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From Bad to Worse?

Drug Use and Treatment in Afghanistan

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KEY POINTS

- In comparison to opium production, since 2002 relatively little attention has been given to the issue of drug use and treatment within Afghanistan.
- Despite warnings, resources directed to treatment services have long remained a fraction of the total counter-narcotics spend with a range of complex and interconnected drivers contributing to Afghanistan likely to have one of the highest rates of substance use disorder in the world.
- More so than in most other countries, accurate data on drug use in Afghanistan are scarce. Opioids are the most frequently used drug type, but others including cannabis and stimulants are also now widespread. Many engaging - for a variety of reasons -with the illicit market are people who inject drugs, with a significant proportion likely to be living with HIV.
- In spite of improvements in recent years, the available treatment facilities for people who use drugs remain woefully inadequate.
- Where facilities have existed – many operated by a range of international organisations and agencies – attention must be given to the nature of interventions that come under the loose definition of 'treatment'.
- Long before the Taliban takeover in August 2021, treatment within the country was recognised to not only be of poor and uncertain quality, but also often abusive and in violation of the fundamental human rights of people who use drugs.
- Despite its inclusion in Afghan policy documents, and within a complex policy environment, widespread rollout of harm reduction interventions has remained challenging.
- Since August 2021, the Taliban has (re)engaged in a brutal approach to people who use drugs, forcibly rounding them up and subjecting them to 'treatment' based on abstinence with no with no Opioid Agonist Treatment provided to alleviate their suffering.
- The heterogeneous nature of the Taliban movement means, however, that in some areas evidence and rights based harm reduction approaches remain in operation in one way or another.
- The occupation of Afghanistan, and the two decades of warfare it caused, created a social catastrophe. An often overlooked aspect of this has been skyrocketing levels of drug use and substance use disorder.
- Addressing Afghanistan's drug use epidemic now falls to the Taliban.
- With vital international aid currently suspended due to the Taliban's position on human rights, particularly those of women and girls, the future of drug treatment remains unclear. It is likely, however, that much will depend upon the future balance of power within the Taliban and the ability of the United Nations and the Global Fund to Fight AIDS, TB and Malaria to sustain a dialogue with the Taliban and the investment and enabling legal environment for harm reduction and drug treatment.

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INTRODUCTION

In 2010, Antonio Maria Costa, the then Executive Director of the United Nations Office on Drugs and Crime (UNODC or Office) remarked that while 'much has been said, and written, about Afghanistan as a leading producer of drugs, causing health havoc in the world,' the time had now come 'to recognize that the same tragedy is taking place in Afghanistan.'[1] In the five years previous, when, according to the Afghan Ministry of Counter Narcotics, the number of people who used heroin grew by more than 140 per cent, the United States spent US$18 million on drug treatment initiatives in Afghanistan, less than 1 per cent of the US$2 billion spent on eradication and interdiction.[2] By 2011, a study by Médecins du Monde found HIV prevalence among people who inject drugs in certain urban centres had surpassed the UNAIDS definition for a concentrated epidemic.[3] On World Drugs Day 2013, the UNODC's representative in Afghanistan legitimately referred to problematic drug use within the country and the lack of associated treatment facilities as 'a silent and creeping tragedy.'[4]

Yet the warning was not heeded: spending on treatment services remained a fraction of total counter-narcotics spending, and the focus remained on opium cultivation. Despite the best efforts of many non-governmental organisations working in the country, the treatment services that did exist were often ineffective, abusive, and abstinence based. Indeed, abstinence has long been the prevailing ideology within Afghanistan. Meanwhile, war, poverty, unemployment, displacement (particularly forcible return from neighbouring states), social upheaval and neglect all contributed to the country having one of the highest rates of substance use disorder in the world, estimated at double the global average.[5] Studies suggest that drug use and substance use disorder have continued to grow, particularly among women and children.[6] The UNODC's *World Drug Report 2021,* acknowledging the increasing market complexity, describes how young people 'are now exposed to not only the largest supply of opiates in the world in one of the largest illicit drug economies, but also in the increasingly diversified market of synthetic drugs.'[7] Recent data is scarce, but the socio-economic implications of the COVID-19 pandemic are likely to have increased the number of people using drugs.[8] And now, with the Taliban takeover and the subsequent severe humanitarian crisis, an already desperate situation has become even more precarious. Amongst the flurry of media stories since the Taliban takeover in August 2021, relatively little attention has been paid to the plight of people who use drugs in Afghanistan. More often the primary focus, including that of the UNODC, has been on the international impact of any changes in opium production.[9] Very few accounts have emerged regarding Afghan drug demand rather than supply, and they have revealed the Taliban's brutal treatment of those people who use drugs.[10]

