social support received after treatment.

At current date, there are 145 patients in OST in Uzbekistan, including a few women. Outreach programmes include 53 individuals, which of 35% are employed. Ending the presentation, Ms. Baymirova pointed out the challenges within OST that Uzbekistan faces today. These include lack of psychological support, lack of trained and educated staff, and the issue of access to remote areas.

The Republic of Lebanon

Mr. Elias Al Aaraj, Director of Soins Infirmiers Developpment Communitaire

He emphasised that the country has very little activities with regards to OST. Although no current data on the number of drug users exists in the country, Mr. Aaraj presented the following estimates:

- According to professional in the field of drug abuse, and to drug users, themselves IV mode of use is the least prevalent;
- As noticed by professionals in the past few years, numbers are increasing and ago of starting drug use is decreasing;
- 5.7% of all reported HIV/AIDS cases are IDU, all males.

A situation analysis has further targeted:

- 101 Men who have sex with men (MSM);
- 101 Female sex workers (FSW);
- 97 Injecting drug users (IDUs).

Methadone and Buprenorphine are both illegal in Lebanon, which naturally explains the lack of activities within these areas of treatment. However, an OST programme is currently piloted together with an NGO in the country, including 120 patients on Buprenorphine. Drug related crimes can give between 3 months and 1 year of prison, however, drug offenders are not considered as criminals as long as they undergo drug treatment. Within prison settings, no harm reduction or treatment exists and the only service available is some assistance in order to help inmates with their withdrawal symptoms. Mr. Aaraj also raised concern over the following key findings among IDUs:

- Ever borrowed a syringe 64.7%
- Borrowed a syringe within the past 6 months 59.6%
- Borrowed syringe for last injection 17.2%
- Average number of partners in syringe 1.24%
- Main partner in sharing: “A friend” 56.7%
- Main partner of sharing: “A group of drug users” 26.7%

In addition to this, 43.5% of the IDUs responded they can get a clean needle/syringe whenever needed. Lebanon’s current outreach programme was presented as follows:

- The project covers all the Lebanese territories;
- Referral system composed from 3 NGOs;
- 30 Peer educators trained;
- 600 to 800 IDUs reached yearly through outreach;
- More than 2000 syringes & 4000 condoms distributed;
- A mobile unit is in service since 4 years;
- Early 2009 a second one will be in service;

- 20 VCT centres are currently active in the country;
- VCT for HIV/Hepatitis is available in the mobile unit (Rapid Test);
- IEC material targeting specific needs are available.

Mr. Aaraj emphasised that drug use should be seen as a part of public health and human rights, which he hopes to see in Lebanon in the near future. With regards to OST, WHO has currently sent an international consultant to Lebanon, in order to develop a framework for this kind of treatment A task force in the country is now working on a protocol for OST.

Islamic Republic of Iran

1. *Dr. Kianoush Kamali, Senior Expert, Office of STIs and AIDS, Ministry of Health, Treatment and Medical Education*

Dr. Kamali presented an overview of the HIV/AIDS situation in the I. R. of Iran.

HIV/AIDS Cases- October 2008	No
Total registered	18320
HIV advanced	2800
Death	1592
Estimation	83000

Although registered cases of HIV/AIDS are 18,320, estimations tells us that this number could be as high as 83 000 infected. Modes of HIV transmission among registered cases was presented as follows:

Groups	Percent
Injecting drug usage	69
Sex	7.9
Mother to child	0.6
Blood or blood products	1.3
Unknown	21.2

Furthermore, around 90% of the known HIV positives cases are covered by HBV vaccine.

2. *Dr. Azarakhsh Mokri, Training Deputy and Head of Treatment and Clinical Psychology Department at Iranian National Centre for Addiction Studies (INCAS)*

Dr. Azarakhsh Mokri shared as the second presenter on OST from Iran, a detailed report on the successful OST programmes in Iran. INCAS has long experience with various substitution treatments and its activities comprise research, training as well as practical treatment. In fact all three substitution treatment modalities available in Iran at programmatic and pilot scales have first been introduced through INCAS as the centre of excellence for addiction studies first time in this country. He started with elaborating on the usefulness of OST as a major strategy for reducing demand of illegal drugs and adhering drug users into programmes resulting in drug and HIV control. As part of the Iranian OST strategy, Dr. Mokri emphasised the importance of separating various drug addiction groups and their treatment, where the most severely addicted group, regular IDUs, receive OST and the irregular group of drug users are focused on detoxification. By separating the high risks groups, it reduces further harm among drug addicts. Dr. Mokri further pointed out some key factors for successful OST:

- Medication needs to be oral, non injectable;
- Long acting;
- Pure;
- Offered in legal facilities;
- Free of charge (or charging a minimum amount);
- Use is properly supervised and documented;
- Offered at optimum dose.

Drop outs were highest in the first few weeks of introduction of treatment and reach a plateau very quickly, after which the retention remains at relatively high levels. He stated that after proper selection of candidates for each of the three substitution modalities: methadone, buprenorphine and opium tincture, the retention rates were similarly high for all three medications. Within the MMT programmes, a study shows that nearly 70% of the cases remained in treatment and their drug consume decreased drastically. Other successes of maintenance treatment are given through decrease in high risk behaviours, decrease in physical and depression measures, improvement of quality of life as well as the social and psychological well-being.

Priority for inclusion of drug users in OST should be:

- Injection drug users;
- Pregnancy and medical states making;
- People who are already HIV+;
- Co-morbid psychiatric problems;
- History of overdose;
- Severe psychosocial damage detoxification risky;
- Unable to become abstinent;
- Failed attempts for abstinence;
- History of crime and imprisonment;
- Financial problem to get drugs.

He presented a chart over treatment retention in various countries:

Country	Baseline N	3-month N (%)	6-month N (%)
China	102	100 (98)	90 (88)
Indonesia	101	94 (93)	86 (85)
Thailand	118	98 (83)	80 (68)
Iran	127	97 (76)	87 (69)
Lithuania	102	85 (83)	75 (74)
Poland	62	56 (90)	50 (81)
Ukraine	76	57 (75)	53 (70)
Australia	42	32 (76)	23 (55)

By 2002 before the introduction of methadone programmes in Iran two issues were prominent:

1. HIV/AIDS epidemic reaching a worrying point;
2. Failure of simple abstinence oriented programs (abstinence rates rarely exceeding 10%/year).

Various interventions offering OST in Iran today includes MMT within governmental, private, and drop-in clinics, prison programmes and Buprenorphine programmes.

All MMT service provision needs to be delivered in a setting with a minimum of criteria. Any MMT service for 50 to 200 patients needs to fulfil following criteria:

- 75 m² office space;
- 1 GP;
- 1-2 nurse (s);
- 1 psychologist or social worker;
- Cheap methadone powder or syrup;
- Training certificate from INCAS or one of the five other designated centres in the country.

An average cost of such service per patient is about USD 100 in month in Iran. Services provided in DICs are less emphasising the psychosocial component and are provided through subsidies of the government free of charge.

OST programmes in the prison are amongst the most important due to the very higher likelihood of HIV transmission in prisons in absence of OST programmes resulting in further dissemination and transmission within communities and the general population.

In addition to this, a large number of practitioners are trained at INCAS each year and after one month of training, practitioners are authorised to provide centre treatment. Iran currently has 115 000 patients in OST (including both maintenance and reduction cases) programmes, but hopes to increase this number to 400, 000 within coming years.

Dr. Mokri also mentioned the cost of Methadone and Buprenorphine:

- Methadone 5 mg tablets, 1 cent;
- Methadone 20 mg tablets 4 cents;
- Methadone 40 mg tablets 6.5 cents;

- Methadone syrup 250 ml (5mg/ml) 2$;
- Buprenorphine 0.4mg 8cents;
- Buprenorphine 2mg 35 cents;
- Buprenorphine 8mg 1.2$.

Further programmes which need to be finalised in the pilot stage and can be envisaged for wide implementation include:

- Substitution with Tincture of Opium;
- Office-based programmes;
- Long lasting medications.

