

Drugs, HIV Treatment and Harm Reduction Services for Afghan Refugees in Iran

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Abstract

In Western Asia, Afghan refugees constitute one of the main vulnerable populations with drug and HIV treatment needs. However, there is not considerable provision of drug and HIV services for this group. The study aimed to describe the provision of drug treatment and harm reduction services for Afghan refugees in Iran, the most populous Persian Gulf country. With the collaboration of the United Nations High Commissioner for Refugees in Tehran, Iran, a project was conducted by Rebirth Society in 2010 to provide free drug and HIV treatment and harm reduction services. Two drop-in-centers were allocated to the project. Six outreach peer members and four staff members were trained. Data were collected by a checklist and analyzed by SPSS version 18. Eighty-one Afghan refugees were admitted. All of them were drug users and needed HIV services. Drug treatments such as methadone maintenance treatment and therapeutic community services were provided. In addition, harm reduction programs such as condom education and distribution, HIV/AIDS education, voluntary counseling and testing, and needle and syringe programs were implemented. The project was an important step in the provision of drug and HIV services for Afghan refugees. Designing and providing long-term related services are suggested.

Keywords: Drug, Harm Reduction, HIV, Persian Gulf, Refugees

In Western Asia, Iran has been widely hosting Afghan refugees since the beginning of Afghanistan's conflicts in the late 1970s. In 2011, the total number of Afghan refugees was 840,200 in Iran (1, 2). Afghanistan and Iran are ancient neighboring countries with Indo-European roots. As the former part of Iran, Afghanistan is a main producer of inexpensive opium (3). Therefore, opiate use is a health concern among some Persian and Afghan groups (4). Drug use among Afghan refugees may lead to drug dependence, high risk behaviors and blood-borne viral infections (5, 6). Two studies found the necessity to provide drug and HIV services for this group (3, 7). In recent years, with the collaboration of the United Nations High Commissioner for Refugees (UNHCR), Rebirth Society (the largest non-governmental organization in Iran) has provided drug and HIV services for Afghan refugees in main cities.

The current report aimed to demonstrate a project of drug and HIV treatment and harm reduction services of Rebirth Society in the most-populated Afghan areas of Tehran, the capital city of Iran.

The study was conducted with the collaboration of UNHCR from 15 June to 29 December 2010. The ethics committee of the research division of Rebirth Society approved the study. A contract was signed between Rebirth Society and UNHCR. The identified Afghan-populated ar-

reas were Shahriyar and Dolat-Abad. Shahriyar area included Nasir-Abad, Baba-Salman, Saeid-Abad and Vireh districts and Dolat-Abad area included Shahr-e-Rey and Bagher-Shahr districts. Two drop-in-centers (Dolat-Abad and Ghale-Hassan-Khan) were well-equipped. Inclusion criteria included reporting illicit drug use and/or engaging with high risk behaviors such as shared injection, sharing needles and syringes or unprotected sex in the last twelve months.

A one-week training workshop was held to train the staff before the project. Mosques, city councils, municipalities, drug treatment centers, police stations, the embassy of Afghanistan, the resorts of seasonal workers and schools with Afghan students were informed about the services available at drop in centers. Six outreach team members who were Afghan peers and four staff members at each drop-in-center were trained. The outreach team identified and approached Afghan refugees and referred them to the drop-in-centers and available services. Clinical files were opened and oral consent was obtained. Data were collected using a checklist and analyzed by performing descriptive statistics, Chi-square test and independent samples t-test by SPSS-version 18.

Eighty-one Afghan refugees were admitted and received drug and HIV services; 96.3% of them were men. The

Table 1. Demographics (n = 81)

Characteristics	No.	Percent/Mean
Gender		
Male	78	96.3%
Female	3	3.7%
Age, y		
20 - 40	69	85.2%
> 40	12	14.8%
Mean age, y		30.5 (SD = 11.9)
Education		
< 12 years	75	92.6%
12 years and more	6	7.4%
Marital status		
Currently married	36	44.4%
Currently unmarried	45	55.6%
Living arrangements		
With family	40	49.4%
Without family	41	50.6%
Employment		
Unemployed	36	44.4%
Worker	35	43.2%
Other jobs	10	12.4%
Duration of residency in Iran		
Maximum, month	20	1
Minimum, month	10	32
Median, month	51	18

mean age of the clients was 30.5 (SD = 11.9) years. Most of them were unemployed (44.4%) or workers (43.2%). The median duration of residence in Iran was 18 months (Table 1).

