HIV prevention and care among injecting drug users in the Islamic Republic of Iran

A review of best practice

World Health Organization
Regional Office for the Eastern Mediterranean
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Preface

The Islamic Republic of Iran has created an evidence-based framework for HIV prevention, care and support for injecting drug users. The health infrastructure in the country operates effectively, and the establishment of clinics for HIV prevention, care and support has added value to the existing health care system. The national response to HIV/AIDS has resulted in important achievements in the development of coordinated HIV prevention and care for injecting drug users. Since 2002, changes in the national drug policy have increased the emphasis on demand reduction and harm reduction activities. In this regard, firm advocacy resulted in the critical support of the judicial system for harm reduction initiatives. Strong and committed leadership, along with unprecedented levels of coordination among different government agencies and other key stakeholders, has ensured support for harm reduction strategies and laid the foundation for effective HIV prevention and care programming for injecting drug users.

Key among important accomplishments in implementing HIV/AIDS prevention and care are:

- the establishment of a large number of triangular clinics providing services related to drug users, sexually transmitted infection services and care and support for people living with HIV/AIDS;
- the acceptance of methadone maintenance treatment as an important drug treatment and HIV prevention component for opioid-using populations, and plans for enhanced delivery at a variety of settings, including closed settings such as prisons;
- the establishment of triangular clinics in the prison system for providing care and support to high-risk and HIV-positive prisoners;
- HIV information, safe sex education and health education related to HIV targeting all inmates in Iranian prisons.

This document reviews the implementation of harm reduction programmes, care and support services for people living with HIV/AIDS, and the attempts to reach and deliver services to hidden populations of injecting drug users in the Islamic Republic of Iran. It is intended for programme managers and policy-makers in all countries in order to share the Iranian experience as a model for a comprehensive approach to introducing and scaling up harm reduction. In addition to identifying harm reduction programme elements and their implementation, the document can also be a useful resource for advocacy.

A number of recommendations are also provided in order to enhance the Iranian response to HIV among injecting drug users. Now is the time to build on these achievements so that prevention and care efforts can reach the majority of injecting drug users. These recommendations can be used by policy-makers and programme managers in the Islamic Republic of Iran to improve and accelerate the positive impact of the services. They may also serve as useful programmatic tips for programme developers currently setting up harm reduction services in other countries of the Region.
Acknowledgements

This report was prepared by Dr. M. Suresh Kumar and edited by Dave Burrows and Ruth Birgin of the AIDS Projects Management Group. It was made possible thanks to the support of the Centre for Disease Control, Ministry of Health and Medical Education, Health and Treatment Office, Iranian Prisons Organization, Drug Abuse Prevention and Treatment Office of the Welfare Organization and other governmental organizations in arranging meetings with key individuals and facilitating the many field visits. Special thanks are due to Dr. Reza Faeeli of the Centre for Disease Control in Isfahan, and Dr. Kianoosh Kamali of the Centre for Disease Control in Tehran, for their support with translation during the review.
Introduction

Background

By late 2005, HIV/AIDS surveillance indicated that the Islamic Republic of Iran was characterized by concentrated HIV epidemics among injecting drug users and prisoners in certain provinces. Injecting drug users accounted for 60.8% of all HIV cases reported to the Ministry of Health and Medical Education, and 94.8% of the reported cases were among men.

The country’s Drug Control Headquarters conducted a survey in 2001 which estimated the number of drug users at 3,761,000. A survey conducted by the Drug Control Headquarters in 2005 estimated the total number of heroin users at 400,000 and injecting drug users at 140,000. At a roundtable meeting of researchers and policy-makers at the Iranian National Centre for Addiction Studies in late 2005, it was agreed that there were between 1.2 and 2 million Iranians dependent on opioids and, of these, about 12% injected, giving a mean figure of about 200,000 injecting drug users. It is well recognized that the overall prevalence and the types of drug use vary considerably across the country; there are particularly high prevalence rates of opioid use in south-eastern provinces such as Kerman, and of injecting drug use in the western province of Kermanshah.

The reported prevalence of HIV among injecting drug users varied from 6.1% to 24% in 2005, while 28.5% of injecting drug users accessing triangular clinics or voluntary counselling and testing (VCT) centres were HIV-positive. A recent research study indicated that 15.2% of injecting drug users and 5.4% of non-injecting drug users from three public drug treatment centres in Tehran were HIV-positive. The major risk factor for injecting drug users was a history of sharing injecting equipment inside prison, while for non-injecting drug users it was a lack of condom use.

In recent years, traditional use of opium (tariak), its boiled residue (shireh) and half-burnt opium (sukhieh) have been increasingly replaced by readily-available heroin, which comes mostly from Afghanistan. Injectable buprenorphine smuggled into the country from India through Pakistan has also contributed to some heroin users in some provinces shifting to injectable preparations; it has been reported that many drug users who switch to buprenorphine believe that this will help them to stop heroin use.

Given that there are between 1.2 and 2 million Iranians dependent on opioids, a considerable proportion of whom will have injected

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2 Drug Control Headquarters, unpublished data, 2005.
at least once in their lives, the potential for HIV transmission among and from this group is very high. Recognizing the potential magnitude of the problem, the Government of the Islamic Republic of Iran has initiated comprehensive prevention and care activities targeting drug users both in the community and in prisons. The national response has included the implementation of harm reduction programmes, including care and support services for people living with HIV/AIDS, and attempts to reach and deliver services to hidden populations of injecting drug users. In 2005, the Ministry of Health and Medical Education commissioned a review of the national response.

**Methodology**

Data utilized in the review were collected through the following methods:

- in-depth interviews and discussions with key agencies and individuals;
- analysis of development and implementation of policy, programmes and interventions related to HIV prevention and care at the national and provincial levels;
- field visits to triangular clinics, a range of methadone maintenance treatment centres, drop-in centres and community learning centres;
- discussions with staff, volunteers and clients of triangular clinics, methadone maintenance treatment centres, drop-in centres and community learning centres;
- review of key documents related to drug use and HIV/AIDS in the Islamic Republic of Iran and relevant published literature.

At the end of the review, the major findings and recommendations were presented to members of the National Harm Reduction Committee and discussed. This report incorporates all the significant suggestions and comments made at that meeting.

**National structures for response to HIV among drug users**

The National AIDS Committee was formed in 2001. In order to reduce the harm related to injecting drug use and to prevent the spread of HIV/AIDS among injecting drug users, the National Harm Reduction Committee was established as a sub-committee in 2002. Currently, the Director of the Office for AIDS at the Centre for Disease Control in the Ministry of Health and Medical Education serves as its secretary. There is multisectoral collaboration between the various ministries and concerned agencies, notably the Ministry of Health and Medical Education, Drug Control Headquarters secretariat, the Welfare Organization, the Iranian Prisons Organization and law enforcement representatives, as well as the Iranian Red Crescent Society. The role of nongovernmental organizations in harm reduction for drug using populations is increasingly being recognized.

Since its establishment, the National Harm Reduction Committee has been responsible for the initiation of harm reduction interventions throughout the country. A five-year plan (2002–2007) for substance use-related harm reduction interventions has been prepared. The objectives of the plan include establishing, consolidating, strengthening and coordinating multisectoral, multilateral harm reduction interventions; and reducing drug injecting-related harms such as bacterial infections, crime, injecting-related mortality and HIV, hepatitis and other bloodborne virus infections. The National Harm Reduction Committee ensures collaboration and coordination between national-level agencies, while the Provincial AIDS Committee ensures collaboration and coordination between provincial-level agencies (see Figure 1).