He concluded his presentation with mentioning his hopes for a nationwide computerised system among centres, which would facilitate access to services as drug addicts can the receive treatment in any centre nationwide.

3. *Dr. Alireza Norouzi, Expert, Substance Abuse Prevention and Treatment Office, Ministry of Health, Treatment and medical Education*

Dr. Norouzi presented a historical background for the successful multisectoral collaboration within OST programmes in Iran. The first MMT programmes were piloted 2003 followed by their release of the first national methadone protocol in 2004. INCAS started providing regular and certifying training programmes in 2005, the current situation is:

- Six OST certifying training centres for physicians in the country;
- 193 courses;
- 2989 trained doctors (as of September 2008).

Methadone use for detoxification has today been restricted through the national protocol. However, there is no limit for Buprenorphine use for detoxification. Furthermore, Dr. Norouzi recommended monthly urine testing for clients on MMT and even if the test would result in a positive test, clients should not be taken off MMT but instead be given sanctions like withdrawal from home privilege.
He presented following entering Criteria for MMT programmes in Iran:

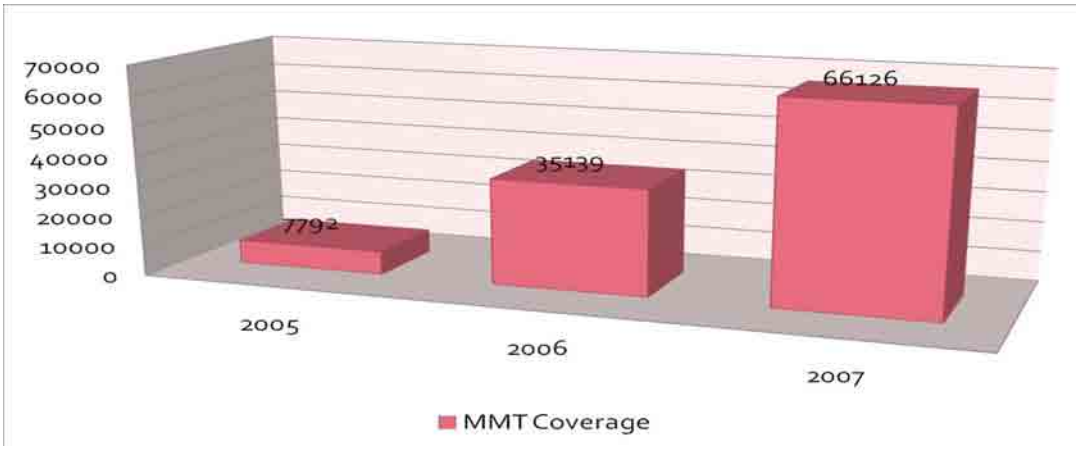
Diagnosis of Opioid Dependence according to DSM-IV;
AND

- Heroin/purified heroin (crack) as main drug of abuse, OR;
- Injecting as main route of administration, OR;
- Opium users who have been affected more than 10 years and history of more than three failed attempt, OR;
- Female clients, OR;
- History of prison, OR;
- HIV positive clients;

AND

- 18 or on more years old;
- Informed consent.

The number of treatment centres has increased within the last years, resulting in 952 substance abuse treatment centres out through the country in 2007. The below chart shows the coverage of patients on methadone reduction and maintenance programmes in the country:



BMT programmes have easier Entering Criteria:

Diagnosis of Opioid Dependence according to DSM-IV;
AND

- Client's preference;
- Lack of contraindication.

Recommendations for dose limits for Methadone and Buprenorphine:

Methadone	Buprenorphine
Recommended dose range: 50-120 mg	Recommended dose range BMT: 12-16 mg
No higher fixed dose limit Caution with upper than 120 mg	Upper dose limit: 32 mg

Dr. Norouzi further presented future directions within OST:

- To revise national treatment protocols for OST;
- To develop standards and manual for adding up psychosocial intervention to OST;
- To establish training courses for substance abuse treatment centres' clinical Psychologists;
- To pilot feasibility of office-based agonist treatments.

Rounding up, Dr. Norouzi pointed out that there is a lack of adequate psychosocial interventions as well as shortcomings in training courses for psychologists and counsellors specialising in substance abuse.

International Best Practices

1. *Professor Gabriele Fisher, Medizinische Universität Wien, Universitätsklinik für Psychiatrie und Psychotherapie*

Professor Fischer gave a presentation of gender differences in drug addiction and treatment. She emphasised that there are many differences between men and women, beside the biological aspects (sex) there are also gender differences referring to the psychosocial aspects. Women are for example of higher risk than men to suffer from depression and other anxiety disorders. She specified differences in addiction according to gender:

- prevalence/incidence (lower drug use higher abuse of prescription drugs);
- age of onset;
- treatment access;
- co-morbidity;
- consumption patterns;
- metabolism;
- secondary damage;
- mortality;
- abstinence behaviour.

In the spectrum of other disorders women do have a higher retention rate in therapy, but not in *addiction* due to limited access to treatment. In terms of outcomes of drug treatment, addicted women display more complexities as compared to men (Hser et al., 1990; Kosten et al., 1993; Pettinati et al., 1997; Weiss et al., 1997 according to Lynch et al., 2002, Green, 2004):

- Women higher drop-out rate
- Factors other than only dose adequacy contribute to improved outcomes, e.g. therapeutic relationship;
- History of physical, sexual and emotional abuse may have negative impact on treatment outcome;
- Remaining abstinent after treatment – no difference?
  - 7 months-abstinence-outcomes after completion of treatment: women who complete multiprofessional treatment do better than men.

Prof. Fischer expressed concern that women today are prescribed the majority of psychotropic drugs, but that there is scarce research made on this subject with regards to its efficiency, tolerability and safety. In addition to this, most medical research has excluded women due to high costs and other factors such as pregnancy and menstrual cycle.

Around 30% of Opioid addicts are women in child bearing ages and with regards to OST for women, it is important to acknowledge the differences between males and females, as the substance doses needs to be adjusted during the pregnancy (higher amount/frequency because of increased metabolism)

Gender/sex related pharmacokinetic/pharmacodynamic differences:
Physiologic factors

- lower body weight and organ size;
- Higher percentage of body fat;
- Lower glomerular filtration rate;

- Different gastric motility in women (slower in luteal phase);
- Ovarian hormones;
- Drug transporters and drug-metabolising enzymes (CYP450-is modulated by sex hormones; women clear some CYP3A4 - enzymes drugs faster than men).

During previous years a higher trend of increasing incarceration rates among women is observable (202% increase among women vs. 112% among men). Thus there is an increasing necessity for screening at entry in prison, treatment in custody, follow-up on release; specialised gender-specific services. She named some background characteristics of substance-abusing women in prison (Langan et al., 2001; Pelissier et al., 2003):

- low educational levels;
- poor job perspectives;
- employment problems;
- mental or physical health problems;
- social environment: close friend and/or spouse with addiction problem;
- chaotic interpersonal relationships;
- family problems;
- experienced trauma (physical and sexual abuse).

Another special issue related to drug treatment and women is the pregnancy. Specified factors of pregnancy and addiction are:

- 30 % opioid-addicts are women of child bearing age;
- Improved treatment approach through diversification of opioid maintenance therapy;
- Constant increasing numbers of patients maintained on opioids;
- Methadone needs to be increased during 3rd trimester (Kreek et. al, 1994-enzyme induction);
- 55 % - 94 % of neonates show signs of NAS;
- 60 % - 87 % require treatment;
- Mean duration of treatment is between 16 and 21 days after methadone, knowing the advantage for keeping women in treatment. No correlation of mean dosing at delivery & intensity of NAS;
- Heterogeneous reports - retrospective, observational, controlled;
- Heterogeneous approach regarding treatment of NAS (with or without nursing data).

