Iran, Islamic Republic of

General Information

Iran, Islamic Republic of is a country with an approximate area of 1648 thousand sq. km. (UNO, 2001). Its population is 69.789 million, and the sex ratio (men per hundred women) is 103 (UNO, 2004). The proportion of population under the age of 15 years is 31% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 83.5% for men and 70.4% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.3%. The per capita total expenditure on health is 422 international $, and the per capita government expenditure on health is 183 international $ (WHO, 2004).

The main language(s) used in the country is (are) Persian, Azari, Gilaki, Kurdish, Mazandarani, Baluchi, Arabic, Turkmani, Armenian and Ashuri. The largest ethnic group(s) is (are) Persian (half), and the other ethnic group(s) are (is) Azerbaijani, Gilaki, Kurd and Mazandarani. The largest religious group(s) is (are) Muslim (Shia), and the other religious group(s) are (is) Muslim (Sunni).

The life expectancy at birth is 66.5 years for males and 71.7 years for females (WHO, 2004). The healthy life expectancy at birth is 56 years for males and 59 years for females (WHO, 2004).

Epidemiology

According to the most recent epidemiologic survey (Noorbala et al, 2004) that used the General Health Questionnaire (GHQ-28) (n=35 014), 21% of the population (25.9% of the women and 14.9% of the men) were detected as likely to be suffering from mental illness. Interview of families by general practitioners revealed that the rates of mental retardation, epilepsy and psychosis were 1.4%, 1.2% and 0.6%respectively. Bash and colleagues (Bash & Bash-Liecht, 1978; Bash 1984) reported on psychiatric-epidemiological surveys (based partly on census studies, partly on random samples) that sampled rural, urban, tribal subjects above 6 years. The surveys employed questionnaires and tests in the screening phase and individual psychiatric examinations of all possible cases in the confirmation phase. Prevalence in various settings for any psychiatric disorder was: rural (14.9%), urban (16.6%), tribal (2.1%); for all psychoreactive cases (included in the foregoing): rural (8.7%), urban (9.8%), tribal (1.2%); for all psychosomatic cases (included in the psychoreactive): rural (1.7%), urban (2.3%), tribal (0.9%). Significant sex differences were found only in the poor strata. Alemi (1978) found the prevalence of opium use disorders in a survey of randomly chosen households from a rural community to be 6.9% in comparison to the rate of 1.1% estimated for the population based on registry of patients. Merchant et al (1976) found that 24% of the university students (n=607) reported life time use of drugs with 11% reporting use more than three times in their lives. The majority of drug users had used marijuana (54%). Use of drugs was significantly associated with sex, age, number of years of university attended, and father's education. In another study on university students (n=501), Ahmadi and Yazdanfur (2002) reported that the prevalence of regular current use of various substances was: cigarettes (36.1%), alcohol (21.4%), opium (7.6%) and cannabis (3.0%). Substance use was significantly higher among males. Ahmadi and Javadpour (2001) found that among randomly selected health care students (n=346), 34.7% used substances at some point in time. Almost 6.9% of the students were current regular users of substances

(cigarettes: 5.5%, alcohol: 1.7%, opium: 1.4%, cannabis: 1.2%, heroin: 0.3% and LSD: 0.3%). Use of substances was significantly related to gender (11.3% of males and 1.4% of females were current regular users). Agahi and Spencer (1982) found that among 712 students aged 14-18 years, 11% had used some drugs of which opium was the commonest, followed by marijuana and heroin. Thornicroft and Sartorius (1993) reported the ten-year follow-up data of the WHO Collaborative Study on Depression (n=439). Almost 18% had very poor clinical outcome, 24% had severe social impairment for more than half of the follow-up period and 21% had no full remissions. The best clinical course (one or two reasonably short episodes of depression with complete remission between episodes) was more common in endogenous depression (65%) in comparison to psychogenic depression (29%). A fifth (22%) had at least one episode lasting for more than 1 year, and 10% had an episode lasting over 2 years during follow-up. Death by suicide occurred in 11% of patients, with a further 14% making unsuccessful suicide attempts. Shokrollahi et al (1999) administered a sexual function questionnaire to 300 healthy married women (16-53 years old) attending a family planning centre. Approximately 38% of the women had at least one sexual dysfunction; the common ones were inhibited desire (15%), inhibited orgasm (26%), lack of lubrication (15%), vaginismus (8%) and dyspareunia (10%). There were significant correlations between sexual dysfunction in women and their knowledge (low) and attitude (conservative) towards sexuality and their husbands' sexual dysfunction. Nobakht and Dezhkam (2000) conducted a two-stage study to assess eating disorders in 3100 schoolgirls in the age group of 15-18 years using the Persian translation of the Eating Attitudes Test (EAT-26), the Eating Disorder Diagnostic Inventory and a supplementary clinical interview. The lifetime prevalence of anorexia nervosa, bulimia nervosa and partial syndrome was 0.9%, 3.2% and 6.6%, respectively. Zarghami and Khalilian (2002) conducted interviews and/or psychological autopsies on 318 cases of self-burning. Self-immolation was associated with young age (average: 27 years), female gender (83%), housewife status, high school education, psychiatric (95%, mostly adjustment disorder) and chronic physical illnesses (30%) and high mortality (79%).

