

A public health approach to alcohol use and its related harms in Iran



In Iran, alcohol consumption, production, and trade are criminalised for Muslim citizens (ie, about 99% of the population);¹ however, bootleg alcohol is common and alcohol consumption is associated with a number of harms (eg, violence, injuries).^{2,3} A nation-wide household mental health survey suggested that 5.7% of the adult population had consumed alcohol in the previous year,³ with a higher prevalence among men, young adults, single adults, urban areas, and some geographical regions.^{3,4} Moreover, alcohol poisoning outbreaks due to the consumption of substandard alcoholic drinks are frequent and contribute to alcohol poisoning deaths and hospitalisations across the country.⁵ For example, 768 cases of hospitalisation due to methanol poisoning were reported in eight provinces in Iran over the course of 4 weeks in late 2018; among these patients, 170 had dialysis, 16 were blinded, and 96 died.⁶ The surge in alcohol poisonings might be partly explained by the collapse in the value of Iranian currency—the Rial—in the past few years, which could have induced people to buy cheap homemade alcohol rather than expensive, illegally imported foreign products.

While the prevalence, amount, and health consequences of alcohol consumption in Iran are lower than in non-Muslim majority settings—because of Islam's promotion of alcohol abstinence and Iran's prohibition policies—the burden of alcohol-related harms is substantial and should no longer be overlooked. Indeed, the Iranian Ministry of Health has acknowledged this issue by establishing a joint multi-sectoral initiative to develop a national programme that aims to reduce alcohol consumption by 10% between 2015 and 2025 through three main action steps: first, integration of alcohol screening, brief intervention, and referral to treatment in primary health care, aimed at detecting problematic drinking practices early and providing appropriate treatment and care; second, primary prevention, aimed at providing non-drug-specific primary prevention programmes for substance use disorders (eg, parental interventions) in community health centres; and third, treatment programmes, aimed at improving access to alcohol treatment services.⁷ Although the development of

such policies is an important step towards tackling alcohol-related problems in Iran, they have not been fully and successfully implemented into the primary health-care system, which is already understaffed and overburdened. Moreover, not including first-line medical and legal settings, in which people with alcohol use disorders are often over-represented, in the early detection programmes is a missed opportunity. Furthermore, despite the initial plan to institute several outpatient and inpatient alcohol treatment programmes, few programmes have actually been established and are functioning.

Iran's current alcohol use policies have, therefore, failed to consider comprehensive primary prevention strategies such as provision of educational programmes to the public, age-specific school-based prevention programmes, and targeted prevention programmes for individuals at risk. For example, there are no interventions aimed at preventing alcohol-related harms through the introduction of guidelines for low-risk drinking for people who would not be able to comply with complete abstinence, or through public education initiatives regarding limits for alcohol blood levels for driving. Absence of such policies is incompatible with the Islamic principles and education regarding the importance of implementing evidence-informed interventions in order to preserve and protect the health and life of individuals and of the society at large.⁸ While Iran's religious-driven zero-tolerance alcohol policy might help keep alcohol consumption at a low level, it is insufficient and fails to reduce alcohol-related harms, particularly among those who either are at risk or already are problematic drinkers.¹

Indeed, Iran could learn from its successful experience of revisiting the country's drug policy. Despite the illegality of recreational drugs, harm-reduction policies—including opioid maintenance treatments and needle and syringe programmes—were adopted in the early 2000s.⁹ Although supply and demand reduction policies were still prominent, the policy shift towards adopting a harm-reduction approach enabled Iran to control HIV epidemics among people who inject drugs.¹⁰ The lessons learned from this experience can be used

to provide a more efficient response to alcohol-related problems. In the absence of specific alcohol-control guidelines and recommendations for countries where alcohol production, distribution, and use are already prohibited,¹¹ we believe it is time for Iran to identify and develop culturally acceptable best-practice models to improve how it addresses alcohol consumption and its related harms among its population. Establishing a consistent and effective dialogue between religious or political authorities and the scientific and public health communities is an essential first step; the pragmatic flexibility granted to revising drug policy and applying harm-reduction approaches should be considered for tackling alcohol misuse and its related harms in Iran.

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