In the management of addicted pregnant women an interdisciplinary team consisting of the drug treatment clinic, the gynaecology, body therapies, neonatology, child neurology and child welfare institutions are needed. Professor Fischer explained in detail the stepwise opioid substitution treatment for pregnant women both with methadone as with Buprenorphine. Management of pregnant women with illicit drug use needs to include various components like outreach services, biological treatment, psychosocial assistance, psychosocial treatment, monitoring and evaluation for the target group as well as training programmes. Accordingly, staff from various disciplines needs to be trained: social workers, obstetricians, mid-wives, nurses, general practitioners, psychiatrists (psychiatric co-morbidity), paediatricians, anaesthesiologists, and other health authorities/welfare system. Concluding the presentation, Professor Fischer called for further research among addiction and OST among females.

2. Alex Wodak, Director of Alcohol and Drug Service at St. Vincent's Hospital, Australia

Dr. Wodak gave a presentation on best practices on of Opioid Substitution Treatment (OST). He emphasised the importance of including prisons in OST programmes since HIV/AIDS are often spread within prisons, and the infection is much more frequent among inmates that the rest of the society.

To ensure proper impact the coverage of services need to include high proportion of heroin users in community and prisons. It is difficult to estimate the exact proportions of heroin users. One useful factor for orientation is the street price (black market) of methadone. This price decreases when unmet demand is small. In order to achieve enough coverage the major involvement of the primary health care seems to be imperative. Saturation of treatment needs results not only in reduction of HIV, drug related deaths and drug-related crime, but also results in significant decrease in the quantity of heroin seized, as the example of Switzerland.

As related to the dose following have shown success in OST:

- Majority studies: higher doses, better results;
- Heroin use MMT: 60 ➡ 80 mg/day 50% ⬇; 80 ➡ 100 mg/day another 50% ⬇;
- Most need 80-100 mg/day methadone; 12-24 mg/day Buprenorphine;
- Some do well on less, some need more.

By dispensing special attention needs to be given to:

- Simplify admission to treatment so easy to enter quickly;
- Supervised daily dispensing for all early, longer if unstable;
- Start take away doses when patients stable;
- Very highly valued, aids rehabilitation;
- But also double edged sword.

In OST best results have been achieved with longer continuous treatment years in treatment. Most patients need several years of treatment. Small minority (<5%?) need indefinite treatment. In case of personal request voluntary, slow and well- planned termination of the maintenance treatment can be considered. Studies have shown poor results with arbitrary duration, involuntary and rapid termination of the substitution treatment.

Agents:

- Methadone, Buprenorphine both important advantages, disadvantages;
- More choice > less choice; choice still limited;
- Methadone better retention > Buprenorphine;
- Suboxone strong theory but evidence still poor.

Harm Reduction Orientation:

- Staff value benefits of slow, small gains;
- Reject sudden heroic gains for all;
- Only 20% treatment variance pre-, post - treatment factors;
- 80% treatment variance explained by treatment factors;
- 'Black box of treatment';
- High staff morale;
- Committed director.

Quality of services can be evaluated through good centralised data. The quality can be ensured through adequate staff training, proper accreditation of clinics offering OST, establishment of complaints mechanism in clinics, consideration and response to consumers inputs and satisfaction, continuous monitoring of methadone overdose deaths, and the methadone black market as well as regular policy review. Other important factors are cost treatment: preferably free or very low price, ensuring a continuity of care systematically to/from community, hospital, prison, links to otherwise treatment need to be in place like to detoxification, others forms treatment, primary health care, STI treatment. At national and local levels authorities need to advocate strongly and there needs to be strong local research on efficiency of OST. As mentioned above, in case of stopping OST treatment, the reduction process needs to be voluntary, planned, slow, supported and should allow re-entry.

The definite need of ancillary care could not be fully established in studies yet, the evidence seems to be weak. But research on this topic is difficult and ancillary care is an accepted component of all other forms of medical treatment.

Dr. Wodak also quoted JC Ball on proper process for ensuring sound maintenance treatment practices:

Base policy, practice on evidence; protect human rights; strong patient involvement

Dr.Wodak concluded his presentation by summarising existing findings on methadone/Buprenorphine treatment: effectiveness beyond question, less certain how benefits could be maximised and negative aspects minimised, involvement of primary health care needed for increase of coverage. He also summarised key factors methadone/Buprenorphine treatment programmes as the need for: high coverage, high dose treatment (80-100 mg/day methadone; 12-24 mg/day Buprenorphine), sufficiently long term of treatment (several years), harm reduction orientation, high staff morale, committed director, strong treatment system, high level of support n the public and the last but not the least: strong patient involvement.

B. Feedback from Working Groups

Group 1: Policy making

Dr. Nasrin Safari presented the first working group.

Check list

1. How do you evaluate the impact of continued drug use on the individual, family, and the society?

We did not find very effective programmes, however Russia states to have has very comprehensive that is spiritual in nature.

2. Are there drug users in your country who despite many trials of abstinence based treatment could not stop using drugs?

All positive

3. What approach do you suggest for drug users not able to abstain from drugs nonetheless willing to undergo treatment?

Opioid substitution treatment could be an option.

Challenges
Such programmes have not been launched in most countries. Making the start is very difficult. In some countries regulations need to change. Exchange of expertise with countries having experience in OST may prove useful.

Recommendations
- Access of scientific community of countries without OST to international scientific findings;
- Study tours including political authorities, expertise information and training exchange;
- Holding video conferences, using legal pattern for reforming laws;
- Developing working groups for studying the possibility of OST;
- Holding major training courses;
- Using technical transmission and technical experiences and facilities and medication.

Group 2: Structure/Coordination

Dr. Esmaeili presented the second working group.

Check list
1. Which structures do you think should be/are involved in establishment of Opioid Substitution Treatment in your country?

Jordan and Pakistan have no OST currently; however the MoH, drug authorities, Prisons Organisation and NGOs should all be involved in such programmes.
A pilot activity is under planning in Pakistan and is going to be implemented in three settings.
Afghanistan said NGOs should be actively involved in OST programmes.
In Iran the organisations involved are the MoH, the State Welfare Organisation, NGOs and the Prisons Organisation, coordinated by the DCHQ.

2. What are the current/potential settings (public, private, for HIV positive Injecting Drug Users) for provision of Opioid Substitution Treatment in your country?

Jordan we have three potential centres and these are hospitals, NGOs
Pakistan does not have project
Afghanistan no OST programme but through MOH they will have such programme very soon.
In Iran various sectors are involved including the governmental sector, NGOs and the private sector. NGOs and the private sector in Iran provide OST under the auspices of the MoH and the State Welfare Organisation in different cities and all of them are under supervision of MOH.

3. What role do/should NGOs play in provision of Opioid Substitution Treatment in your country?

In Jordan the main task of NGOs is screening and early detection.
Pakistan does not have OST; however NGOs should play a role in OST, and steps have been taken in this direction.
Iran NGOs are providing under MOH supervision. Services of public NGOs have been very successful.

4. Are/should specified protocol/guideline be in place for Opioid Substitution Treatment in your country?

Jordan and Pakistan and Afghanistan have no protocol, protocols are needed.
Iran has protocols on OST.

Challenges

- Information dissemination and providing training related to OST;
- Limited coverage of OST centres;
- Lack of follow-up of people covered by OST;
- Costs of OST are high, therefore there is no proper training and education;
- Restriction of import of Methadone in many countries.

Recommendations

- Advocacy through media;
- Increase the number of centres;
- Reducing costs;
- Involvement of PHC to support National Strategy OST;
- OST should be covered by insurance;
- Active collaboration in training/research at regional level;
- Creating smart cards for individuals to follow-up;
- Close contact of NGOs with governmental organisations;
- More governmental support on holding seminars;
- More active cooperation between different organisations;
- Training activities;
- Highlighting international activities;
- More reach out;
- UNODC should facilitate exchange of information.

Group 3: Management of human and financial resources

Colonel Mahmoud Rahhal presented the third working group.

Check list

1. Are/should specific criteria and training for qualifying staff involved in Opioid Substitution Treatment in your country?

Jordan, Afghanistan and Palestine do not have OST centres; according to the current law provision of OST is not allowed in any case all suggested that such programmes, once in place should be regulated.
In Iran OST is provided based on Iranian laws and regulations.