Providing some important historical context, this Policy Brief aims to offer an overview of the state of drug use and treatment provision, particularly in relation to the harm reduction approach, in Afghanistan. In so doing it sets the scene for exploratory discussions of how the Taliban takeover is likely to impact people who use drugs in Afghanistan and so doing suggests issues to be aware of when attempting to assess their future plight.

DRUG USE IN AFGHANISTAN: AN OVERVIEW

It has been noted how little research has been done on illicit drug use in Afghanistan, 'even though most of the world's opium originates in the country'.[11] More so than in most other countries, accurate data on drug use in Afghanistan are scarce. A combination of factors, including inadequate reporting mechanisms and enduring security concerns

means that comprehensive data collection within the country is highly problematic. With that caveat in mind, the *Afghanistan National Drug Use Survey*, undertaken in 2015 by the 'regional' organisation the Colombo Plan, placed the number of people who use drugs in the country between 2.9 and 3.6 million, in a population of 37 million.[12] An Afghan government-UNODC study around the same time suggested the number was between 1.9 and 2.4 million.[13] Aligning with such figures, reports in January 2020 suggested that there were at least 2.5 million people who use drugs in Afghanistan.[14] In urban areas, a 2014 *Lancet Global Health* study suggested, around 10 per cent of the male population in Kabul were people who use drugs.[15] Based on their sample study, which was an attempt to address the serious 'gap in knowledge' through the creation of the Afghanistan National Urban Drug Use Survey, the authors estimated national prevalence rates of drug use to be 7.2 per cent for men and 3.1 per cent for women. Other research suggests that the rate of drug use in rural areas is 2.5 times higher than in urban areas. [16] While recent data are unavailable, the UNODC estimated in 2009 that there were between 18,000 and 23,000 people who inject drugs in the country.[17] According to an Afghan Ministry of Public Health/WHO joint press release on World AIDS Day on 2015, an estimated 4,500 people were living with HIV in the country at the end of 2014. [18] In general, drug use appears to be most common in the poorest regions of the country, typically on the northern and western borders, as well as in Kabul city.

These estimates demonstrate both the gravity of the problem and the partial state of our knowledge of drug use in Afghanistan. Undoubtedly, drug use, including via injection, drug dependence rates and associated negative health consequences have all increased since these surveys were taken. Several factors have contributed to this crisis. As Momand and Jones note, drivers for the interconnected issues of drug production and problematic use may include 'the ravages of four decades of war, easy access to inexpensive drugs, limited access to drug use disorders treatment, prevalent poverty, severe gender inequality, ever increasing insecurity, movement of refuges, internal displacement, urban crowding, corruption, an absence of timely or predictable justice, and overall lack of stable governance or security.'[19] To be sure, well before the Taliban takeover, millions of Afghans lived in poverty, with half of the population considered to be below the national poverty line.[20] The official unemployment figures, which recently were around 10 per cent, tell little of the story. As the International Labour Organisation has pointed out, in Afghanistan 'more than 90 per cent of jobs can be classified as vulnerable employment because they do not offer secure, stable or sufficient income.'[21] The war also became more brutal after the drawdown of foreign forces in 2014. Forced displacement increased and civilian casualties reached record levels. The insecurity, migration, and displacement, particularly to urban slums, worsened the underlying causes of problematic drug use. Mental health is likely another contributor. In 2002, a US Centers for Disease Control and Prevention study found 19 million Afghans suffered from either post-traumatic stress disorder or severe depression.[22] By 2009, the UN observed that 'Many Afghans seem to be taking drugs as a kind of self-medication against the hardships of life.'[23] Such self-medication often included the use of psychotropics and constituted an important component of what was referred to in 2008 as Afghanistan's hidden drug problem.[24] Years of conflict since have no doubt exacerbated this grave situation. In 2020, Zalmai Afzali, spokesperson for the now defunct Afghan Ministry of Counter Narcotics, noted that if current trends continue the country could become the world's top drug-using nation per capita.[25]