More recently, draft protocols and guidelines for establishing government
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More recently, draft protocols and guidelines for establishing government
and private methadone maintenance treatment clinics have been developed as well as guidelines for establishing and operating outreach programmes, drop-in centres and shelters for drug users. In addition, the Substance Abuse Prevention and Treatment Office of the Ministry of Health and Medical Education created the Iranian National Centre for Addiction Studies at Tehran University of Medical Sciences in 2003 to carry out a range of tasks, including ongoing research into the effectiveness of harm reduction interventions (to date concentrating on methadone maintenance treatment services). Some provinces (e.g. Kermanshah, Fars) have formed multisectoral high-level AIDS committees to coordinate activities related to HIV/AIDS control in their provinces.

Activities related to drug control are coordinated by the Drug Control Headquarters. About 45% of all incarcerations are related to drug use and attempts are being made to examine alternatives to incarceration. These efforts have reduced the total prison population from 170,000 to 130,000. As an outcome of sustained advocacy, there is growing support for demand reduction and harm reduction among Iranian policy and decision-makers.

The Treatment, Rehabilitation and Vocational Training Committee is currently headed by an official of the Ministry of Health and Medical Education and is planning (with approval from the Drug

Voluntary counselling and testing
HIV care and support
Sexually transmitted infection care
Harm reduction services

Pre- and post-test counselling
Harm reduction services
Primary health care

Pro-social environment
Harm reduction services
Primary health care

Community-based information, education, counselling
Harm reduction services

Supported by the Ministry of Health and Medical Education and Iranian Prisons Organization

Viral counselling and testing clinics
(Iranian Red Crescent Society)

Drop-in centres
(Welfare Organization and Ministry of Health and Medical Education in collaboration with nongovernmental organizations)

Community-based organizations and centres for disease control
(Welfare Organization)
Community outreach
(Welfare and Ministry of Health and Medical Education)

Methadone maintenance treatment
operated by Iranian Prisons Organization
Ministry of Health and Medical Education
Welfare Organization
Drop-in centres
Private sector

Figure 1. Model for HIV prevention and care in the Islamic Republic of Iran
HIV prevention and care among injecting drug users in the Islamic Republic of Iran

Kermanshah AIDS Committee

HIV/AIDS prevention and care activities are guided and coordinated by a high-level provincial committee under the leadership of the provincial governor. Sub-committees address specific issues such as information, education, and communication; treatment and care; advocacy and support; monitoring and evaluation; and engaging various stakeholders. Prevention and care is organized at different levels and coordinated by the Ministry of Health and Medical Education (the medical university and the centre for disease control), Welfare and Prisons Organizations, nongovernmental organizations and the Iranian Red Crescent Society.

Control Headquarters Joint Committee) to address issues related to drug use through a comprehensive package of treatment, harm reduction and vocational therapy camps. Through this new approach, street drug users could be provided the options of voluntary treatment or provision of HIV prevention services for those with high-risk behaviour before entering through the criminal justice system.

In early 2005, the Head of the Judiciary Organization issued a circular to all courts in support of harm reduction programmes for drug users. The circular stated that judges at all courts and prosecutors’ offices must consider the issue of public health in the implementation of interventions by the Ministry of Health and Medical Education (such as provision of sterile injecting equipment, as well as methadone maintenance programmes for opioid-dependent people). The letter also asked judicial authorities not to impede the implementation of these much-needed and successful programmes (see Annex 1).

Towards a comprehensive approach to HIV prevention and care for injecting drug users

Outreach, drop-in centres and peer education

The plan for harm reduction among street drug users was designed in response to the need to access hard-to-reach, hidden populations and provide HIV prevention education and services. The implementation of such services required strong coordination and changes in attitude towards drug use issues. Outreach is the most effective way to access hidden drug user populations and has been demonstrated to be effective in reaching a large proportion of the injecting community quickly, particularly where people with experience of illicit drug use are employed as outreach workers. They can also play an important role in supporting equitable access, and adherence, to HIV treatment, care and support among injecting drug users.

The task of organizing a pilot outreach service was undertaken as a joint endeavour between the Government of the Islamic Republic of Iran and the UN Office on Drugs and Crime (UNODC). Given the nature of the services, it was deemed necessary to engage a community-based nongovernmental organization that has good access to, and acceptance among, the target population. The nongovernmental organization Persepolis was selected for this purpose in south Tehran.

In 2003, a rapid situation assessment by the Welfare Organization (that included ethnographic observation, in-depth interviews with street-recruited drug users, and various stakeholder and focus group discussions) was carried out by trained assessors in south Tehran. The assessment led to the development of outreach and harm reduction intervention responses. A trained
team initiated outreach in two neighbourhoods identified through rapid
assessment as areas with high prevalence of injecting drug use. A drop-
in centre was established in the Ghaar neighbourhood to provide health
education; risk assessment and risk reduction counselling; primary
health care (e.g. abscess management); provision of harm reduction
materials and supplies (needles, syringes, injecting paraphernalia
and condoms); and voluntary pre- and post-test counselling services.
During March 2004, methadone maintenance treatment was added
to these services, and this has attracted a large number of clients to
the drop-in centre. Currently, the drop-in centre serves as a “one-stop
service centre” for the drug using population in the neighbourhood.

Following the Persepolis experience, the Ministry of Health
and Medical Education has encouraged medical universities, in
collaboration with various nongovernmental organizations in 7
cities (Tehran, Shiraz, Isfahan, Kermanshah, Mashad, Kerman and
Ahwaz), to establish 12 drop-in centres. The Welfare Organization,
in collaboration with various nongovernmental organizations, also
has 28 drop-in centres across 13 provinces of Tehran, Kermanshah,
Fars, Lorestan, Khorasan-e Razavi, south Khorasan, Kordestan, east
Azarbayjan, Isfahan, Golestan, Markazi, Hormozgan and Hamedan.

Most of the drop-in centres have been operating since mid-2005
and are in the early stages of development. The scope and focus varies
in different drop-in centres. However, most have yet to pay attention
to the importance of developing an outreach system to access drug
using populations.

In addition to Persepolis in Tehran, there are other nongovernmental
organizations involved in organizing drop-in centres and—at least,
potentially—outreach in Tehran, Kermanshah, Fars, Kordestan,
Isfahan and Lorestan. Some of them operate the drop-in centres
with assistance from former drug users. Some nongovernmental
organizations in Kordestan are trying to organize outreach services
for drug-using populations through either community workers or with
the help of recovering drug users. They identify suitable geographical

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**Outreach and drop-in centre supported by the Welfare Organization at Kermanshah**

This drop-in centre, supported by the Welfare Organization, is run
by the nongovernmental organization Green Life and was one of
the first to be established in the country. Located in an area where
many impoverished drug users live, its main activity is reaching
out to injecting drug users congregating in 12 “shooting galleries”
on a regular basis and distribute needles, syringes, cotton, soap
and condoms to them. Used syringes and needles are collected in
safety boxes and destroyed. A single full-time worker supported
by the nongovernmental organization is a former drug user who is
from the same area. His familiarity with drug use settings, drug users
and the community has helped to win the trust of the drug using
communities.
locations, and activities include distribution of harm reduction materials to drug users in the community as well as collecting used needles and syringes thrown indiscriminately in the streets or parks or other common drug-using places.

Drop-in centres are located in areas that are easily accessible to drug users, allowing clients to use the service in a confidential and anonymous manner. Ensuring the building is not identifiable as a service for drug users has been found to be important. Drop-in centres have realized it is useful to consult with current and former drug users in choosing the location, and that the drop-in centre is open when drug users are active. Ideally, the services should operate seven days a week and be open when drug users need the service. However, a balance needs to be achieved between what the clients want and what opening hours the staff can manage.