2. Do/should staffs involved in Opioid Substitution Treatment in your country receive training on a regular basis?

Syria, Afghanistan, Jordan said there is currently no training programme but they hope that in future there would be such courses even if there is short training.
In Iran, training is mandatory for physicians before certifying for provision of OST. Some additional training is also available, however is not regular and neither mandatory.

3. How are/should be the costs of Opioid Substitution Treatment in your country covered?

In Iran the government pays for almost 50% of patients under OST.
In Afghanistan there is no OST programme yet but when this programme is in effect, the government is supposed to cover the costs.
Palestine, Jordan and Syria have no programmes; the government should provide support in covering the costs.

Challenges

- Training programmes and material;
- Ensuring sufficient financial resources to make the programme run effectively.

Recommendations

- Have training courses for OST;
- Having legal mechanisms and making amendments in the law of some countries;
- Dispatch Experts to countries which have the ability of OST training;
- Mobilising resources which could be made available for funding facilities and services.

Group 4: Practice

Dr. Alireza Norouzi presented this working group.

Check List

1. How do you define acceptable accessibility to Opioid Substitution Treatment for your country (in terms of waiting times, location, etc.)?

In the countries different stages of OST programme are running:
In Iran OST is offered widely and both Methadone and Buprenorphine are provided.
Azerbaijan has introduced since the year 2000 substitution treatment and covers 100 patients in Baku; 95 male and 5 female.
In Turkmenistan OST is not offered yet.
In Uzbekistan both Methadone and Buprenorphine are available with 136 patients covered.
In Kyrgyzstan about 700 patients are under Methadone treatment.
Russia does not offer OST.
Kyrgyzstan intends increasing access, making use of primary health care potential.
In Uzbekistan one of the obstacles is stigma. Change in negative attitude is necessary for increasing coverage.
In Iran there is acceptable availability and more or less good geographical distribution of centres offering OST. There are different layers of OST programmes and a system between the layers should be established. OST programmes are available both in community and in prison. Iran has provided outpatient models, no hospitalisation is required.
Treatment costs should be affordable.
It should be easy to enter the programme so that more people enter the programme.
Patients' dignity should be taken into account.
Specialised services are provided in one location.
In brief: distribution of centres should be sufficient, stigma should be addressed, and the treatment should be more affordable.

2. Are/should be specialised services of Opioid Substitution Treatment in place for female drug users for in your country?

In Iran, women can refer to all centres, additionally; there are some special centres for women in place where the service is needed.

In Azerbaijan the number of pat4ints on OST is still too low. Stage of the programme does not allow specialised programmes.
In Turkmenistan no OST exists and with respect to the cultural conditions of the country there are special considerations when it comes to women.
In Kyrgyz women are part of the programme.
In Uzbekistan from 136 patients 12 are women. Due to the stage of implementation, there are no special services for women.
In Russia these programmes may be such programmes could be established.

Challenges
These programmes are implemented in different centres. They should work closely. There might be negative attitude. Many countries do not have basic data and to have a comprehensive programme we should have capacity building. So training should be provided. Training courses for physicians are needed.

Recommendations

- Need for epidemiology analysis and need analysis for advocacy and informing officials;
- All countries should have easy access to OST centres;
- Affordable OST treatment;
- The inclusion criteria should be easy;
- Decrease negative attitude towards drug users by public communication campaigns;
- Integration of specialised services;
- Training programme for service providers;
- OST in prisons and outside prisons;
- Decrease stigmatisation;
- Capacity building and trained staff and training programme.

V. Needle and Syringe Programmes

Chair: Dr. Jean Paul Grund
Vice Chair: Dr. Saeed Sefatian

A. Plenary Session Presentations

Islamic Republic of Pakistan

Dr. Hassan Zaheer, Programme Manager, National HIV/AIDS Control Programme, Ministry of Health

UNAIDS has estimated 70-80 thousand HIV cases in Pakistan but only 4500 cases have been registered, 1527 of which are injecting drug users. HIV prevalence among injecting drug users is 60-70% and in large cities is 50%.

The following table indicates the HIV cases according to the mode of transmission.

Mode of Transmission	Qtr 2. 2008				Cumulative Total			
	Male	Female	Unknown	Total	Male	Female	Unknown	Total
Heterosexual	28	4	0	32				1273
Homosexual/Bisexual	5	0	0	5				120
Blood/Blood Products	12	2	0	14				372
Injecting Drug User	128	0	0	128				1527
Mother to Child	1	0	0	1				49
Unknown	52	4	0	56				1154
Total	226	10	0	236	3756	440	299	4495

In 2003 Pakistan compiled a 5-year programme for HIV/AIDS control in the country which was financially supported by the World Bank. 12% of injecting drug users (IDUs) was covered by this programme but no drug substitution treatment was available for the drug users.

During these 5 years, many problems were solved and a system for providing services packages to injecting drug users was established.
Many challenges and gaps were also involved in the implementation of the programme, which are as follows:

- Low coverage;
- Absence of comprehensive services;
- Unfocused communication campaign;
- Monitoring & Evaluation;
- Shortage of technically qualified professionals;
- Limited knowledge of policy makers;
- Low capacity for scaling-up.

The Government of Pakistan's commitments:

- Millennium development goal – to be achieved by 2015;
- UN special session on HIV/AIDS (UNGASS) – to decrease spread of HIV/AIDS;
- National Health Policy 2001;
- Poverty Reduction Strategy 2005-10;
- Vision 2030;
- More capacity building and services;
- Increase service coverage by next 5 years.

Current coverage of injecting drug users is 15,000 (12%). This coverage can be reached to 80% of injecting drug users through government resources to 45,000 injecting drug users (36%), One UN initiative for 10,000 IDUs (8%) and international donors' assistance and GFATM for 28,000 IDUs (23%) and establishment of pilot oral drug substitution programme.

For campaigning on HIV prevention and treatment, advocacy is needed among policy makers and leaders including politicians, senior public officials as well as religious/community

leaders. For general population, the focus of campaign must be on reducing stigma and fear through raising awareness and information dissemination and capacity building, which can be done through developing human resources, holding regional and international seminars and conferences on reducing HIV epidemic and generating and collecting accurate data for analysis.

The Republic of Uzbekistan

Dr. Luiza Baymirova, Head Expert, Treatment and Care Central Department, Ministry of Health

One of the programmes for HIV prevention and care is to reduce injecting drug use, which has been initiated in 1998 in Tashkent in the HIV Control Centre. Since 1999, experts in drug control are being sent to different countries to see and get familiarised with drug control programmes of each country.

Initially 20,000 drug users were reported in Uzbekistan, 10,000 of which were IDUs. According to UNODC statistics in 2006, the number of IDUs has been 80,000 cases without any changes since then.

The programme for reducing the harm of injecting drug use has been anticipated for 235 centres. There is less staff in private sectors and most people work in public organisations.

Since 2000, private rooms have been established for drug users to meet their spouses, especially polyclinics for reducing the prevalence of HIV together with distributing condoms and implementing other preventive measures.

Since 1998, around 2.5 million syringes were distributed through the mentioned services.

For the time being, injecting drug users can get services through mobile groups and drop-in centres (DIC). These centres are being more stabilised and there are more than 40 branches in 4 districts. Necessary trainings have been provided to these centres and the government of Uzbekistan is trying to participate more and more in international projects and conferences.

In 2003, a Memorandum of Understanding (MOU) was signed for preventing drug use effects. According to this MOU, centres have been established in Samarkand and Tashkent for providing health services to injecting drug users, to which 1000 IDUs referred in 2004.

Standards have been set for providing health services to drug users, which contain legal context as well.

The Republic of Tajikistan

Dr. Sulkhidin Nideov, Director of the National Centre on Drug Prevention, Monitoring and Assessment, Ministry of Health

Dr. Nideov shared his concern on the difficult situation of Tajikistan as being a transit corridor for the vast drug trafficking from Afghanistan. The number of people living with HIV, Hepatitis C, and Tuberculosis, is estimated at 140,000.

