Original Article

Lived Experience of Individuals Covered by Harm Reduction Centers in Isfahan: A Qualitative Study

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Abstract

Background: Addiction is among the most pressing matters across the globe. Harm reduction (HR) is among the most basic public health approaches aimed at altering high-risk behaviors in the addict population. The authors of the present work sought to investigate the health issues of addicted people through a qualitative study of the "lived experience of individuals covered by harm reduction centers in Isfahan." **Materials and Methods:** The researcher in this qualitative research conducted in-depth 30–45-min semistructured interviews with 35 individuals utilizing the services of six HR centers in Isfahan and some of their family members. The data collected from interviews were analyzed using the qualitative content analysis method, employing Granheim and Lundman's conventional inductive approach. **Results:** Participants had a mean (SD) age of 38 ± 3.5, among whom 77.14% were unemployed, 48.57% were illiterate, and 80% used drugs more than once daily. Codes were classified into the three main categories of reasons behind addiction, reasons behind quitting, and various life challenges of respondents, encompassing 14 subcategories. **Conclusions:** Findings from the interviews and identified challenges suggested the imperativeness of further attention to the studied population regarding health, well-being, and socio-economic issues.

Keywords: *Harm reduction, qualitative research, substance abuse, substance disorder*

Introduction

Addiction is among the most pressing matters impacting countries across the globe,[1] imposing high costs on every country resulting from its associated damages. According to the multiyear statistics of the United Nations Office on Drugs and Crime, over 35 people suffered from substance abuse in 2019. Iran is among the countries struggling with dire substance abuse problems, as the latest statistics estimate a national population of 2.8 million addicts in the country.[2] Addiction is a chronic disease involving the brain and is generally characterized by compulsive substance abuse despite adverse consequences, regardless of circumstance.[3,4] Substance dependence is considered a physical and psychological disorder whose progressive nature impacts all aspects of life for the patient as well as their family and community.[5] A chronic and severe illness, such as addiction, within a family would impact not only the household but also the roles, functions, and overall quality of life of the household members, along with repercussions on society.[6] Addiction disrupts the family's internal dynamics, altering the interactions and relationships. Relatives and acquaintances are likely to refrain from engaging with such families, and the family's lack of support can significantly harm the mental and social well-being of the affected household.[7]

Drug abuse is a chronic and relapsing disease whose onset and continuation depend on varied biological, environmental, psychological, and social factors. Treatment measures also vary depending on the patient's unique conditions.[8] Various drug treatments, such as methadone maintenance treatment (MMT) (involving adjusted doses of methadone to reduce cravings for other substances and deter the euphoria resulting from abuse), along with nondrug approaches such as enhancing interpersonal skills, behavioral techniques, boosting self-esteem, and establishing support networks.[9] Methadone is among the prevalent medical treatments to address addiction. MMT has many advantages, including a significant drop in the illegal use of opioids, enabling a nonstagnant lifestyle, allowing patients to

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adopt a vital and stable life, and ultimately reducing high-risk behaviors, especially joint injection, which reduces the risk of hepatitis and AIDS transmission.[10]

HR is among the most basic public health approaches adopted to alter high-risk behaviors in addicted community members. It refers to a set of plans and policies aiming chiefly to reduce the adverse health complications and consequences resulting from substance abuse. Such plans provide all individuals struggling with substance abuse, such as marginalized drug abusers, with social health services with no discrimination and judgment.[11] Therefore, it would be crucial to establish accessible centers where individuals struggling with addiction can receive educational, preventive, and therapeutic interventions.[12] A temporary HR center is a facility where addicts and substance abusers who do not presently wish to quit and people with an addiction who are currently pursuing their high-risk behaviors visit to receive well-being, educational, and medical services.[13] High-risk addicts exposed to infections such as hepatitis and HIV refer to these facilities to obtain services such as free needles, syringes, safe and low-damage injection devices, and educational programs. Drug abusers who are reluctant to be physically present at the centers also receive appointments by the mobile aid teams affiliated with the temporary HR centers with the target group in regular shifts in the hangout of addicted people, providing training and services such as distributing sterile syringes, needle heads, contraceptives, and educational and information leaflets to aid the patients.[12]

Majlesi *et al*. studied individuals covered by HR centers in Kermanshah, examining why these individuals would not use the HR package.[14] Bastani *et al*.[15] conducted a study titled the risk environments of people who use drugs accessing two harm reduction (HR) centers in Tehran, Iran, and found that compulsory drug treatment programs, social stigma, police encounters, and difficulties in obtaining governmental identification documents, among other factors, contribute to social marginalization of Drop-In Center (DIC) clients. Fahimfar *et al*.[16] conducted a study titled Counseling and Harm Reduction Centers for Vulnerable Women to Human immunodeficiency virus/Acquired immune deficiency syndrome (HIV/AIDS) in Iran. They found that HR (40.5%) and counseling (36.6%) were the most delivered services. Rahmani *et al*.[17] conducted a study titled "The managers' perspectives on service providing in women's HR centers during the COVID-19 pandemic: mixed method study." They found that during the COVID-19 pandemic, providing some services and client referrals decreased in the centers, and center managers faced increased challenges. Many of these challenges were found in the communication, executive, management, structural, educational, financial, civilizational, facility, and sociocultural sectors. Managers used their skills to manage and control these challenges. It is essential to address these challenges and develop managerial capabilities to manage future crises effectively.