Drug users often feel discriminated against and alienated in mainstream health services, so drop-in centres should offer a welcoming and non-judgemental environment for drug users, tailoring services to meet the specific needs of this community. The aim of the drop-in centre is to provide a place where drug users feel comfortable and safe, to assess their various needs, provide some services (where possible) and refer them to a range of other relevant services.

**Needle syringe programmes**

Needle syringe programmes have proven to be effective in reducing the sharing of needles and syringes and in preventing HIV transmission, and they are a critical component of HIV prevention among injecting drug users. Needle syringe programmes are currently operating at varying degrees and on a limited scale, through a variety of settings (outreach, triangular clinics, VCT clinics, drop-in centres and community learning centres). The possibility of introducing needle syringe programmes for drug-injecting prisoners is currently under consideration.

Needle syringe programmes provide harm reduction prevention packages similar to that pictured below. This package is distributed by the Iranian Red Crescent Society and all of the drop-in centres and outreach teams. It includes a week’s supply of needles and syringes, condoms, other injecting paraphernalia, and soap. Triangular clinics also provide harm reduction packages to drug users accessing their services. Many nongovernmental organizations involved in drop-in centres and outreach have begun preparing information pamphlets highlighting their activities and have also developed their own “prevention packages”.

Ensuring that sterile injecting equipment is made available to people who inject drugs is an important part of effective HIV prevention. Even though the cost of injecting equipment may be low, drug users are often reluctant to buy sterile equipment for a variety of reasons. These include added cost to the existing financial burden of paying for drugs, fear of arrest, and the threat of being identified as a drug user. The Iranian authorities are recognizing the need to improve distribution of sterile injecting equipment to injecting drug users.

**Drug dependence treatment**

The Ministry of Health and Medical Education has been quick to recognize that drug dependence treatment is an effective way to reduce both drug demand
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Needle syringe distribution in Khoram Abad, Lorestan VCT clinic

This VCT clinic in Khoram Abad has been established in a community health centre situated in an area with a very high prevalence of injection drug use. In the narrow alleys a few metres away from the VCT clinic, many drug users live in impoverished settings. Most injectors in the neighbourhood are very poor, unemployed and have poor health status.

The clinic staff go out to the community and motivate drug users to visit the clinic for VCT services. Harm reduction services are available and one staff member goes into the community to deliver clean needles and syringes to injecting drug users. Primary health care is available for the drug users at the VCT centre. The local triangular clinic receives referrals from VCT centres.

and the risks associated with drug use, and that drug dependence treatment services also offer opportunities to provide integrated HIV treatment, care and support. Drug substitution and maintenance programmes are particularly effective in reducing HIV transmission risks.

Methadone maintenance treatment has been established and is expanding in many settings including university clinics, triangular clinics, clinics supported by the Welfare Organization, the Iranian Prisons Organization, drug rehabilitation centres, nongovernmental organizations and the private sector. With an ongoing training programme for physicians, methadone maintenance treatment was initially scheduled to be delivered to about 30 000 opiate-dependent people by the end of 2005. Methadone maintenance treatment can assist some patients in adherence to ART, but has yet to be scaled-up as a standard option for opiate-dependent people requiring it. Abstinence-based drug treatment services are also beginning to incorporate harm reduction approaches.

Until recently, methadone was predominantly used for detoxification. A protocol for methadone maintenance treatment drafted by the Substance Abuse Prevention and Treatment Office and approved by the Treatment, Rehabilitation and Vocational Training Committee was ratified by the Drug Control Headquarters Joint Committee in 2002. The first pilot methadone maintenance treatment project was initiated in October 2002 at Rozbeh Psychiatric Hospital (affiliated with Tehran University of Medical Sciences), and the second methadone maintenance treatment pilot programme was implemented in March 2003 both at the West Tehran Triangular Clinic (affiliated with Iran University of Medical Sciences) and Ghezelhesar prison in Karaj (by the Iranian Prisons Organization). The pilot projects were supported by UNODC and, following their successful implementation, the methadone maintenance
treatment programme is being expanded in several parts of the country.

The Substance Abuse Prevention and Treatment Office assesses the country’s total methadone supply requirement. Currently, methadone is available as 5 mg tablets and is inexpensive (5 mg methadone costs US$ 0.01; a dose of 75 mg would cost US$ 0.15), and the tablets are administered to clients after grinding and mixing with water. The Substance Abuse Prevention and Treatment Office and the Iranian Prisons Organization have recommended inclusion of methadone syrup in the country’s pharmacopoeia to the Food and Drug Administration. The Iranian National Centre for Addiction Studies is also examining other delivery options.

Methadone maintenance treatment is currently available through the following organizations and settings.

Ministry of Health and Medical Education. There are about 14 methadone maintenance treatment centres supported by the Ministry where treatment is provided through triangular clinics; methadone maintenance treatment clinics, operated by the medical university; specialized university clinics; or through psychiatric hospitals.

Scaling up methadone maintenance treatment

A protocol for the “treatment of opiate dependence with agonist medications” was developed during 2004 by the Substance Abuse Prevention and Treatment Office, based on the methadone maintenance treatment experience from the pilot programmes and protocols from other countries. Treatment algorithms and information booklets have been prepared for patients and families. Furthermore, the regulation for the establishment of treatment centres for substance abuse has been finalized and approved by the Minister of Health and Medical Education.

Through this regulation, all physicians are eligible to operate such centres and methadone maintenance treatment can be delivered through a wide range of centres if the founder is approved by the local medical university. Methadone maintenance treatment clinics are supervised by the medical university and their physicians and psychologists are trained in centres in Tehran, Shiraz, Mashad and Tabriz. The physicians undergo a two-week course that includes lectures and practical case management components. The course is mandatory for the licensing of treatment centres by the medical university for the purpose of operating methadone maintenance treatment and obtaining methadone supplies, and many physicians in the private sector are keen to complete the course. Private patients pay US$ 40–80 per month for methadone maintenance treatment.

Up to August 2005, 100 physicians have been trained with support from the Ministry of Health and Medical Education, the Health Bureau of the Iranian Prisons Organization, and the private sector (five courses each training 20 physicians). By the end of 2005, it was planned that 600 physicians be trained in methadone maintenance treatment, with the capacity to initially treat a minimum of 30,000 clients (600 x 50 clients). These 600 trained physicians have the potential to treat up to 120,000 clients as their caseload builds over time.

In order to facilitate supervision by the medical university, there will be one agonist treatment centre for every 100,000 people. Only these licensed centres can provide methadone maintenance treatment or other agonist treatment (e.g. sublingual buprenorphine). Initially, the centres will provide methadone maintenance treatment for a maximum of 50 patients, with a longer-term patient load of 200.
Health Bureau of the Iranian Prisons Organization. There are 52 methadone maintenance treatment centres (in 26 provinces) in Iranian prisons, with additional centres established in some prisons and drug rehabilitation centres.

Welfare Organization. All of the treatment and rehabilitation centres offer methadone maintenance treatment services.

Nongovernmental organizations. Methadone maintenance treatment is provided at drop-in centres operated by nongovernmental organizations such as Persepolis in south Tehran.

Private sector. Having completed the training course and obtained a licence, any physician (not necessarily a psychiatrist) can establish methadone maintenance treatment in their practice provided they have the services of a counsellor (with a bachelor's degree in psychology or social work).

Currently, methadone maintenance treatment coverage is inadequate. It should be noted that methadone maintenance treatment is useful for all opiate-dependent people, not just those who inject heroin. As the Islamic Republic of Iran is estimated to have a total opiate-dependent population of 1.2 to 2 million people, the provision of opiate agonist treatment will need to be rapidly expanded for several years. Buprenorphine has been included in the Iranian pharmacopoeia and pilot projects for treatment with buprenorphine have already been initiated by the Iranian National Centre for Addiction Studies. Supported by the National Institute on Drug Abuse, the Iranian National Centre for Addiction Studies has initiated a double-blind controlled study comparing buprenorphine and naltrexone. Since injectable buprenorphine is also being used, sublingual buprenorphine can be used to shift to safer sublingual ingestion of the drug.