Dr. Nideov pointed out that the country has taken measures to deal with this issue, such as harm reduction programmes including needle and syringe programmes in form of Drop-in Centres as well as mobile services.

Further examples include providing other services for drug addicts, border control, and various policies and programmes.

Islamic Republic of Iran

Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Headquarters of I.R. Iran

Dr. Saeed Sefatian summed up the country's harm reduction programme. Within policy making he pointed out the following key factors:

- Acceptance of programme;
- Achievement to an overall consummate in health system;
- Briefing high – ranking authorities;
- Ratification of programmes in law – making sectors;
- Special Committee on Drug Control of State Expediency Council;
- Health Commission of the Parliament;
- Circular of Head of Judiciary and the Public Prosecutor;
- Acceptance of harm reduction policy by the Police Forces.

He gave an overview of Iranian strategies, including national workshops, information dissemination through media, briefing local authorities, appointment of key persons in community, creating pilot project, and further involvement of NGOs.

Dr. Sefatian further pointed five problems on this issue:

1. Resistance of middle level authorities in Police, health and judicial system;
2. Closure of some of the centres due to local pressure;
3. Insufficient media campaign;
4. Negative approach of some influential individuals;
5. Instability of management and high turnover in managers of the programme.

Concluding his presentation, he presented following solutions as the way forward:

- Believe in the accuracy of the programme;
- Pay attention to criticism;
- Brief high rank authorities on weekly sessions;
- Utilise mass media;
- Regular monitoring;
- Adequate financial resources;
- Hold international workshops.

International Best Practices

Dr. Beatrice Stambul, President, French Harm Reduction Association

Dr. Stambul first mentioned relevant risks and harms of injecting drug use: transmission of blood-borne pathogens (HIV, HBV, and HCV), infections of the skin, and vein problems due

to recurrent injection and or use of dull needle, septicaemia, endocarditic through needle sharing, needle reusing, drug sharing and sharing of paraphernalia.

She pointed out required characteristics of needle syringe programmes:

- No obligation to return used syringes;
- Easy access:
  - -Location;
  - - Schedule;
  - - Free of charge;
  - - Information to the network.
- Variety of equipment;
- One for one;
- Good coverage;
- Good assessment.

She emphasised the crucial role of education within these programmes:

- Role of peers:
  - -Specific knowledge on patterns of use;
  - -Able to create trust;
  - -Able to deliver appropriate messages of prevention.
- Messages:
  - -1 shoot/1 syringe;
  - -If shortage reuse your own;
  - -Never share;
  - -know where to shoot;
  - -know how to shoot;
  - - Asepsis;
  - -Have general knowledge on human physiology.
- Health education;
- Empowerment.

Needles should be offered in various qualities in size, gauge and brands adapted to the various consumptions and patterns of use of each injecting client. Return of syringes should not be mandatory but highly encouraged. There should not be any limitation in the number of syringes provided each time to clients. The number should be decided upon assessing the habits of the client, the frequency she/he is able to come to the centre. Secondary exchange through clients presenting regularly in the centre on behalf of those drug users who do not present personally is very useful and important.

Use of containers for used syringes is important to avoid spreading of used syringes in public areas, to avoid reusing, to eliminate contaminated medical waste. The disposal of such containers should be according to local regulations. If no standard containers are available, rigid containers such as soda bottles can be used. Needle syringe programme staff should be trained that they should never recap needles should not touch returned needles and they should learn of modality and location of relevant centres offering post-exposure prophylaxis.

Cookers used for preparation are very often shared/reused. Usually spoons, can bottoms and bottle caps are used for this purpose. The need for single use of cookers should be highly emphasised and stericups should be provided through NSPs.

Filters are used on the tip of the needle to prevent undissolved particles to enter syringe are a further time shared in injecting drug use. Cotton balls, cigarette filters are often used and frequently reused. A usual pattern of use is that the mentioned filter is washed and used again. Large pore filters increase likelihood of formation of abscesses. Infections can disseminate in case of sharing. Therefore it is advisable to include sterifilt in harm reduction packages.

Brown heroin needs to be acidified to become soluble and thus suitable for injection. IDUs usually use lemon juice, or vinegar. Septic medium can cause infections with bacteria and fungi. Sachets of Acidifier, or ascorbic acid should therefore also be included in the package. Sterile water should preferably also be included to ensure clean dissolving of drugs.

Alcohol swabs should be used to clean the injection site. In the absence of alcohol, aftershave, soap and water are also helpful. Alcohol has a strong protection effect against abscesses and other infections.

Tourniquets provide pressure to increase the blood flow into the vein and ease injection. They should be thin, pliable, with a clean non-porous surface. Sleeve, rope or shoe laces are not elastic enough. Clients should be educated on the correct single-person use of tourniquets. Regular use of tourniquets helps injectors protect their venous capital.

It is necessary to attract and retain as many clients in NSPs as possible. Drug users have particular daily routines with different personal preferences, their difficult daily lives and limited financial resources makes it often difficult to be able to refer to services at all times. Needs of drug users vary according to their age, gender and cultural background. All this calls for varied services and facilities tailored according to each location, time, access and price.

Fixed NSPs offer education and other services on-site. They also offer opportunity for disposal of used equipment. However their hours of operation are less flexible, their location might be difficult to access and/or identifying. They are often crowded when the programme is busy.

Mobile NSP also offer free services for IDUs and are user friendly. They increase accessibility and make possible to reach out for hard-to-reach IDUs. However they may not be able to offer sufficient space for counselling sessions, arranging referrals, HIV and other disease testing, helping clients fill out forms and contacting other agencies. Costs and maintenance of vehicle might be difficult to cover for the programme.

Home visits like other NSPs offer free services for IDUs. They are effective in reaching hard-to-reach IDUs. They help build credibility in the IDU community. However these programmes lack safety for staff and might be Intrusive for clients.

Pharmacies can also play a role in offering needle syringe exchange activities. They offer long hours of operation, even round the clock opening times in many cases. They are multiple lactated and less stigmatising/more anonymous. However they imply costs for IDUs to purchase needles. They do not allow disposal of used equipment. They do not offer harm reduction services. Additionally there is a reluctance to sell to IDUs and to sell small quantities of needles.

Peer-based NSPs utilise effectively peer knowledge of drugs, drug use and the drug scene. They also allow proper use of peer knowledge and empathy about living conditions and context. Such programmes Increase reach of the NSP to IDUs who will not/cannot use other NSP modalities. They may provide employment skills and income for peer exchangers. They improve self esteem and self worth. Peer-based NSPs are more convenient/accessible for clients. The most important advantage of peer-based NSPs is that peers have credibility and can be important role models for risk reduction. However there might be conflicting identities as peer worker and IDU community member. There might be some violation of worker/client boundaries.

Vending machines could be suitably located and be 24 hours available. They are convenient and easy of use. Additionally they demand limited staff. However they do not offer any face to face harm reduction services. Also it is difficult to maintain anonymity when in a public space.

NSPs should allow referral and provision of following services to ensure a complete package of services:

- Safer injection education;
- Safer sex promotion;
- Over dose prevention education;
- Referrals to drug treatment;
- HIV and HCV counselling and testing;
- HBV vaccination;
- Referrals to mental health services;
- Referrals to primary health care;
- Access to opiates and substitution treatment.

B. Working groups and discussions

Due to organisational issues working groups did not take place and the session moved directly towards wrap-up.