More than half of the clients reported heroin Kerack use (Crack refers to a highly addictive form of cocaine in the world but Kerack is a street name for a chemical form of heroin in Iran (3)). The main route of drug administration was smoking (67.9%). Eight clients reported current drug injection mainly heroin Kerack. Heroin Kerack users were younger (30.1 vs. 35.6 years, $P < 0.01$), more unemployed (59% vs. 41%, $P < 0.01$) and were more likely to be engaged with high risk behaviors (63% vs. 37%, $P < 0.01$) than the other drug users. At each drop-in-center, drug and harm reduction packages were provided, listed in Table 2. UNHCR also provided free health insurance for all Afghan refugees.

As the most-populated Persian Gulf country, Iran hosts one of the largest refugee populations in the world (8, 9). With the support of UNHCR, Rebirth Society provided

some specific drug and HIV services in two Afghan areas. The study found that all of the clients were drug users. Those with heroin Kerack use problem were younger, more unemployed and reported more high risk behaviors compared with the others. This issue should be considered for treatment and social rehabilitation. Most of the clients had poor education and not-well paid jobs. This is consistent with other studies which showed that Afghan refugees had drug problems and a low socio-economic status (10, 11). Almost 10% of the study clients were injecting drug users. Drug injection was likely to occur in unsafe health conditions and lead to unprotected sexual behaviors. High risk behaviors are documented among Afghan injecting drug users along with low HIV awareness and no condom use (5, 12). Culturally-sensitive models of drug treatment and harm reduction will need to be developed for this group.

Referrals to free therapeutic community centers, condom distribution, peer counseling, HIV/AIDS education, voluntary counseling and testing (VCT) services, the distribution of hygiene and nutrition kits, family counseling, safe sex education, primary healthcare, individual counseling, referrals for free tuberculosis (TB) and hepatitis C virus (HCV) treatment, referrals for free antiretroviral therapy (ART), referrals to triangular clinics, injury and abscess management, safe injection education and the distribution of safe injecting kits, referrals of homeless clients to dormitories, methadone maintenance treatment (MMT) and needle and syringe programs (NSPs) were implemented. These programs included both Afghan refugees and their families. It is essential to develop continued family services along with culturally responsive practices (10). This issue will also help to design and implement specific Afghan programs. It is necessary to fund ongoing programs for drug and HIV education and treatment among Afghan refugees in Iran. The role of UNHCR in providing support is highlighted. As the most populated Persian Gulf country, Iran has taken great steps to reduce drug and HIV problems among Afghan refugees. Providing more similar services is suggested.

Footnotes

Authors' Contributions: Roya Noori and Abbas Deylamizade designed the study, collected the data, contributed to data analysis and writing the paper. The authors read and approved the final version of the paper.

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Table 2. Drug and HIV Services for Afghan Refugees

Variable	No.	%
Referrals to free therapeutic community centers	50	61.7
Condom distribution	46	56.8
Peer counseling	46	56.8
HIV/AIDS education/voluntary counseling and testing (VCT)	45	55.5
Distribution of hygiene kits	42	51.9
Distribution of nutrition kits	39	48.1
Family counseling sessions	35	43.2
Safe sex education	32	39.5
Primary healthcare services	24	29.6
Individual counseling	22	27.2
Referrals for free tuberculosis (TB) and Hepatitis C (HCV) treatment	19	23.4
Referrals for free antiretroviral therapy (ART)	18	22.2
Referrals to triangular clinics	16	19.8
Injury and abscess management	8	9.9
Safe injection education/the distribution of safe injecting kits to drug injectors	8	9.8
Referrals of homeless clients to dormitories	7	8.6
Methadone maintenance treatment (MMT)	6	7.4
Needle and syringe programs (NSPs)	4	4.9

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