However, it is important for opiate-dependent people living with HIV/AIDS (PLHIV) to have the option to stabilize themselves with substitution therapy for improving adherence to HIV treatment; for HIV negative individuals, methadone maintenance treatment remains part of an effective HIV prevention strategy.

The Welfare Organization primarily offers abstinence-oriented treatment approaches to drug treatment comprising outpatient detoxification⁴, non-pharmacological treatment approaches for drug abuse treatment; naltrexone treatment for relapse prevention; and rehabilitation⁵. Though the focus of the Welfare Organization has been to promote community-based drug use prevention efforts, and to support drug dependence treatment and rehabilitation, harm reduction activities are increasingly being integrated into treatment programmes with active support from the organization.

Drug detoxification is also provided through the Ministry of Health and Medical Education, and approximately 25,000 patients were treated at the various centres of the medical universities during 2004. Furthermore, 50,000 prisoners have completed detoxification in the prisons and drug rehabilitation centres⁶. The private sector has also been actively involved in

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⁴ Detoxification is provided by about 450 detoxification centres. About 20% of them are supported by the government; the rest are supported through the private sector and subsidized by the government.

⁵ Rehabilitation is mainly provided by 37 therapeutic communities or through referrals to self-help groups.

⁶ Detoxification is supported with use of clonidine or methadone or symptomatic medication.
providing detoxification services, although this is at a high cost to the drug user.

In addition to safe sex education which is now available in abstinence-oriented treatment programmes, HIV prevention information, risk reduction counselling and referrals to VCT centres for individuals at risk should be included. The Iranian Prisons Organization has undertaken remarkable harm reduction work in prisons and drug rehabilitation centres, and this commitment needs to be continued and expanded.

Community-based organizations and community learning centres have been established by the Welfare Organization with the aim of carrying out community-based drug prevention initiatives, and to follow up those who have been through abstinence-oriented treatment programmes. These organizations and centres promote social activities, including recreation and sports, among vulnerable populations. Recently, there have been attempts to provide harm reduction services at these organizations and centres. Being in close proximity to communities with a high prevalence of drug use means they have the potential to make contact with and provide services to hard-to-reach populations.

**Challenges to HIV prevention among injecting drug users**

**Challenges for nongovernmental organizations**

The concept of nongovernmental organization participation in the social and health fields is relatively new in the Islamic Republic of Iran. Most nongovernmental organizations are not involved in drug use and HIV activities and, with lack of experience and expertise in the field, they may be reluctant to become involved. Nongovernmental organizations may be of the opinion that it is easier for them to engage in activities which the general community recognizes

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**Methadone maintenance treatment in Adil Abad prison, Shiraz, Fars**

At the Adil Abad prison, a large facility with a total of 3500 inmates, the triangular clinic has added methadone maintenance treatment to its existing services. The criteria for access to methadone maintenance treatment are that patients be opiate-dependent injecting drug users; professional injectors who administer injections to other drug users in the prisons; have served at least six months of incarceration before initiating methadone maintenance treatment; and have a history of recurrent relapse following detoxification. HIV status is not a criterion for consideration. A trained physician is responsible for methadone maintenance treatment provision, and currently 146 inmates are receiving methadone. During the induction phase, methadone maintenance treatment patients are admitted to the clinic for three days. The average dose for maintenance is 80–140 mg per day. In addition to methadone, drug users receive counselling and group therapy to improve adherence and to address other issues. Services of psychologists and visiting psychiatrists are available to methadone maintenance treatment patients.

Methadone maintenance treatment has been extremely beneficial for the prison management and to the inmates receiving methadone treatment. The obvious benefits are a decline in injecting in prison; a reduction in the number of violent incidents; a fall in illicit drug use; a decrease in criminal acts in prison; enhanced self-care; and improved general behaviour of prisoners on methadone maintenance treatment. One of the patients explained: “I have been using drugs for the past seven years. I have attempted to quit but always went back to drugs. My life was unmanageable. Even in prison, I always got into trouble. For the past eight months, since I have been on methadone, my life has completely changed. I have never felt happy the way I am now. I hope I continue after my release too.” There is the possibility for post-release methadone maintenance treatment continuation at the triangular clinic or the methadone maintenance treatment run by the Welfare Organization. Additionally, some private physicians in Shiraz provide methadone maintenance treatment for a fee of US$ 60 per month.
Activities of the Welfare Organization, Isfahan in drug treatment and harm reduction

This outpatient treatment centre provides safe sex education and condoms to all clients. Drug-related harm reduction is addressed through a nearby drop-in centre supported by the Welfare Organization. There is also a proposal to establish methadone maintenance treatment at the centre, also supported by the Welfare Organization.

and approves. Some nongovernmental organizations also worry about timely allocation of funds as they depend solely on these for carrying out activities. In addition to other possible disincentives, registering with the government can be a long and tedious process for a nongovernmental organization, although efforts are being made to speed up this process.

Though the role of nongovernmental organizations is being recognized, there are considerable challenges that need to be overcome if they are to shoulder major responsibilities in establishing community-based services. Relevant nongovernmental organizations operating in the Islamic Republic of Iran are few, and there is a low level of experience and expertise in the field of drug use and HIV among existing nongovernmental organizations. Training of staff at suitable organizations will enhance their capacity. Nongovernmental organizations applying to run HIV prevention programmes for injecting drug users should be considered based on their commitment to working with drug-using populations, and they should be willing to involve people familiar with or from a drug using background in their team. They should be capable of winning the trust of the drug-using communities. Organizations that are not seeking profit as their prime motive could become involved through an easy registration process, and provided with government support for their community-based outreach activities. Allowing nongovernmental organizations to function from government centres is also recommended.

Apart from human resources, material resources are also critical for sustainability. As noted during a presentation of the major findings of this review to the National Harm Reduction Committee, community resources are usually “hidden”, and innovative strategies have to be developed to tap them.

Limited scale of outreach and needle syringe programmes

The limited scale of outreach work that has so far occurred has successfully shown that more at-risk clients can be accessed through this method. However, outreach services are yet to expand to meet the needs of the total population of injecting drug users. As more nongovernmental organizations are trained to become involved, outreach work can more readily springboard from similarly expanding services (triangular clinics, VCT centres, drop-in centres and community learning centres).
Providing clients with needles and syringes should continue with the expansion of needle syringe programmes. Some outreach workers travel long distances to meet few clients (or vice versa), and need to provide them with sufficient quantities of injecting equipment to last until the next visit.

Currently, the return rate of needles and syringes is low so that, in addition to working with police to create a supportive environment, efforts should be made during outreach-based needle syringe distribution to promote return of used syringes and needles, or their safe disposal. Outreach workers should also collect needles and syringes thrown in parks and neighbourhoods where possible, and safely destroy them. This activity is often appreciated by the communities and can improve support for outreach-related activities. Community ownership and endorsement can also facilitate local funding options.

**Logistics of methadone delivery**

At present, methadone is only available as 5 mg tablets and the dose required for patients is prepared by clinic staff before administration. This is a time-consuming process that limits the number of patients that can be dosed in the clinics. It is believed that methadone liquid would escalate the cost considerably. Alternate and cost-effective methadone preparations should be examined and piloted.