Summing up, the chairmanship Dr. Jean Paul Grund, Senior Researcher CVO at Addiction Research Centre, Netherlands, pointed out some of the points that had been brought up during the fourth session. He concluded that most countries suffer from a large number of IDUs, many of whom are infected by HIV/AIDS. Needle exchange programmes are unfortunately fairly low but an increase has been seen in the last few years. Dr. Grund urged for increasing efforts in training, short term pilot programmes, monitoring, and evaluation

Recommendations

"The Regional Seminar on Reducing Harms of Drug use in Middle East, West and Central Asia"

Recommendations

"The Regional Seminar on Reducing Harms of Drug use in Middle East, West and Central Asia" took place 27-29 October 2008 in Shaghayegh Cultural Complex in Tehran. The seminar was hosted by the Iranian Drug Control Headquarters jointly with the United Nations Office on Drugs and Crime (UNODC) Country Office I.R. of Iran. The consultations arrived at following recommendations:

HIV is still spreading among and from Injecting Drug Users in this region and represents a very serious threat to the health of drug users and the general community. The harm reduction package has been found to be an effective, safe and cost effective way of controlling HIV infection in drug injector populations in the community and in prisons. But time is running out. Implementation to scale of Harm Reduction interventions is needed urgently.

Harm Reduction refers to policies and programmes aiming primarily to reduce the adverse health, social and economic costs of psychoactive drugs *without necessarily* reducing drug consumption. Harm Reduction is an integral element of drug policy. Advocacy among key persons such as policy makers and religious leaders plays a major role in integrating Harm Reduction policies in the current national drug policies of the region. Also communication initiatives with mass media may prove useful.

Countries in the region can establish a network/forum to exchange positive and negative experiences and good practices, implement and discuss common projects through technical and financial support of organisations. National, regional and international seminars, round tables, tele-video conferences, round emails, websites, newsletters and study tours are among the effective means of achieving progress. It was agreed that Islamic Republic of Iran serves as the secretariat of this network.

The necessity of capacity building especially training is considered to be high even so in universities and academic centres. Nonetheless the region already has a number of available resources to be utilised for training in terms of ongoing projects as well as institutions in operation:

- The Regional Harm Reduction Centre of ECO member countries in Tehran/Iran;
- The Treatnet resource centres including the Iranian National Centre for Addiction Studies (INCAS), the National Research and Clinical Centre on Medical and Social Problem on Drug Abuse Kazakhstan, the Regional Research Centre of Necrology & Psychopharmacology affiliated to St. Petersburg Pavlov State Medical University; as well as the Central Asian component of the UNODC Global project on effective responses to drug dependence treatment and for prevention of health consequences of drug abuse (J71);
- WHO Knowledge Hubs especially the Iranian National Centre for Addiction Studies (INCAS) and the Soins Infirmiers et Developpement Communautaire (SIDC) Association in Lebanon;

- UNODC projects like Bridging the Gap, implemented by the Regional Office for Middle East and North Africa-XNAJ58, Advocacy and Regional Cooperation of Country Office Iran-I57, and other UNODC Regional and National projects with components of capacity building (trainings), exchange of expertise, etc.

Countries in the region need to create a regional database containing information on national and international research/studies specifically on epidemiology, legislation, norms/standards, regulatory and mechanisms related to harm reduction implementation, monitoring and evaluation in general and in prisons. UNODC can be considered as the custodian.

Different drug treatment and comprehensive harm reduction approaches are currently running in the countries of the region, especially programmes of the Islamic Republic of Iran were considered at an advanced level in this regard. Further scaling up of all these varieties including psychosocial treatments, counselling and rehabilitation programmes are deemed necessary and urgent.

In addition to maximisation of the quality and quantity of treatment and comprehensive harm reduction services, accessibility needs to be increased. Stigma and discrimination are among serious barriers hindering proper scaling-up.

NGOs and peer groups are playing a significant role in comprehensive harm reduction activities and positive prevention in countries of the region. They should be further empowered and strengthened in carrying out their roles both inside community and in prisons.

There is a growing awareness of the critical contribution that injecting drug users in prisons make to the spread of HIV. The same HIV intervention strategies required in the community are also needed in prisons. Wherever possible the size of prison populations needs to be reduced to help control HIV spread.

Opioid Substitution Treatment and Needle and Syringe Programmes are still not available in many countries neither in community and nor in prison settings; proper training, utilising expertise from inside the region as well as other countries seems very useful. In some countries introduction of Opioid Substitution Treatment may require amendments in legislations and regulations. More cooperation and collaboration between countries in the region is needed to improve responses.

In establishing Opioid Substitution Treatment special consideration should be given to reducing the costs for drug users and ensuring that adequate government resources are provided.

Governments should play a more active role regarding with integration of treatment and comprehensive harm reduction services including Opioid Substitution Treatment and Needle and Syringe Programmes in Primary Health Care systems.

Appendix 1- Seminar Agenda

Agenda

Regional Seminar on
"Reducing Harms of Drug Use in the Middle East, West and Central Asia"
27 to 29 October 2008 - Tehran, Islamic Republic of Iran

Day 1 : 27 October 2008		
Time	**Agenda Item**	**Presenter/Facilitator**
Opening Ceremony		
08:30 – 09:00	Registration	
09:00 – 10:30	Welcoming and Introduction	Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Headquarters (DCHQ) of I.R. Iran Mr. Roberto Arbitrio, Representative, United Nations Office on Drugs and Crime (UNODC) – Country Office Iran H.E. Dr. Esmaeil Ahmadi Moghadam, Advisor to the President and Secretary General, Drug Control Headquarters of I.R. Iran Dr. Gilberto Gerra, Chief of Health and Human Development Section, United Nations Office on Drugs and Crime – Vienna H.E. Dr. Kamran Bagheri Lankarani, Minister of Health, Treatment and Medical Education, I.R. Iran H.E. Dr. Abdolreza Mesri, Minister of Welfare and Social Security Mr. Mohammad Ali Zanjirehie, Deputy of Development and Resources Management and the Fully Authorized Representative of the Iranian Prisons Organisation in Drug Control Headquarters (DCHQ) of I.R. Iran Mr. Christian Jorge Salazar Volkmann, Chair of United Nations Thematic Group on HIV/AIDS
10:30 – 10:50		Tea / Coffee Break
10:50 – 11:30	Country Report : Islamic Republic of Iran	Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Headquarters (DCHQ) of I.R. Iran Dr. Mohammad Mehdi Gouya, Head, Centre for Disease Control, Ministry of Health, Treatment and Medical Education; Dr. Mohammad Nafarieh, Deputy, Prevention and Cultural Affairs, State Welfare Organisation Dr. Marziyeh Farnia, Director General , Health and Treatment Department of Iranian Prisons Organisation;

		Dr. Mohammadbagher Saberi Zafarghandi, Director General, Psychosocial Health and Addiction, Department, Ministry of Health, Treatment and Medical Education;
Session One: Harm Reduction in Prison Settings Chair: Professor Ambros Uchtenhagen, Head of Research Institute for Public Health and Addiction, Co-Chairs: Dr. Marziyeh Farnia, Dr. Saeed Sefatian		
11:30 -13:00	Plenary Session on Harm Reduction Programmes in Prison Settings (Country/ Regional Reports, International Best Practices)	
	Country Report: The Kyrgyzstan Republic	Mr. Kalybek Nazbekov Head, General Directorate Execution Punishment Ministry of Justice
	Country Report: Islamic Republic of Pakistan	Mr. Mohammed Yameen Khan Inspector General, Prisons Sindh Province
	Country Report: Palestine	Colonel Mahmoud Rahhal Director of the Rehabilitation and Administration Reform, West Bank
	Country Report: Hashemite Kingdom of Jordan	Major Ahmad Elayyan Meqbel Abu Zaid Head of Forgery Crimes, Control and Credit Cards Section, Anti Narcotic Department, Ministry of Interior
	Country Report: Islamic Republic of Iran	Dr. Bahman Ebrahimi Deputy to Director General of Health and Treatment Department, Iranian Prisons Organisations
	International Best Practices	Dr. Alex Wodak, Director of Alcohol and Drug Service, St. Vincent's hospital, Australia
13:00 -14:00	Lunch	
14:00 -15:30	**Harm Reduction Programmes in Prison Settings Working Groups:**	
	Working Group 1: Policy making	DCHQ and UNODC Experts
	Working Group 2: Structure/ infrastructure/ coordination	
	Working Group 3: Management of human and financial resources	
	Working Group 4: Practice/challenges	
15:30 -17:00	Working Group Wrap up Session & Identifying Follow up Actions	Professor Ambros Uchtenhagen, Head of Research Institute for Public Health and Addiction , Switzerland
19:30 -21:30	Dinner Reception hosted by the Drug Control Headquarters (DCHQ) of I.R of Iran	