According to the Islamic Republic of Afghanistan Ministry of Counter Narcotics – UNODC, *Afghanistan Drug Report 2015*,[26] opioids are, perhaps unsurprisingly, the most frequently

used drugs in Afghanistan. At that time the national opioid drug use rate was estimated to be 4.9 per cent among the general population and 8.5 per cent among adults. The rate of cannabis use – another drug produced in large quantities in the country - was estimated at 2.2 and 3.8 per cent respectively. Following behind these substances were benzodiazepines, amphetamine type stimulants (ATS) and barbiturates, with drug use rates in adults estimated at 1.4, 0.5 and 0.2 per cent and among the general population at 0.8, 0.3 and 0.1 per cent respectively. [27] Seven years later, the authors of the *World Drug Report* were only able to note that 'high levels of opioid use are estimated in Afghanistan'.[28] That said, more detailed but narrow data generated by UNODC surveys of young people revealed that 5.5 per cent (range 4.5 -6.7 per cent) of students aged 13-18 had used cannabis in the past year.[29] In terms of synthetics, it is estimated that in 2019 between 1.3 and 2.6 per cent of Afghan secondary school students were using the form of "ecstasy" known as "Tablet K".[30] Of particular concern is the growing use among different age groups of methamphetamine, which – using autochthonous ephedra plants - is now being produced in large quantities in Afghanistan.[31] Many people using methamphetamine, known locally as "shisha", initially adopted the practice while living in neighbouring Iran. However, by 2015 a community consultation with people who use drugs showed that methamphetamine was being widely used by those with opioid dependence in Kabul following assertive marketing since the domestic production and sale of the drug. The UNODC highlights reports of the emergence and increasing use of methamphetamine which, as observed in other countries, is in Afghanistan frequently used 'concomitantly with opiates as well as on its own.'[32] A 2019 UNODC survey on drug use among young people showed that 1.3 per cent of those enrolled in secondary schools reported methamphetamine use in the past year.[33] Apparently confirming a trend of increased use, a 2019 news report from a rehabilitation clinic in Kabul pointed out that 70 per cent of the patients were being treated for methamphetamine use disorder.[34]

The patchy data guarantees that gaining anywhere near a comprehensive understanding of drug markets in Afghanistan is currently impossible. But it is clear that the most vulnerable Afghans are the most at risk. As the UNODC highlighted in 2009, although 'almost any Afghan from any ethic group can be a drug user, most drug users share similar social and demographic characteristics.' Indeed, the 'archetypal drug user' is likely an illiterate, unemployed male with limited education who lives in poverty.[35] However, women and children are also considered to be particularly vulnerable with some officials within the country estimating that they comprise a quarter of Afghanistan's people who use drugs.[36] Determinants of an individual's drug use or dependence in any country are complex and multifaceted. In Afghanistan this reality is magnified enormously, including in relation to rural economies where activities, weaving for example, take place inside poorly ventilated family homes. In this regard, around a decade ago, researchers investigating the passive effects of adult drug use on children encountered levels of exposure that researchers called 'stunning', putting children 'at risk of abnormal development, including failure of the brain and lungs to grow properly'.[37] In the same year, the UNODC estimated that - often due to a lack of access to essential medicines in many regions of the country - perhaps half of parents are forced to rely on opium as a sedative or painkiller for their children. In the words of the then Executive Director of the UNODC, this meant 'the next generation of Afghans risk being condemned to a life of addiction.'[38] According to the 2015 *Afghanistan National Drug Use Survey*, in terms of children aged 0-14 years, among those tested 9.2 per cent showed positive results for psychoactive drugs, with 90 per cent of them exposed by either

their environment or given drugs by their caregivers.[39] In its 2014 report, *Impacts of Drug Use on Users and Their Family in Afghanistan*, the Office stressed that the problem of drug use 'needs immediate attention if young people are to be properly protected.'[40] This message is even more apposite today. Afghanistan now has one of the youngest and fastest growing populations in the world. Research suggests that almost half (48 per cent) of the population is under the age of 15 while adults 65 years or older represent only 3.7 per cent of the nation's population.[41] Considering the context within which this demographic shift has taken place, it is little surprise that children seeking drug treatment have suffered social and psychological problems that need serious attention.[42]