Currently, methadone can be obtained from medical universities by clinics that are certified as addiction treatment centres. Methadone maintenance treatment can be initiated by any prison or any private sector clinic that undergoes training and satisfies the criteria stipulated by the Ministry of Health and Medical Education. The Welfare Organization also licenses clinics for addiction treatment after the clinic physician undergoes a three-day training programme. Certified physicians and clinics can also receive methadone from the medical university for the purpose of detoxification, even though it is not specified how long the methadone should be administered for detoxification purposes. It would be better if methadone was issued by the medical universities through a single licensing system, preferably coordinated by the Ministry of Health and Medical Education.

**Lessons learnt**

Though a range of services can be provided at the drop-in centre, the minimal complement should include:
- harm reduction information
- education and communication
- provision of harm reduction packages (needles, syringes, injecting-related paraphernalia, condoms)
- risk reduction counselling
- voluntary confidential counselling and referral for testing
- psychological support
- group discussions and facilitation of support groups
- primary health care (e.g. abscess care, sexually transmitted infection care)
- referrals (preferably offering accompanied referrals) to other care providers.

Drop-in centres are also often good venues for training peers in harm reduction and running education sessions for clients. Some drop-in centres can also offer methadone maintenance treatment.

To be effective, outreach workers must be able to reach and relate to active drug users, understand the public health imperative of HIV prevention, and view themselves as advocates for those at risk. Respect for the client’s life choices, communication skills, conviction about one’s purpose, and commitment to the work are all desirable attributes for outreach workers. Staff training is important for professional growth for those working in outreach. WHO has developed a manual for training outreach workers which can be

A clearly written policy on staff recruitment, training and promotion is helpful. While the role of people with drug-using backgrounds is well-recognized, programmes should also consider non-drug users who are willing to take up this work. An appropriate salary is essential if workers are to be retained. Health insurance for staff working in outreach should be considered given that they may be exposed to occupational health hazards. Staff weariness can be reduced significantly by ensuring emotional support, staff training, regular staff meetings with de-briefing opportunities, properly planned career paths, professional affiliations, exchange visits and attendance at conferences.

Community outreach should be initiated and strengthened in the places with a high prevalence of drug use and drug injecting. The outreach team should be capable of reaching out to different identified groups (e.g. women, sex workers, different ethnic groups, migrants etc.) and it may be useful to have members of drug user “sub-groups” in the outreach team. Efforts should be made to access the hard to reach populations of middle and upper socioeconomic groups who are also at risk.

The majority of drug users are aware of HIV transmission but this knowledge does not necessarily help with HIV risk perception. To address this credibility gap, peer-driven approaches are strongly recommended and, to this end, training peer educators is required. Peer-based approaches can influence knowledge levels, risk perception, protective and safer behaviours, and can initiate and sustain behaviour changes among current users. They can also provide useful information regarding relevant services, offer referrals and provide harm reduction packages.

Information must be consistent, evidence-based and credible to the audience. Peer training can be organized periodically at the drop-in centres and appropriate manuals may be adapted to help with the training process. Peer-based education should be made available to all drug injectors as well as drug users who are potential drug injectors.

Peer educators must be educated and trained to spread HIV prevention messages and materials among their peers. Interventions should also target risk environments like using, selling and dealing locations. In order to carry out these community-based initiatives smoothly, advocacy with police is essential. To develop optimal community-based interventions, drug users must be involved in the design as well as the implementation of services. Nongovernmental organizations must be encouraged to engage former drug users in their teams.

Community outreach should target not only drug users and injectors, but also the families of drug users (in particular the spouses of married drug users) and the general community. Community barriers to sometimes controversial interventions can only be overcome through efforts to win the confidence of communities in which the drug users
live. Community participatory processes are recommended and community advisory boards (comprising local community and religious leaders), which can help navigate the development and implementation of interventions, are critical to this process.

Working with the police is important for the successful implementation of outreach and needle syringe programmes. Training programmes for police are an effective way to educate law enforcement officials about the importance of harm reduction programmes for drug users.

Indirect sharing of injecting paraphernalia is common among injecting drug users and this contributes to the transmission of hepatitis C virus and potentially of HIV; it is therefore important to distribute cookers, water, alcohol swabs and other necessary injecting equipment. Despite the added costs incurred, this is an important step in reducing the transmission of bloodborne infections.

Outreach and needle syringe programmes suffer from a lack of standardized service monitoring processes to assess and improve the quality of programmes. Parameters for monitoring quality should include: “user-friendly” services that are attractive to drug users; adequate numbers of syringes and needles and other injection-related paraphernalia for the injecting needs of the target population; flexibility of operational hours; presence of satellite/secondary programmes; scope for other services; referral to drug treatment and other services; programmes that ensure community participation; and client satisfaction.

In the process of scaling up methadone maintenance treatment, priority should be given to reach injecting drug users and heroin users; the latter have significant potential for switching to injecting drug use. Most injecting drug users are poor and cannot afford private treatment, so free treatment should be provided where possible. Clinics that exclusively offer methadone only to PLHIV should re-examine their approach as methadone should be provided to opiate-dependent injecting drug users irrespective of their HIV status.

In order to promote safe practices, regular attendees of methadone maintenance treatment clinics can be equipped to distribute clean needles and syringes to their peers. Some regular clinic attendees can be trained to be effective peer educators to spread HIV prevention messages and materials to their drug using peers.

Although the beneficial effect of detoxification alone is limited, this is currently the most common form of treatment. Provision of HIV prevention information, and ready and confidential access to VCT, should become integral components in both outpatient and residential abstinence-oriented services. Counsellors working in abstinence-oriented services should receive training in HIV prevention and risk reduction strategies.

### Care and support for HIV-positive injecting drug users

#### Overview

Care and support services for PLHIV including HIV-positive injecting drug users now operate from 73 triangular clinics and 31 VCT centres funded by the Ministry of Health and Medical Education, 20 VCT clinics funded by the Iranian Red Crescent Society and 51 triangular clinics funded by the Iranian Prisons Organization. Most of the services have adequate infrastructure for scaling up ART for PLHIV injecting drug users, provided they receive adequate supplies of medication and necessary training support. Integrating HIV treatment, care and support with HIV prevention interventions among injecting drug users is likely to lead to the increased effectiveness of both sets of activities. The various services are organized hierarchically to
maximize effectiveness and access to a continuum of HIV-related care and support services, incorporating harm reduction services.

**Triangular clinics**

The concept of the triangular clinic is innovative and pragmatic. It deals with three frequently overlapping issues: injecting drug use through harm reduction; the treatment of sexually transmitted infections; and care and support for PLHIV. Triangular clinics utilize the services of medical doctors as well as paramedical staff and counsellors. Some clinics have visiting specialists, such as infectious diseases specialists and psychiatrists. Prevention efforts directed at people with high-risk behaviours include provision of harm reduction packages where clients are usually provided with up to one week's supply of injecting equipment at a time, as well as condoms. The clinics have been organized in such a way that other agencies can refer clients to the clinics for counselling and testing as well as for care and support.

The first triangular clinic was established in Kermanshah's central prison in October 2000. The Kermanshah clinic demonstrated that by grouping the three service areas together, it was possible to deliver a responsive, comprehensive and integrated service to drug users, their local community and PLHIV, including drug users and their families (Figure 2).

Following the experience of the Kermanshah clinic, the triangular clinic model has been expanded throughout the country. By late 2005, there were 73 such clinics across 28 provinces, and 51 triangular clinics funded by the Iranian Prisons Organization. In all the clinics the focus is on the provision of care and support for PLHIV. The clinics avoid stigmatization by not making direct, specific public references to HIV/AIDS. The triangular clinics are also sometimes referred to as the "counselling and treatment centres for behavioural diseases", or VCT centres.