Day 2 : 28 October 2008			
Time	**Agenda Item**		**Presenter/Facilitator**
Site Visit			
Group I		**Group II**	
8:00	Pick up from Hotel	07:00	Pick up from Hotel
8:30 - 10:30	Visit to Iranian National Centre for Addiction Studies (INCAS)	09:00 – 10:30	Visit to Ravan Pouya Drop In Centre (DIC) and Rajaee Shahr Prison - Karaj
11:00-12:00	Visit to Pardis-e-Mehr Drop In Centre (DIC)	10:30 – 13:00	Transport to the venue of Seminar
12:00-13:00	Transport to the venue of Seminar		
13:00-14:00	Lunch		
Session Two: Abstinence- based Treatment Programmes Chair: Professor Ambros Uchtenhagen, Head of Research Institute for Public Health and Addiction, Switzerland Co-Chairs: Dr. Mohammad Nafarieh, Dr. Sadeed Sefatian			
14:00-15:30	Plenary Session on Abstinence based Treatment Programmes (Country/ Regional Reports, International Best Practices)		
	Country Report: Islamic Republic of Afghanistan		Dr. Abdullah Wardak Director, Drug Demand Reduction Ministry of Public Health
	Country Report: The Republic of Kazakhstan		Mr. Zhumagali Ismailov Director of the Department of Health Administration, Ministry of Health
	Country Report: Kurdistan Province The Republic of Iraq		Dr. Sirwan K Ali Consultant, Psychiatrist Head of Psychiatric Department / Hawler Teaching Hospital College of Medicine / Hawler Medical University
	Country Report : The Republic of Lebanon		Mr. Elias Al Aaraj Director of Soins Infirmiers Developpment Communitaire
	Country Report: Islamic Republic of Iran		Dr. Mehrdad Ehterami Head of Research and Development Office, and Head of Community Based Organisation Committee, State Welfare Organisation
	Treatment of Drug Dependence –Abstinence-based programmes-		Dr. Gilberto Gerra Chief of Health and Human Development Section, United Nations Office on Drugs and Crime – Vienna
15:30-16:30	**Abstinence-based Treatment Working Group Sessions:**		
	Working Group 1: Policy making		DCHQ and UNODC Experts
	Working Group 2: Structure/infra structure/coordination		
	Working Group 3: Management of human and		

	financial resources	
	Working Group 4: Practice/challenges	
16:30-17:30	Working Group Wrap up Session & Identifying Follow up Actions	Professor Ambros Uchtenhagen, Head of Research Institute for Public Health and Addiction, Switzerland

Day 3 : 29 October 2008			
Time	**Agenda Item**		**Presenter/Facilitator**
Session Three: Opioid Substitution Treatment (OST) Chair: Dr. Gilberto Gerra, Chief of Health and Human Development Section, United Nations Office on Drugs and Crime – Vienna Co-Chairs: Dr. Parviz Afshar, Dr. Sadeed Sefatian			
08:30-10:30	Plenary Session on Opioid Substitution Treatment (OST) Programmes (Country/ Regional Reports/ International Best Practices)		
	Country Report: The Kyrgyzstan Republic		Mr. Ruslan Tokubaev Director Republican Narcology Centre
	Country Report : The Republic of Uzbekistan		Ms. Luiza Baymirova Head Expert, Treatment and Care Central Department
	Country Report : The Republic of Lebanon		Mr. Elias Al Aaraj Director of Soins Infirmiers Developpment Communitaire
	Country Report : Islamic Republic of Iran		Dr. Abbas Sedaghat Head of AIDS and Sexually Transmitted Diseases Office, Centre for Disease Control, Ministry of Health Dr. Azarakhsh Mokri Training Deputy and Head of Treatment and Clinical Psychology Department Iranian National Centre for Addiction Studies Dr. Alireza Norouzi, Expert of Prevention and Substance Treatment Department, Ministry of Health
	International Best Practices	Oral Substitution Treatment in women	Professor Gabriele Fischer Medizinische Universität Wien Universitätsklinik für Psychiatrie und Psychotherapie
		Global over view on international best practices in Oral Substitution Treatment	Dr. Alex Wodak Director Alcohol and Drug Services St. Vincent's Hospital
10:30-11:30	**Opioid Substitution Treatment Working Group Sessions:**		DCHQ and UNODC Experts
	Working Group 1: Policy making		
	Working Group 2:Structure /infrastructure/ coordination		
	Working Group 3: Management of human and financial resources		
	Working Group 4: Practice/challenges		

11:30-12:30	Working Group Wrap up Session & Identifying Follow up Actions	Dr. Gilberto Gerra, Chief of Health and Human Development Section, United Nations Office on Drugs and Crime - Vienna
Session Four: Needle & Syringe (NSP) Programmes Chair: Dr. Jean Paul Grund, Senior Researcher CVO – Addiction Research Centre, Netherlands Co-Chairs: Dr. Mohammadsadegh Zafarghandi, Dr. Sadeed Sefatian		
13:30 –15:00	Plenary Session on Needle and Syringe (NSP) Programmes (Country/ Regional Reports/ International Best Practices)	
	Country Report : The Kyrgyzstan Republic	Mr. Ruslan Tokubaev Director Republican Narcology Centre
	Country Report : The Republic of Kazakhstan	Mr. Zhumagali Ismailov Director of the Department of Health Administration Ministry of Health
	Country Report : Islamic Republic of Pakistan	Dr. Hassan Zaheer Programme Manger, National HIV/AIDS Control Programme Ministry of Health
	Country Report : The Republic of Tajikistan	Mr. Sulkhidin Nidoev Director ,National Centre on drug prevention monitoring and assessment Ministry of Health
	Country Report : The Republic of Uzbekistan	Ms. Luiza Baymirova Head Expert, Treatment and Care Central Department
	Country Report : Islamic Republic of Iran	Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Headquarters of I.R. Iran
	International Best Practices	Dr. Beatrice Stambul, Médecins du Monde President, French Harm Reduction Association
15:00 –16:00	**Needle& Syringe Programmes Working Group Sessions:**	DCHQ and UNODC Experts
	Working Group 1: Policy making	
	Working Group 2: Structure/infra structure/coordination	
	Working Group 3: Management of human /financial resources	
	Working Group 4: Practice/challenges	
16:00 –17:00	Working Group Wrap up Session & Identifying Follow up Actions	Dr. Jean Paul Grund, Senior Researcher CVO – Addiction Research Centre, Netherlands

Session Five: Final Wrap up of the Sessions Chair: Dr. Gilberto Gerra, Chief of Health and Human Development Section, United Nations Office on Drugs and Crime – Vienna Co-Chairs: Dr. Mohammad Mehdi Gouya, Dr. Sadeed Sefatian		
17:00 –18:00	Conclusions and Recommendations	Dr. Gilberto Gerra, Chief of Health and Human Development Section, UNODC - Vienna
	Closing Remarks	Dr. Saeed Sefatian, Director General, Treatment, Rehabilitation and Vocational Training Department, DCHQ of I.R. Iran