Given the scarce research in this respect, the negligence to the other aspects of individuals covered by HR centers, and the fact that such individuals generally include misplaced and homeless people who are vulnerable in terms of health, the authors of the present work as community health nurses, sought to investigate "lived experience of individuals covered by HR centers in Isfahan."

Materials and Methods

This qualitative research was conducted in 2023 at six HR centers in Isfahan with 35 individuals who were addicted. The author collected data through individual semistructured interviews. Research inclusion criteria included the ability to read and write, the ability to complete the demographic questionnaire, the absence of severe physical or psychological diseases that would disable the respondent from participating, and the willingness to participate in the study. Research exclusion criteria included the respondent passing away before the interview and the participant expressing unwillingness to continue participating. After connecting with suitable participants, the researchers introduced themselves, explained the research goal, and asked participants to complete a written consent form if they were willing to participate. After coordinating with the participants and setting a place and time for the interview based on their preferences, the interviews were conducted utilizing a guide prepared by the author. The guide inquired about the participant's biographical details, including age, gender, and marital status. It included other guiding questions such as "How did you come to know the HR centers?" and "Tell us about your experience with substance abuse. What ups and downs have you gone through in this respect?" The interview duration varied depending on the participants' availability, with an average interview length of 30–45 min. Following each interview, the researcher listened to the recorded information several times and transcribed the contents word for word on paper. The researcher then read the transcribed several times and coded the interview before starting the following interview. This process continued until data saturation was reached, when no new codes were identified in the subsequent interviews. Exploratory questions were asked. Thus, the present study continued sampling until data saturation was reached when the categories within each group of respondents became repetitive. The researcher determined that saturation had been reached and ceased sampling due to data redundancy. The standard suggested by Guba and Lincoln in 1985 is considered the gold standard of qualitative studies. They introduced the four qualitative data trustworthiness criteria: credibility, transferability, dependability, and confirmability. These criteria translate to the internal validity, reliability, objectivity, and external validity of quantitative studies.[18] According to Guba and Lincoln, assessing the validity, trustworthiness, and accuracy of qualitative research ensures that the study remains true to the participants' experiences.[19] To ensure the validity

of the findings, sampling was conducted with maximum diversity, the long-term presence of a researcher in the research environment, and the utilization of colleagues' complementary opinions. To increase reliability, a precise method and coding framework were established. Furthermore, the findings were validated by two external experts proficient in qualitative research methodology. Controlling findings with three participants and researchers' commitment to setting aside personal biases ensured nonbiased data. As the research question entailed the author exploring the experiences and challenges that individuals face when visiting temporary HR centers, the data collected from interviews were analyzed using the qualitative content analysis method, employing Granheim and Lundman's conventional inductive approach. After each interview, the primary moderator conducted data analysis by entering the transcribed word by word into Word 2013 software and then transferring them to MAXQDA v10 software. The contents of each interview were then reviewed and coded. The resulting codes were compared with the previous ones, and similar codes were clustered. The main categories were ultimately formed by clustering the subcategories that shared common meanings and content. The entire research team reviewed and approved the interviews and codes.[20]

Ethical consideration

Isfahan University of Medical Sciences approved the project's ethical guidelines and national norms and standards (IR.MUI.NUREMA.REC.1402.143). Before recruitment, each participant will be informed about the study objectives, assured of the privacy of their study data, and asked to sign a written informed consent form. Participating in the study and stopping it are both optional.

Results

The mean (SD) age of participants was 38 (3.5). About 77.14% were unemployed, 48.57% were illiterate, and 80% used drugs more than once daily. About 45.71% of the participants had been struggling with substance abuse for between six and 10 years, 48.57% started taking drugs between the ages of 19 and 35, and 51.42% had another addicted family member [Table 1]. Codes were classified into the three main categories of reasons behind addiction, reasons behind quitting, and various life challenges of respondents, encompassing 14 subcategories. Table 2 demonstrates the main reasons behind addiction, quitting, and personal, family, and social problems of the participants derived from in-depth interviews with individuals attending HR centers.