After formal registration and documentation of relevant details, which are kept confidential in files that can be accessed only by counselling or treatment staff, patients are offered the services of a counsellor for pre- and post-test counselling. Blood is usually drawn at the triangular clinic and sent to the Blood Transfusion Organization for HIV and hepatitis B virus testing, and hepatitis C virus testing is included for those with a history of injecting. Blood samples are coded to maintain confidentiality. The results are sent back to the triangular clinic, where they are given to clients with post-test counselling.

The clinics have the potential to diagnose and effectively treat HIV as well as offer prophylactic treatment for opportunistic infections. Suspected tuberculosis cases are screened and, after establishing a diagnosis, are usually referred to a DOTS (directly observed treatment, short-course) programme—which is already operational in the Iranian health system. Similarly, clients with various medical and psychiatric problems are referred to respective clinics.
Methadone maintenance treatment is offered free of charge for opiate-dependent PLHIV in some triangular clinics. Staff at clinics offering methadone maintenance treatment report that this has helped more injecting opiate users to access their services. Methadone treatment is attractive to opiate-dependent clients, and since many clinics do not have strong linkages with injecting drug user communities, the clinics emphasize the significance of methadone maintenance treatment in promoting themselves to drug users. In some areas, the prime reason for clients registering with the clinic is the desire to access methadone treatment.

Triangular clinics are not all the same. Their capacity to provide treatment and care for PLHIV varies with only some of them providing ART to a limited number of patients. Clinics also differ in their ability to

Figure 2. The Kermanshah triangular clinic
Triangular clinic at Khoram Abad, Lorestan

The triangular clinic at Khoram Abad, Lorestan, was established in 2002 in response to the escalating incidences of HIV in the province. The building for the clinic was donated by a private philanthropist. From the time of its inception, the clinic has registered 570 PLHIV. Of the HIV cases registered at the clinic, 90% are injecting drug users. The clinic involves the services of physicians, psychologists, laboratory technicians, a staff member in charge of methadone delivery, an administrator and a public relations officer. In addition, there are a number of volunteers who help with the smooth functioning of the clinic. Clients are referred from VCT clinics in the community as well as through other clients.

All clients attending the clinic are offered information and education relating to HIV prevention, and injecting and high-risk sexual behaviour are also addressed. Clients have the opportunity to receive harm reduction packages from the clinic, and safe boxes are in the clinic to receive used injecting equipment. Consultation and a thorough medical examination is offered to registered patients, and primary medical care, like wound care, is available. Clients with a history of risk behaviours who have negative test results are provided risk reduction counselling and are advised to return for HIV testing every six months. They are also counselled to utilize the harm reduction and other services in the clinic.

Currently, 12 patients (nine of whom are injecting drug users) are receiving ART. Nutritional support is available for patients with HIV/AIDS. Syndromic diagnosis and treatment of sexually transmitted infections can be provided at the clinic. Injecting drug users requesting drug dependence treatment are referred to the treatment services organized by the Welfare Organization. There is also close coordination with the Iranian Red Crescent Society to facilitate support services.

Opiate-dependent patients living with HIV/AIDS are also offered methadone maintenance treatment, which is provided in the clinic itself. Methadone maintenance treatment has been attractive to these clients, and there is a huge demand. Methadone maintenance treatment is delivered at the clinic with daily dosing conducted under direct observation. The average dose is 40-60 mg. So far, 184 injecting drug users have been registered for methadone maintenance treatment. To date, 1637 people who inject drugs have accessed the services of the Khoram Abad triangular clinic.

organize other support services for PLHIV. The formation of self-help groups that can provide support and advocacy is an important step in an effective response to HIV/AIDS. Some triangular clinics, such as in Khoram Abad (Lorestan) and Shiraz (Fars), have facilitated the organization of such groups among their clients.

The Iranian Prison Organization triangular clinics

There are 220 prisons in the Islamic Republic of Iran. Currently, the total number of prison inmates is about 130,000, with 45%
of them incarcerated for drug-related offences. Sentinel surveillance from 70 prison sites indicates that prisoners are a high-risk group, with the national average for HIV prevalence among prisoners who exhibit risky behaviour at 3.34%. The Iranian Prisons Organization has responded effectively to the growing problem of HIV among prisoners, and 51 triangular clinics have been established in prisons and drug rehabilitation centres across the country.

Triangular clinics coordinated by the Iranian Prisons Organization are modelled on those operated by the Ministry of Health and Medical Education. The clinics were established separately from regular health centres in prisons to provide specialized care, namely health education; risk reduction information; risk reduction counselling and harm reduction services to drug users; screening, diagnosis and treatment of sexually transmitted infections; and organizing care and support services for HIV-positive inmates. The clinics have confidential settings and counsellors for pre- and post-test counselling.

Tuberculosis is the most common opportunistic infection among PLHIV, and a research study has indicated that a quarter of tuberculosis patients in prisons are also HIV-positive. In response to the clear connection between tuberculosis and HIV/AIDS, the triangular clinics provide screening, diagnosis and treatment facilities for tuberculosis. With assistance from the Ministry of Health and Medical Education, the clinics offer ART for selected individuals. Investigations are under way to identify mechanisms to continue ART from triangular clinics after inmates are released from prison.

There is significant emphasis on HIV-related health information in prisons and drug rehabilitation centres. From the point of entry into these closed settings, the inmates are educated about harm reduction through audiovisual aids and group education, as well as individual counselling sessions. There are posters related to HIV prevention displayed in places where inmates gather as well as in health centres. Information pamphlets and brochures relating to harm reduction have been developed by the Iranian Prisons Organization and are distributed to the inmates. Harm reduction services are given a high priority in the triangular clinics. Training on harm reduction is provided to all prison staff. Training is also offered to some prison inmates attending the triangular clinics, and selected trained prison inmates have taken the role of educating their peers at the clinics.

When prisoners receive visits from their spouses, they are allowed to meet in a private room where condoms are provided. For example, in Isfahan central prison there are about 21 suites that are available for prisoners to be with their spouses, and about 100 prisoners per day make use of the facilities. Health education programmes targeting family members of inmates are also provided.

Wide-ranging precautions are exercised at the health facilities in the prisons. Recently, new equipment for sterilization was provided to different prisons. All surgical and dental procedures use disposable instruments and equipment. Prison inmates are provided with disposable blades for personal shaving, while barbers receive training and certification. Tattooing is also recognized as a risk activity and is being addressed in the prisons; 60% of inmates living with HIV/AIDS have a history of tattooing.

Structural and other reforms that have taken place in prisons in recent years are noteworthy in that health facilities are now more easily accessible by prison inmates. For example, in Sanandaj central prison in Kordestan, the buildings have been

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7 Previously, approximately 700,000 people were imprisoned each year, and due to the consideration of alternatives to incarceration (in particular for drug-related arrests) the number is expected to be reduced significantly in the coming years.
Triangular clinic in Isfahan’s central prison

Isfahan has a large prison facility that currently accommodates about 4000 inmates. A triangular clinic has been established in the prison, separate from its health centre and 25-bed hospital. The clinic offers services for prisoners living with HIV and those with a history of high-risk behaviour.

Regular triangular clinic services are provided, and about 185 inmates are on methadone maintenance treatment. This has had a beneficial effect of reducing illicit injecting, violence and crime within prison.

The prison also has a women’s ward where a separate triangular clinic provides services with women physicians and other professionals. For drug-dependent women, detoxification services are offered. To date, no women have been identified for methadone maintenance treatment.

restructured so that inmates have improved access to both triangular and main health clinics. The number of prison hospitals has increased from 3 to 15 in recent years, and a central prison in Kerman has received ISO certification for its nursing and health facilities.