Comparisons of drug use estimates generated by the UNODC in 2005 and 2015 reveal that during the intervening decade drug use among women increased by 608 per cent, from 120,000 to 850,000 users. [43] As with all members of the population, the causes of female drug use are complex. The UNODC has recognised that 'while numbers of women drug users are far fewer than of men, they too have defining characteristics,' with the typical female drug user 'more likely to be widowed or divorced, have even less education, and is more than twice as likely to not have a job.'[44] It should be noted that use among women (as with young children) is extremely difficult to estimate in Afghan society 'as it is easier to conceal and most often occurs in the home'.[45] Nonetheless, available data suggests that while opiate use is common, women display higher levels of tranquilizer and sedative use. Cardozo et al (2004) and Macdonald (2008) note how high levels of depression combined with reports of psychotropic substance exposure suggest women are self-medicating.[46]

While there are clearly parallels here with men who use drugs, a key difference lies in the broader societal reaction. As in many countries around the world, people who use drugs in Afghanistan suffer profound social stigma and marginalization within a largely conservative community. Yet significant gender inequality within the country generates what has been called a 'double stigma' with significant prejudice against girls and women that use drugs, 'even if their own family members introduce them to the practice.' Due to several factors - including patrilineal family structures, constitutional and legal inequalities, and females as the bearers of family honour - it is often harder for women to 'find and utilize help,'[47] and while statistics on their plight are certainly rare, women who use drugs are understood to face stigmatisation and encounter difficulties accessing treatment.[48]

TREATMENT PROVISION

The available facilities for all Afghan people who use drugs are woefully inadequate given the scale of the problem. According to Afghan government data from 2015, 99 per cent of people who use drugs did not receive any treatment[49] and most of those that did relapsed within a year at most.[50] The Afghan Ministry of Public Health (MoPH) has itself explicitly acknowledged that 'The number of drug treatment centres is very low compared to the high number of addicts.'[51] A study on the topic in the *International Journal of Drug Policy* in 2012 found that services for people who use drugs 'continue to fall far short of requirements in urban areas, remain practically non-existent in rural areas, and are characteristically under-resourced and under-staffed.'[52] The authors observed that 'there has been no systematic assessment of treatment approach or treatment efficacy to date.'[53] Evaluating the situation from a similar perspective, the MoPH Department of Mental Health and Substance Abuse report highlighted that 'the existing treatment capacity raises questions when compared to average international standards' [54] These observations hold true today.

As would be expected, the relevant authorities have tended over the years to praise the improvement in treatment provision, which began from a very low base. The *Afghanistan Drug Report 2015*, one of the last specific publications on the issue to be produced by either the Afghan government or the UNODC, commented: 'The number and capacity of treatment centres in the country has increased continuously over the past five years. In 2015 the total number of drug treatment centres in the country was 123, an increase from 108 in 2013.' The *Report* notes the mix of providers (government, donors, and some private centres) and the range of services offered, including inpatient or residential, outpatient, outreach, community based, shelter based and harm reduction. Some services, it should be recognised, are provided on a project basis.[55] Within the context of a geographical imbalance between urban centres and the rest of Afghanistan – a disparity generated in many ways by longstanding security concerns and reduced access for international donors and implementing organisations - the Ministry of Counter Narcotics also identified the need to include 'the formulation of treatment settings that are culturally adapted to the needs and capacity of women and children in the rural areas of the country.[56]