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1986.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Community education is a component of the policy.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1987. Alcohol is prohibited by both religion and legislation.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1986.

The national mental health programme was evaluated in 1995 and 1997 and changes were made based on suggestions. In 1995, it was evaluated jointly by the WHO and the Teheran Psychiatric Institute. Recently, different sub-programmes on service delivery in urban areas, prevention and promotion have been added to the main body in accordance with the population shift and change of priorities. Other related programmes are Integration of Substance Abuse Prevention within the Primary Health Care and a Harm Reduction Programme.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1988.

The essential drugs list was last updated in 2001.

Mental Health Legislation

Though there are different laws regarding the mentally ill, there is no modern mental health legislation. Since last year, a team has been working on a draft for a new legislation. A mandate by the Minister of Health has been issued in 1997 to allocate 10% of all general hospitals to psychiatry beds. The Mental Health Department has recently started a nation-wide advocacy campaign to implement this mandate.

Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing

There are budget allocations for mental health.

The country spends 3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, social insurance and private insurances.

The national health service in Iran is funded by the Government and health insurance. If covered by health insurance, patients pay 25% of the fee for outpatient and 10% of the fee for inpatient treatment (consultation, laboratory investigations or medicines). Fees do not vary across age ranges. All emergencies are treated immediately without prior payment. The private sector can accept patients without insurance but it provides a limited range of services and the fees are high. Psychologists cannot send bills to insurance companies directly.

The country has disability benefits for persons with mental disorders. Since 2001, the disabled mentally ill patients are entitled to a stipend of about $30 per month if they do not receive other free services. Already, about 10 000 disabled patients are receiving disability benefits and the number is increasing. Institutional care is free of charge for the disabled mentally ill.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Mental health delivery for severe illnesses is one of the objectives in rural and deprived areas.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 20185 personnel were provided training. Mental health services at the primary care level are available to more than one-fifth of urban and more than four-fifths of the rural population. Behvarz (multipurpose health workers), who are selected from the target community have a pivotal role in the country's primary health care network. Their training lasts two years and equips them for active case finding, appropriate referral to the GP and active follow-up of the patients. Psychologists are playing a vital role at the level of primary health care and supervision of health houses. Postgraduate training facilities for medical and nursing graduates are available. Training facilities for general physicians and mental health workers (or Behvarz) is also present. Manuals for the training of medical doctors and Behvarz are available. A difficulty noted in the provision of primary mental health care was the rapid turnover of doctors at this level (average stay of 3-6 months), which often led to many of the

posted doctors not having specific mental health training. To keep up with the urban shift in population, neighbourhood health volunteers are being trained for preventive and promotive activities and appropriate referral.

There are community care facilities for patients with mental disorders. Mental health is integrated into the primary care system whose basis is community care. Community participation is sought through involvement of NGOs and religious establishments in mental health care and public education (e.g. during mental health week).

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	1.6
Psychiatric beds in mental hospitals per 10 000 population	1.4
Psychiatric beds in general hospitals per 10 000 population	0.2
Psychiatric beds in other settings per 10 000 population	0.04
Number of psychiatrists per 100 000 population	1.9
Number of neurosurgeons per 100 000 population	0.4
Number of psychiatric nurses per 100 000 population	0.5
Number of neurologists per 100 000 population	0.6
Number of psychologists per 100 000 population	2
Number of social workers per 100 000 population	0.6

Among the other 325 professionals are occupational therapists and medical assistants. Facilities for treatment of drug abusers (300 beds) and re-orientation centres for drug abusers with criminal and social problems are available. At least 100 beds are available for children with behavioural disorders. Board certification in child psychiatry with a two-year additional training period is available. There is no requirement for licensure or certification of clinical psychologists and they do not have prescription privileges. There are numerous psychologists working outside the mental health sector. Guidelines have been developed and refresher/training workshops have been held for physicians, nurses and social workers on demand-reduction issues.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy and promotion. In 2004, many joint activities between the Department of Mental Health and NGOs were started on prevention, promotion and homecare for mentally ill patients.