Factors contributing to addiction

Factors contributing to addiction included living in an unhealthy social environment, broken taboo of addiction in the family, migration to other cities during military service or college, lack of family supervision, and career failures and financial bankruptcy.

Living in an unhealthy social environment

Many of the respondents admitted that living in an unhealthy social environment had led them down the path of addiction. As Participant No. 3 explained, "Opium and heroin were as available as candy in our neighborhood; you could get any substance you wanted down an alley."

The broken taboo of addiction in the family

Over half of the interviewees pointed to the lack of taboo for addiction in their family. For instance, participant No. 5 admitted, "In our family, my father was a substance

Table 1: Distribution of demographic variables

Variables	Category	*N* (%)
Employment status	Unemployed	27 (77.14)
	Employee	3 (8.57)
	Freelance	4 (11.42)
	Retired	1 (2.85)
Educational status	Illiterate	17 (48.57)
	Subdiploma	10 (28.57)
	Diploma	5 (14.28)
	University education	3 (8.57)
Number of uses per day	Once a day	7 (20)
	More than once a day	28 (80)
	Weekly	0
	Monthly	0
Time of onset	Under 12	2 (5.71)
	12–18	12 (34.28)
	19–35	17 (48.57)
	36–59	4 (11.42)
Use by another family member	(51.42) Yes	(48.58) No
Total	35 (100)	

Table 2: Concepts extracted from qualitative data analysis

Categories	Subcategories
1. Factors contributing to addiction	1. Living in an unhealthy social environment
	2. The broken taboo of addiction in the family
	3. Migration to other cities during military service or college and lack of family supervision
	4. Career failures and financial bankruptcy
2. Factors involved in quitting	1. Getting tired of substance abuse
3. Personal problems	1. Criminal record and unemployment
	2. Problems getting married
	3. Homelessness and trash picking
4. Family problems	1. Economic dependence on parents
	2. Rejection by family members
	3. Fear of losing parents and its consequences
5. Social problems	1. The operation of unlicensed addiction treatment centers
	2. Inappropriate behavior of some government bodies
	3. Lack of supervision and recreational programs for students and soldiers

abuser. His friends would sometimes come over and smoke together. He would occasionally let me have a smoke as well until I was addicted too."

Migration to other cities during military service or college and lack of family supervision

Military service or attending college in another city was among the most common factors resulting in addiction. Participants 9 and 11 said, "We were assigned to military service in Kerman. I found a friend there who brightened me a dark substance one day. I asked him what it was, and he said it was opium and would be fun if we smoked it together. I was alone and having a terrible time missing my family, so I tried. It was a blast, and I gradually became dependent on it."

Career failures and economic bankruptcy

A few interviewees suggested that they had resorted to addiction due to financial bankruptcy. Participant No. 32 explained, "I had a master's in electrical engineering and my own business. My partner stole all my money, and I went bankrupt. It was hell to pay back the money I owed. My wife got a divorce, and I, depressed, turned to unhealthy friendships and substance abuse…."

Factors involved in quitting

The participants were also asked why they would quit, and they all responded that they were tired and felt like they had reached the end of the road. Participants No. 10 and 14 said, "…I have been an addict my whole life. I have taken anything you can think of. I lost everything; my wife left me and took the kid. I became homeless and lived in abandoned ruins. I am tired. There is nothing at the end of this road. I want to live a decent life again…."

Respondents were asked about the challenges in their lives, and their responses were categorized into the following three groups.

Personal problems

Homelessness and trash picking

Almost half of the interviewees were homeless trash pickers and barely managed to pay for the minimal fees charged by the HR center. As Participant No. 4 complained, "I gather cartons and trash every day and sell them to feed myself, and at night, I sleep under a bridge. It is okay in the summer, but winters are extremely harsh…."

Criminal records and unemployment

Most individuals attending the studied centers had been imprisoned before, where they had been put on maintenance methadone treatment and later introduced to the deputy health department by the prison administration, allowing them to continue their treatment and receive their daily methadone dose at HR centers. They complained about employment problems due to their criminal records. Participant No. 28 said, "…No one hires me because I am an ex-prisoner. I can only pick trash from the streets and sell it…."

Problems getting married

Most participants reported that they struggled with choosing a spouse and getting married due to their long history of substance abuse and, in some cases, criminal records. Participant No. 17 said, "…No one agreed to marry me because I was an addict, so I want to quit; maybe then I will find someone willing to marry me…."

Family problems

Economic dependence on the parents

Many of the participants still lived with their parents and were economically dependent, including participant No. 13: "… I am unemployed. I have no wife, kid, home, or car. I still live with my mother on my late father's pension…."