According to data provided by the UNODC's Afghan country office for this Policy Brief, as of August 2021 there were 129 drug treatment centres in Afghanistan – only six more than existed in 2015. As was the case in 2015,[57] the majority are foreign-funded, supported by the US Bureau of International Narcotics and Law Enforcement Affairs (INL) or the MoPH with funding from the World Bank and Global Fund to Fight AIDS, TB and Malaria (GFFATM) or are part of a long standing INL-Colombo Plan collaboration on drug treatment. Implementation relies on a mix of NGOs, with some involvement from international partners, and the MoPH. The official annual treatment capacity is 48,228 clients, which means both the number of centres and the places available for treatment are insufficient, given the scale of problematic drug use. Moreover, most of these centres are abstinence based - a point to which we will return. According to the UNODC data, only four of centres within the country explicitly offer harm reduction services - the most effective, health-oriented, evidence and human rights-based approaches that are widely, if not universally, accepted by the international community, including all thirty-two UN agencies.[58] Of these centres, two are sponsored by the World Bank, and the other two by the Catholic crisis relief organisation, Caritas Internationalis, and the Norwegian Church. Three of these centres are in Kabul province, with the other in Nangahar.

In addition to relative scarcity, any discussion of provision must also acknowledge the quality of interventions that come under the loose definition of 'treatment.' Long before the Taliban takeover, treatment in Afghanistan was recognised to not only be of poor and uncertain quality,[59] but often abusive and in violation of the fundamental human rights of people who use drugs. With drug use considered a criminal offence, treatment was frequently compulsory, and people who use drugs could be forcibly detained for several months. Women who use drugs in particular were often compelled to enter treatment centres by their families. Reports of abuse are widespread.[60] An expert with extensive in-country experience interviewed for this research recalled eyewitness reports of human rights abuses at the Afghan government-operated Aviceena Medical Hospital for Drug Treatment. Located on the outskirts of Kabul, it was established as a military base (Camp Phoenix) by the US army in 2003 and converted into a treatment centre in 2016. According to some reports it is now Kabul's largest centre, with capacity of 1000.[61] While the managing agency claimed to be motivating people to engage with treatment, in reality people were put through 'cold turkey' detox and kept against their will for three months. Residents

were forced to have their heads shaved and to wear stripped pyjamas. While forced round ups of people who use drugs were hidden practice under the previous Government, the Taliban now openly follows this practice leading to reports of severe overcrowding. There are also accounts of INL-Colombo Plan funded detoxification programmes across Afghanistan in which residents were beaten with rubber hoses and sprayed with ice water as a form of treatment. This and other reports of abusive treatment towards people who use drugs by staff, including doctors,[62] have been backed up by the findings of the Afghanistan Independent Human Rights Commission. Speaking in 2016, a Commission representative reported that 'users and addicts' were 'systematically discriminated against and their basic rights recurrently violated'.[63] Corruption in treatment centres has also been reported as common, with some doctors accused of providing and selling drugs to patients. This is a view rejected by officials in Ministry of Public Health, who blamed private hospitals for such behaviour. [64] What is clear, however, is that human rights abuses have been a regular occurrence in treatment centres and programmes, even those connected to significant international donors. Private programmes also ignore the fundamental rights of residents. At Mother's Trust, for example, a drug treatment programme in Kabul run by Laila Haidari, 'it's all about tough love'. Here the degrading practice of forcible heading shaving is used, and the male residents are forced to wear purple uniforms to discourage them from absconding. Moreover, in the words of Haidari, 'If they relapse and come here a second time, I shave their eyebrows off too … If they break the rules, I'll beat them.'[65] This punitive attitude towards relapse appears widespread, and it transcends the private/ government treatment divide. An interview with a hospital director, conducted by the NGO International Alert in 2016, revealed how some within the sector recommended the model adopted in Singapore, where the 'government funds the treatment of addicts for the first time, with families funding the addict's treatment the second time.' It is not clear whether supporters of this approach were also in favour of the death penalty for a person who relapses for a third time, as is the case in Singapore. That aside, as International Alert point out, 'With even hospital staff labelling users as threats to society and their families, it is easy to understand where the push for criminalising potential relapse comes from.' [66]

Within such a socio-cultural environment it is perhaps understandable, if not excusable, to learn of the relatively limited availability of harm reduction services and the bureaucratic complexities that have surrounded implementation of the approach. While there is no universally accepted definition, the NGO Harm Reduction International (HRI) defines harm reduction as 'policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws … Grounded in justice and human rights [harm reduction] focuses on positive change and on working with people without judgement, coercion, discrimination or,' crucially, 'requiring that they stop using drugs as a precondition of support.'[67] Key interventions include needle and syringe programmes (NSPs) and Opioid Assisted Treatment (OAT). As HRI notes, 'Approaches such as these are cost-effective, evidence-based and have a positive impact on individual and community health.'[68]