Twelve life skills learning centres have been established in different prisons across the country and they focus on training in problem-solving techniques, vocational training and crisis intervention. Since mental health problems are common among prisoners, mental health is also being addressed; many inmates receiving methadone maintenance treatment are also being treated for major depressive disorders with assistance from visiting psychiatrists.

As with the triangular clinics supported by the Ministry of Health and Medical Education, some prison clinics provide methadone maintenance treatment. Even though needle and syringe distribution is not widely available in prisons at present, there will be consideration given to implementation in the future.

Voluntary counselling and testing clinics

VCT centres, also referred to as “sentinel clinics”, are community-based centres operated by the Ministry of Health and Medical Education (31 centres), and the Iranian Red Crescent Society (20 centres). These centres differ from triangular clinics in that no care and support services for PLHIV are provided.

VCT clinics offer the following services:

- primary health care;
- harm reduction services, including provision of needles, syringes and condoms to people who inject drugs;
- health education related to HIV/AIDS;
- risk reduction information and counselling;
- assessment of high-risk behaviour;
- pre- and post-test counselling;
- referral to triangular clinics for those in need of further services.

*The recent circular from the Head of Judiciary (see Annex 1) will be used to advocate needle syringe programmes within custodial settings.*
HIV-positive network in Shiraz triangular clinic

The Shiraz triangular clinic was established in 2004 in an urban medical centre in south-eastern Shiraz. In addition to the regular services provided by triangular clinics, a visiting infectious diseases specialist provides ART for 30 HIV-infected individuals. Methadone maintenance treatment was initiated in mid-2005 and is being delivered to 47 injecting drug users.

The clinic has facilitated the formation of a support network among PLHIV who regularly attend the clinic. One of these regular attendees, a former drug user, has taken leadership and organized a group comprised of 12 members. They have received training from clinic staff and the network members are now providing health education to groups attending the clinic. The HIV-positive network members want to register formally as a nongovernmental organization.

The objectives of the network include advocating better support services for PLHIV (many of whom are unemployed and have no housing facilities); informing drug users about HIV prevention; disseminating information to drug users about the various services that are available; and attracting the attention of the media to issues related to drug use. Many network members feel that they are in a strong position to reach out to drug-using populations, and they are confident that they can help with the design and development of services for injecting drug users. Furthermore, some of them can serve as effective health educators, peer trainers and counsellors. They also hope that their potential will be recognized for gainful employment.

HIV-positive networks and PLHIV support activities

Some triangular clinics (e.g. in Shiraz) help PLHIV clients to organize support networks. HIV-positive networks are active in some places and, in at least one province, there are plans to register the network as a nongovernmental organization. Involvement of PLHIV is a positive development and should be encouraged in triangular clinics across provinces.

Despite efforts to create multiple access points to HIV treatment, care and support, the majority of patients registered in the many clinics are those identified through the sentinel surveillance system. Very few clinics are attracting people who seek services voluntarily. The establishment of methadone maintenance treatment in some triangular clinics has attracted drug users to seek additional services provided at those clinics. An immediate priority is to expand such successes by attracting injecting drug users and others with high-risk behaviours to seek voluntary help for confidential counselling and testing and HIV-related treatment services.

Most triangular clinics have established good referral linkages with many other health agencies (e.g. DOTS for tuberculosis, opportunistic infection treatment, detoxification services, internal medicine, dermatology, dentistry and psychiatry) and the referral system functions well.

The role of the Iranian Red Crescent Society in providing support services for PLHIV is noteworthy. Support measures for PLHIV include providing food, clothing, general medical care, and the cost of treatment for detoxification services. For a selected few, the Iranian Red Crescent society also covers the cost of ART.

Drug users accessing services such as those provided by the triangular clinics and/or methadone maintenance treatment clinics are generally poor and marginalized. They frequently have multiple basic difficulties to manage such as housing, employment and food, with health needs not necessarily self perceived as a priority. Attending to these multiple needs is also important in
The case of Mrs X

Mrs X, a widow living with HIV (her husband, who had been an injecting drug user and HIV-positive, had died) and with a five year old daughter, was forced to leave her rented house fearing intimidation and harassment. Completely dejected, she was in a hopeless state when she approached the triangular clinic. Apart from organizing clinical services for her (she is now receiving ART from the clinic), staff also provided her with additional assistance. With support from the provincial committee, she has been provided with a house and lives in a secure environment. She is now a proud mother; her only daughter is not only attending school but is also getting good grades. She wants to be a doctor one day and wants to work in the triangular clinic.

order to provide meaningful services for stigmatized, impoverished communities. Some clinics have coordinated with other agencies such as the Iranian Red Crescent Society, the Imam Khomeini Welfare Committee and other government agencies. For example, widowed and separated women face significant economic hardships and income-generating activities are important for them. By coordinating with various agencies, some clinics help these women to obtain economic and other material support.

Lessons learnt

One area in which the triangular clinics have scope for improvement is the number of people receiving ART. The cost of HIV medication is prohibitive in the Islamic Republic of Iran and this limits the number of individuals who can receive ART. Most clinics are offering ART to only a small number of patients. At the triangular clinics, only 21.6% of all injecting drug user clients in the AIDS stage are on ART, so urgent measures are required to scale up treatment for those requiring it. Co-infection with hepatitis C is common among injecting drug users. The treatment regimen with ART needs to be appropriately modified for injecting drug users with HIV and hepatitis C. Training triangular clinic staff is important and many physicians and other workers have yet to have the opportunity to receive any.

Staff at some triangular clinics frequently find it difficult to identify laboratories where tests can be done for PLHIV case management. Some laboratories refuse to perform even routine tests for PLHIV. Advocacy, training and procedural reform is required to educate laboratory staff on this issue.

Given that 23.8% of all HIV/AIDS patients attending triangular clinics have active tuberculosis, it is important that HIV and tuberculosis treatment are more closely integrated through providing DOTS at the clinics.

Active screening and diagnosis of sexually transmitted infections occurs in some clinics, while others refer the patients to sexually transmitted infection clinics outside the triangular clinic. It is recommended that all triangular clinics establish active case detection and treatment procedures as sexually transmitted infection control
is critical to HIV prevention. In some of the clinics, it is observed that not enough attention is paid to sexual health issues apart from condom promotion. Sexual risk behaviour of drug users needs to be addressed. Given that 19% of spouses of HIV-positive clients attending the triangular clinics are also living with HIV, promoting safe sex practices among sexually active drug users is very important. Condom use may be low in marital relationships, but all efforts should be taken to promote safe sex among couples. Peer education can be significant in promoting condom use among drug users, and women-controlled safe sex measures should also be considered. Sexual health services and comprehensive treatment for sexually transmitted infections, partner notification and counselling, and making VCT available to spouses are all of paramount importance.

Opportunities should be provided for PLHIV to organize support networks. Such a network within the clinic can serve as an advocacy group that actively seeks support from other agencies and government organizations. Since some triangular clinics have already taken the lead in this direction, others can learn from and build on their experience.

Cross visits (i.e. staff of one clinic visiting others) will stimulate learning from each other to address common concerns. One of the more successful triangular clinics could be modified to become a demonstration/training site, assisting newly-established clinics by offering hands-on clinical training.

Conclusions and recommendations

Conclusions

There are many signs that the Islamic Republic of Iran has already made an excellent start to the process of gaining control of its HIV/AIDS epidemic. First, there is widespread appreciation, including at very senior levels, of the seriousness of the threat. Second, the Islamic Republic of Iran is firmly committed to harm reduction and evidence-based policies and programmes at senior and other levels. Third, the country has begun implementing and expanding harm reduction programmes; The Islamic Republic of Iran is already a model for many other developing and transitional countries to follow. Fourth, the number of capable and knowledgeable officials committed to the country gaining control of the epidemic is very impressive. Fifth, there is a strong base in drug research in the country.