Appendix 2- Speakers at the Training Seminar

List of Seminar Speakers in Alphabetic Order

Major Ahmad Abu Zaid	Head of Forgery Crimes, Control and Credit Cards Section, Anti Narcotic Department, Ministry of Interior, Hashemite Kingdom of Jordan
Mr. Elias Al Aaraj	Director of Soins Infirmiers Developpment Communitaire, The Republic of Lebanon
Dr. Sirwan K Ali	Consultant, Psychiatrist, Head of Psychiatric Department / Hawler Teaching Hospital, College of Medicine / Hawler Medical University, Kurdistan Province of the Republic of Iraq
Dr. Farhad Aghtar	Director General of Prevention and Addiction Affairs, State Welfare Organisation
Ms. Luiza Baymirova	Head Expert, Treatment and Care Central Department, The Republic of Uzbekistan
Dr. Bahman Ebrahimi	Deputy to Director General of Health and Treatment Department, Iranian Prisons Organisations, I.R. of Iran
Dr. Mehrdad Ehterami	Head of Research and Development Office, and Head of Community Based Organisation Committee, State Welfare Organisation, I. R. Iran
Dr. Marzieh Farnia	Director General, Health and Treatment Department of Iranian Prisons Organisation, I. R. of Iran
Professor Gabriele Fischer	Medizinische Universität Wien Universitätsklinik für Psychiatrie und Psychotherapie, Austria
Dr. Gilberto Gerra	Chief of Health and Human Development Section, United Nations Office on Drugs and Crime – Vienna
Dr. Mohammad Mehdi Gouya	Head, Centre for Disease Control, Ministry of Health, Treatment and Medical Education, I. R. of Iran
Mr. Mohammad Yameen Khan	Inspector General, Prisons, Sindh Province, Islamic Republic of Pakistan
Dr. Azarakhsh Mokri	Training Deputy and Head of Treatment and Clinical Psychology Department, Iranian National Centre for Addiction Studies, I.R. of Iran

Dr. Mohammad Nafarieh	Deputy, Prevention and Cultural Affairs, State Welfare Organisation, I. R. of Iran
Mr. Kalybek Nazbekov	Head, General Directorate Execution Punishment, Ministry of Justice, the Kyrgyzstan Republic
Mr. Sulkhidin Nidoev	Director, National Centre on Drug Prevention Monitoring and Assessment, Ministry of Health, the Republic of Tajikistan
Dr. Alireza Norouzi	Expert of Prevention and Substance Treatment Department, Ministry of Health, I.R. of Iran
Colonel Mahmoud Rahhal	Director of the Rehabilitation and Administration Reform, West Bank, Palestine
Dr. Mohammadbagher Saberi Zafarghandi	Director General, Psychosocial Health And Addiction, Department, Ministry of Health, Treatment and Medical Education I. R. Iran
Dr. Kianoush Kamali	Senior Expert of AIDS and Sexually Transmitted Diseases Office, Centre for Disease Control, Ministry of Health, I.R. of Iran
Dr. Saeed Sefatian	Director General, Treatment, Rehabilitation and Vocational Training Department, Drug Control Headquarters of I.R. Iran
Dr. Beatrice Stambul	President, French Harm Reduction Association, Franc
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Appendix 4- Working Group Tasks

Harm Reduction in Prisons	
Group 1: Policy Making	**Group 2: Structure/Cooperation**
A. Check list (30 minutes) – Is drug use in prisons recognised as a special concern in your country? – Is the link between drug use, HIV and prisons considered as concerning in your country? – Is the reduction of the number of inmates entering prisons recognised as an important strategy to address the two mentioned problems above in your country? – Are harm reduction measures in prisons recognised as an important strategy to address the two mentioned problems above in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning**	**A. Check list (30 minutes)** – Is there a defined coordination body/forum existing to link drug treatment in prison to the Ministry of Health (MOH)? – Are HIV positive inmates segregated in prisons in your country? – Are specialised after release services provided to drug users and HIV positive inmates? – Are NGOs/peer groups active and involved in programmes in prisons in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**
Group 3: Management of Human and Financial Resources	**Group 4: Practice**
A. Check list (30 minutes) – Is there a regular budget line for programmes on HIV and drug treatment programmes in prisons? – Are drug treatment/HIV prevention staff parts of the prisons human resources chart? – Do you consider the turnover of drug treatment/HIV prevention staff in prisons as high? – Is regular training on drug treatment/HIV prevention/education part of routine managerial measures in prisons? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – Do any protocol and/or guideline exist on the regulation of harm reduction measures in prisons in your country? – Is Opioid Substitution treatment such as methadone maintenance treatment offered in prisons in your country? – Are Needle Syringe programmes offered in prisons in your country? – Are condoms offered in prisons in your country? – Are there voluntary Counselling and testing programmes existing in prisons in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**

Abstinence-based Treatment

Group 1: Policy Making	Group 2: Structure/Cooperation
A. Check list (30 minutes) – Do you have a written policy on drug treatment in your country? Is psychological treatment /counselling considered as one of the most important pillar in drug treatment in your country? – Do you have compulsory drug treatment programmes in your country, like mandatory residence of drug users in prison-like closed settings (except for drug court treatment)? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning**	**A. Check list (30 minutes)** – Which structures are involved in provision of abstinence- based treatment? – Coordination with other sectors ensured (Health, social, welfare, criminal justice) – Are Relapse prevention/psychological treatment mandatory parts of drug treatment? – How far are NGOs/Peer groups involved in provision of drug treatment in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**
Group 3: Management of Human and Financial Resources	**Group 4: Practice**
A. Check list (30 minutes) – Are there written criteria for staff standardising qualification for provision of drug treatment? – Is drug treatment integrated in curricula of medical and nursing schools? – Is there a regular budget line for programmes on HIV and drug treatment programmes in prisons? – Is regular training on drug treatment/HIV prevention/education part of mandatory qualification criteria in drug treatment centres in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – Do you consider waiting times for drug treatment rather as appropriate in your country? – Are drug treatment centres highly accessible in your country? – Is the private sector involved in provision of drug treatment supervised according to a standardised written protocol? – Is free of charge drug/low cost treatment feasible for most drug users in need in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**

Opioid Substitution Treatment

Group 1: Policy Making	Group 2: Structure/Cooperation
A. Check list (30 minutes) – How do you evaluate the impact of continued drug use on the individual, family, and the society? – What approach do you suggest for drug users not able to abstain from drugs nonetheless willing to undergo treatment? – Are there drug users in your country who despite many trials of abstinence based treatment could not stop using drugs? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – Which structures do you think should be/are involved in establishment of Opioid Substitution Treatment in your country? – What are the current/potential settings (public, private, for HIV positive Injecting Drug Users) for provision of Opioid Substitution Treatment in your country? – What role do/should NGOs play in provision of Opioid Substitution Treatment in your country? – Are / should specified protocol / guideline is in place for Opioid Substitution Treatment in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**
Group 3: Management of Human and Financial Resources	**Group 4: Practice**
A. Check list (30 minutes) – Are/should specific criteria and training for qualifying staff involved in Opioid Substitution Treatment in your country? – Do/should staff involved in Opioid Substitution Treatment in your country receive training on a regular basis? – How are/should be the costs of Opioid Substitution Treatment in your country covered? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – How do you define acceptable accessibility to Opioid Substitution Treatment for your country (in terms of waiting times, location, etc.? – Are/should be specialized services of Opioid Substitution Treatment in place for female drug users for in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**

Needle and Syringe Programme

Group 1: Policy Making	Group 2: Structure/Cooperation
A. Check list (30 minutes) – How far does the HIV epidemic in your country relate to injecting drug use? – How would you describe the prevalence of HIV among IDUs in your country? – How do you think the HIV epidemic among IDUs disseminates to the general population? – Have you ever come across scientific evidence that Needle and Syringe Programmes increase injection rates? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – What structures should be involved in Needle and Syringe Programmes in your country? – How should NGOs working in Needle and Syringe Programmes coordinate their activities with government? – What role can pharmacies play in Needle and Syringe Programmes in your country? – Is there a system in place in your country for referring IDUs in need of medical/psychological care from Needle Syringe Programmes to other health services? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**
Group 3: Management of Human and Financial Resources	**Group 4: Practice**
A. Check list (30 minutes) – What specific training do you think could be helpful for staff of Needle and Syringe Programme in your country? – How far ex-drug users and/or drug users under Opioid Substitution Treatment should be involved in providing Needle and Syringe Programmes in your country? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**	**A. Check list (30 minutes)** – What services are provided in Needle and Syringe Programme settings in your country? – How far can the Needle and Syringe Programme services be involved in Voluntary Counselling and Testing? – How are/should be used needles and syringes disposed? **B. Identify gaps and challenges (30 minutes)** **C. Recommendations and follow-up planning (30 minutes)**