Rejection by parents

Some interviewees who still lived with their parents were rejected or left the house. Participant No. 27 admitted, "Just this morning, before I came here (the HR center), I ran an errand. When I returned home, my father refused to open the door. No matter how much I begged and the neighbors insisted, he would not open the door. Eventually, I called my sister to come and talk to him, at which point he finally let me in (bursts into tears)…."

Fear of losing parents and its consequences

Those who still lived with their parents were afraid of losing them and the respective consequences. Participant No. 23 explained: "…I am scared of being alone if my mother passes. I am afraid my siblings may want to sell the house for their inheritance, which will leave me out on the streets…."

Social problems

The operation of unlicensed addiction treatment centers

The individuals visiting these centers often faced a problematic ordeal with their past attempts to quit drug addiction in unlicensed private camps. For instance, client number ٤ recounted, "…my family called a camp to send people and take me there by force. The owner had quit through personal practice and wanted to experiment with the same methods on others. They put me in a room and closed the door. I was deprived of food for several days as they aimed to crush my spirit. They intend to break you. I managed to escape and started using drugs again…."

Inappropriate behavior of some government bodies

Another challenge faced by these individuals, especially people experiencing homelessness, was the indecent behavior of government bodies such as the health and military forces. As Participant No. 10 complained, "…I

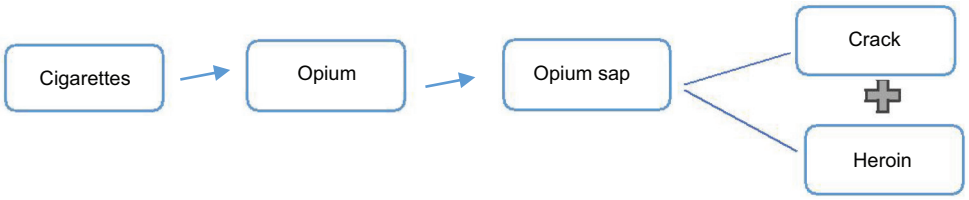

Figure 1: Addiction pattern

sleep under the bridge on a blanket and pillow that random people have given me out of pity. However, health forces some and take our belongings from us, setting them on fire. The police arrest us as well. They take away all we have, take us in for a few days, and let us go…."

Lack of supervision and recreational programs for students and soldiers

Most of the interviewees reported that they started their addiction as teenagers who had just moved to another city on military service or to attend college, suggesting the lack of supervision and recreational programs for students and soldiers. Participant No. 35 explained: "…I was sent to another city on military service. We had no recreation there except gathering with the other guys in a park on the weekends. Once, one of the guys who lived in the same city invited us over. When I got there, I found a couple of people smoking in a circle. I said I would not smoke, and they told me I was too chicken to do it. Having hurt my ego, I smoked with them. That one time was enough for me to become a part of the gang and become and get involved with drugs…."

The participants revealed a pattern of initiation and involvement with drugs as follows [Figure 1]:

Discussion

The present study found that the factors contributing to addiction included living in an unhealthy social environment, broken taboo of addiction in the family, migration to other cities during military service or college, lack of family supervision, and career failures and financial bankruptcy. Previous research has persistently highlighted the influence of social environment on addiction. Kuehn (2005) and Niv (2007) accentuate the significant role of environmental stressors such as poverty and exposure to violence in an increased risk of substance abuse.[21,22] Bibi (2021) focused on the role of family problems and social conditions in one's decision to abuse drugs.[23] Previous findings thus indicate the need for comprehensive intervention in terms of the social factors involved in addiction.[24] A wide range of factors, such as euphoria, curiosity, and peer pressure, contribute to addiction.[25] Substance abuse is associated explicitly with urban communities characterized by consumerism and the middle class.[26] Military service can also be a significant factor, as it is influenced by one's upbringing, social groups, and exposure to traumatic events.[27] The study participants were asked why they would quit, and all responded that they were tired and felt like they had reached the end of the road. The decision to stop drug use is affected by various factors, such as health concerns, dissatisfaction with the drug-dependent lifestyle, and the need to alter one's life circumstances. This choice can be a particular challenge for long-term drug users, who often experience fatigue and a sense of hopelessness.[28] A considerable portion of individuals seeking assistance from HR centers are trash pickers and homeless people suffering from severe poverty and homelessness. These individuals frequently struggle to cover the minimal expenses associated with these facilities. This highlights the need for more accessible, cost-effective support services.[29-32] Many of the individuals visiting these centers had been imprisoned before, where they were put on maintenance methadone treatment and later introduced to the deputy health department by the prison administration, allowing them to continue their treatment and receive their daily methadone dose at HR centers.[33,34]

Conclusion

The findings of this research, in line with previous studies, emphasize the need for dedicated attention to services provided by MMT centers and drop-in facilities.

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Conflicts of interest

Nothing to declare.

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