One of the most important achievements of the Iranian response has been the coordinated, concerted effort by several government ministries and organizations, as well as the growing role of nongovernmental organizations in providing some key services. Coordination of HIV prevention and care activities has been made possible through the establishment of AIDS committees in many provinces modelled on the National Harm Reduction Committee, and involving stakeholders engaged in a wide range of activities.

The foundation for effective HIV prevention and care programming has also been laid through favourable drug policy (focusing on demand reduction as well as harm reduction strategies), support from the judiciary, and a committed leadership. Building on this solid foundation, the required elements for a strong HIV prevention and care programme targeting injecting drug users have already been initiated. This coordination and effort by multiple agencies has led, in some cities, to a comprehensive response in which the communities are receiving general HIV information; injecting drug users and their families are reached through outreach drop-in centres and VCT centres; and people requiring drug treatment have a variety
of services available to them from a range of providers, some of which link harm reduction and drug treatment services with sexually transmitted infection services and HIV treatment, care and support. VCT centres established in some provinces offer pre- and post-test counselling services as well as harm reduction services. Patients requiring HIV care and treatment are referred to the triangular clinics where they also receive harm reduction services.

The Iranian Prisons Organization must be commended for its harm reduction efforts within prisons and drug rehabilitation centres. Harm reduction services in prisons include individual and group health education; risk reduction information; risk reduction counselling; provision of condoms; VCT, with methadone maintenance treatment available in certain prisons (currently 52 centres). Harm reduction services do not yet include the provision of needles and syringes, but the health bureau of the Iranian Prisons Organization suggested that in 2005 that, with support from the judicial system, it would soon be possible to include needle syringe programmes as part of a system for harm reduction in prisons.

Drug use and HIV-related services are thus provided in a wide variety of settings. For successful integration of services, policy changes have been crucial. One of the pragmatic approaches for effective implementation being rapidly adopted is to allow nongovernmental organizations to operate and deliver harm reduction services. The foundation for an integrated system has been created paving the way for future development and expansion.

The next step forward is to scale up activities to achieve control, and eventually reduction, of HIV prevalence among injecting drug users. Harm reduction, drug treatment and care and support services should be available for the majority of drug using populations in the country. A good estimate of the number of drug users, in particular, opiate-dependent drug users, will help with planning services. It is also important to have an estimate of the total number of injecting drug users and the number of heroin users, as these groups require priority attention for HIV prevention efforts. Where adequate data are lacking, rapid assessment and response methods are recommended.

Coverage is the key to a successful sustained response to HIV and drug use. For the purposes of this report, coverage can be defined as the percentage of the total estimated number of drug-injecting people who have regularly accessed HIV prevention and care services. The triangular clinics have excellent infrastructure and are capable of enhancing their coverage of ART treatment, provided medicines are made available to the clinics. At present, the coverage of highly active antiretroviral therapy is very limited and the number of drug users on ART in prisons is also low. Current coverage of methadone maintenance treatment is low, though efforts are being taken to correct this shortfall. Coverage through needle syringe programmes is very low, with outreach methods under-utilized. During 2005, efforts were made to establish drop-in centres with the support of nongovernmental
organizations to access additional drug-using populations. Coverage through the drop-in centres can best be enhanced by outreach-based, low-threshold harm reduction services (including outreach-based needle syringe programmes and behaviour change communication). More needs to be done to initiate, strengthen and expand outreach activities.

The following discussion between Isfahan officials (from the Ministry of Health and Medical Education and the Welfare Organization) highlights challenges to effective coverage:

"The centre for disease control in Isfahan estimates the number of injecting drug users in the province at 7000. Currently, the number of registered patients receiving regular services at the triangular clinic is around 185, most of whom are injecting drug users. Methadone maintenance treatment is being offered in the central prison in Isfahan for about 100 injecting drug users. Two drop-in centres have been established by the Ministry of Health and Medical Education and the Welfare Organization and they are expected to cover around 200–250 injecting drug users each. Furthermore, in-patient facilities at the medical university for drug treatment, outpatient treatment centres of the Welfare Organization and the therapeutic communities provide care for drug users. Isfahan reports a HIV prevalence of 2.8% among injecting drug users (below the critical level of 5%) and hence if efforts are made to increase the coverage of injecting drug users through harm reduction strategies, it is very much possible to control HIV among injecting drug users in Isfahan. Officials believe it is difficult to cover the majority of injecting drug users through methadone maintenance treatment and care and support services only, as these interventions may be too expensive to achieve coverage of the majority. They agree that it is possible to reach effective coverage only through low-threshold interventions like outreach-based behaviour change communication and needle syringe programmes. Peer educators will play a significant role in order to achieve this."

**Recommendations**

1. Outreach-based education, needle syringe programmes and referrals to appropriate services should be made available to the majority of injecting drug users throughout the country.

2. Ongoing training programmes should be implemented to build the capacity of nongovernmental organizations to implement HIV prevention and care services (particularly utilizing outreach) among drug users.

3. A variety of needle syringe programmes should be implemented with the support of the local communities and the police.

4. Currently, all needle syringe programmes provide a comprehensive package (referred to as harm reduction package) and this practice should be continued during the scaling-up of programmes.

5. Training and registration of methadone maintenance treatment prescribers should be accelerated, as the coverage is currently inadequate. Methadone maintenance treatment can assist some patients in committing to ART, and should be scaled up as a standard option for opiate-dependent people requiring ART.

6. Involvement of drug users and PLHIV is beneficial and should be encouraged in triangular clinics and other relevant settings across provinces.

7. Provision of ART should be expanded.

8. Provision of HIV prevention information, and ready and confidential access to VCT should become integral components of all drug treatment settings.
9. All triangular clinics should establish active sexually transmitted infection case detection and treatment procedures.

10. As sexually transmitted infections can facilitate HIV transmission, injecting drug users and their sex partners (spouses) should be provided with ready access to diagnostic screening and treatment.

11. Where adequate data are lacking, rapid assessment response methods are recommended.
Annex 1

Executive Order to All Judicial Authorities [translated from Farsi]

Date: 24 January 2005
Ref: 1-83-14434

ISLAMIC REPUBLIC OF IRAN
Judicial Branch

Executive Order to All Judicial Authorities Nationwide
Among the legal obligations of the Ministry of Health and Medical Education is the implementation of programmes necessary for the prevention of transmission of communicable diseases, aimed at harm reduction and the maintenance of public health and the well-being of society, based on guidelines required to fulfil its mission.

The interventions carried out by the Ministry of Health and Medical Education include the provision of needles, syringes and other material used by drug addicts and AIDS patients, as well as methadone maintenance treatment programmes which help to combat HIV and hepatitis infections among drug addicts.

According to the ministry, some judicial authorities have considered such interventions to be assisting criminal activity and subject to punitive action. This unintentionally impedes the implementation of health and treatment programmes aimed at preventing and combating the transmission of dangerous contagious diseases.

This order is to remind judges at all courts of justice and prosecutors’ offices throughout the country that, since a major element of criminal action is verifiable malicious intent, the aforementioned interventions are clearly void of such intent and, instead, are motivated by the will to protect society from the spread of deadly contagious diseases, such as AIDS and hepatitis.

Therefore all judicial authorities must consider the lack of malicious intent in the interventions of the Ministry of Health and Medical Education as well as those of other centres and organizations that are active in this field.

They must not accuse service providers of assisting in the criminal abuse of narcotics and must not impede the implementation of such needed and beneficial programmes.

Seyed Mahmood Hashemi Sharoudi
Head of the Judiciary
24 January 2005