Information Gathering System

There is mental health reporting system in the country. There is a simple information system for mental disorders like psychosis, depression, epilepsy, mental retardation, etc.

The country has no data collection system or epidemiological study on mental health. The Department of Mental Health in the MOH has recently started collecting national data on

mental health with collaboration of the National Health Research Center. A national epidemiological study on mental health was done in 1999 (Noorbala, 2004) as an adjunct to the periodic National Health Survey.

Programmes for Special Population

The country has specific programmes for mental health for disaster affected population and children. Though the mental health programme caters to all populations, since 2003, children and adolescents have been receiving more attention.

There are special facilities for child and adolescent psychiatry in the form of special departments, training facilities, school mental health programmes. Special projects on school mental health and on prevention of child abuse and violence against women (in collaboration with UNICEF and WHO) are under way. Life skills training has gained impetus and cascade training of main focal points in all provinces was accomplished in 2003. Four foundations provide special services ranging from consultation to rehabilitation to populations affected by war. Under the national programme on mental health interventions in natural disasters, more than 70 000 survivors received planned interventions during the 8 months after Bam earthquake and over 400 psychiatrists/psychologists and 1500 teachers were trained. Pilot projects on suicide prevention, under way in 4 cities have shown promising results. Integration of substance abuse prevention within primary health care and harm reduction activities including methadone maintenance and outreach activities for street drug users has been launched with collaboration of MOH and NGOs.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine ,phenobarbital, phenytoin sodium, sodium valproate, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden.

In 2003, the list was amended to include 32 medications, e.g. nortryptiline, fluoxetine, trihexiphenedyl, risperidone, etc.

Additional Sources of Information

•Agahi, C., Spencer, C. (1982) Patterns of drug use among secondary school children in post-revolutionary Iran. Drug & Alcohol Dependence, 9, 235-242.

•Ahmadi, J., Benrazavi, L. (2002) Substance use among Iranian nephrologic patients. American Journal of Nephrology, 22, 11-13.

•Ahmadi, J., Javadpour, A. (2001) Assessing substance use among Iranian healthcare students. Journal of Substance Use, 6, 196-198.

•Ahmadi, J., Yazdanfar, F. (2002) Current substance abuse among Iranian university students. Addictive Disorders & Their Treatment, 1, 61-64.

•Alemi, A. A. (1978) The iceberg of opium addiction. An epidemiological survey of opium addiction in a rural community. Drug & Alcohol Dependence, 3, 107-112.

•Bash, K. W. (1984) Epidemiology of psychosomatic disorders in Iran. Psychotherapy & Psychosomatics, 42, 182-186.

•Bash, K. W., Bash-Liechti, J. (1978) Psychiatric resurvey of a central Iranian village thirteen years later. Nervenarzt, 49, 713-719.

•Ghobari, B., Bolhari, J. (2001) The current state of medical psychology in Iran. Journal of Clinical Psychology in Medical Settings, 8, 39-43.

•Hashemi, N., London, M. (2003) Psyciatric practice in Iran and the UK. Psychiatric Bulletin, 27, 190-191.

•Merchant, N. M., Pournadeali, E., Zimmer, S. P., et al (1976) Factors related to drug abuse among Iranian university students. Pahlavi Medical Journal, 7, 516-528.

•Nobakht, M., Dezhkam, M. (2000) An epidemiological study of eating disorders in Iran. International Journal of Eating Disorders, 28, 265-271.

•Noorbala, A. A., Bagheri Yazdi, S. A., Yasamy, M. T.,et al (2004) Mental health survey of the adult population in Iran. British Journal of Psychiatry, 184, 70-73.

•Shadpour K. (2000) Primary health care networks in the Islamic Republic of Iran. Eastern Mediterranean Health Journal, 6, 822-825.

•Shokrollahi, P., Mirmohamadi, M., Mehrabi, F., et al (1999) Prevalence of sexual dysfunction in women seeking services at family planning centers in Tehran. Journal of Sex & Marital Therapy, 25, 211-215.

•Thornicroft, G., Sartorius, N. (1993) The course and outcome of depression in different cultures: 10-year follow-up of the WHO Collaborative Study on the Assessment of Depressive Disorders. Psychological Medicine, 23, 1023-1032.

•Yasamy, M. T., Shahmohammadi, D., Bagheri Yazdi, S. A., et al. (2001). Mental health in the Islamic Republic of Iran: achievements and the areas of need. Eastern Mediterranian Health Journal, 7, 381-391.

•Zarghami, M., Khalilian, A. (2002) Deliberate self-burning in Mazandaran, Iran. Burns, 28, 115-119.