According to the *Global State of Harm Reduction 2022*, Afghanistan performs relatively well in relation to the key indicators used. The country has explicit references to harm reduction in national policy documents, has at least one NSP programme and one OAT programme operational, has take home and peer distribution of naloxone and operates OAT in at least one prison.[69] As the *Global State* notes, in 2020 there were 24 and eight NSP and OAT sites respectively.[70] Although,

as these figures demonstrate, there were very few harm reduction centres in operation relative to need and geographical distribution, the quality of what did exist was considered 'reasonably good,' in the words of a Kabul-based Afghan drug service provider.[71] This, however, has not always been the case and the policy terrain, even before August 2021, has long been complicated.

As Todd and colleagues carefully detail in their 2012 analysis of opiate use, treatment and harm reduction in Afghanistan, harm reduction has been included in policy documents since 2002. In May 2005, the MoPH and the Ministry of Counter Narcotics even jointly signed a National Harm Reduction Strategy for people who inject drugs and the prevention of HIV and AIDS. This approved a wide range of interventions, including NSP and a pilot methadone-based OAT. 'However,' they note, 'this collaborative policy approach has not been sustained, due to challenges created by a fractured and conservative polity.'[72]

In Afghanistan there has been a clear disconnect between policy 'on the books' and facts on the ground. There is no need to reprise Todd et al's excellent evaluation here. It is also plausible to suggest that many of the early policy documents and statutes were the product of a process of policy transfer involving international actors, including the UNODC which wrote Afghanistan's drug policy in 2002; an approach that incorporated harm reduction.[73] Yet, on the ground, structural impediments and political obstacles have hindered engagement with harm reduction interventions, which have involved a range of actors, including not only different and often competing government ministries but also NGOs and international donors like the GFTAM. A case in point is OAT provision. In 2011 a pilot methadone programme supported by the MoPH failed to properly get off the ground due to opposition from the Ministry of Counter Narcotics, which refused to award an import licence. Todd et al suggest one of the key explanations for the limited engagement with the harm reduction approach relates to donor funding, which 'entails either adoption of the ideology upon which funding is contingent or preferential recipient selection based on ideology rather than capacity.'[74] In this regard the Colombo Plan has played an important role. Often in direct collaboration with the INL, the organisation has over the years provided substantial funding for abstinence-based programmes. Moreover, it has 'negatively portrayed harm reduction programmes' to Afghan officials and medical professionals. In one case in 2010 this involved organizing training in Singapore and presenting to key Afghan policymakers that country's punitive approach as an example to follow. That, a decade later, hospital officials still look to Singapore for policy guidance on relapse perhaps hints at the sustained legacy of the Colombo Plan's influence. Moreover, at a systemic level it is significant that the Ministry of Counter Narcotics' *Afghan National Drug Action Plan 2015-19,* published in October 2015, notes the intention to increase treatment in rural areas, including increasing training 'in coordination' with the Colombo Plan.[75] Even today, individuals interviewed for this research recognized the role played by the organization in blocking other initiatives, and this role was certainly enhanced by a general misunderstanding of the harm reduction concept and a pervasive and misplaced fear that interventions would lead to increased drug use. Interviewees with first-hand knowledge of the policy environment also expressed the view that the Colombo Plan has been very keen to defend its own funding against any potential investment in harm reduction programmes.

Although there is a severe shortage of harm reduction provision across the country, the situation has certainly improved in recent years. This may be thanks to human rights defenders, drug activists and NGOs who have worked hard to change attitudes and help

normalise and implement the approach over time. A key actor in this regard in the early 2000's was Médicins du Monde (MDM). That said, while certainly influential in rapidly increasing harm reduction provision, it must also be noted that some accounts of the period view its involvement – initially at least – as somewhat problematic. As with other organisations attempting to operate within a notoriously difficult environment, it has been argued that MDM in many ways lacked an understanding of the cultural and political nuances of Afghanistan, and consequently did little to endear itself to the few Afghans who were already working in the country and trying to implement harm reduction services at their own pace. Moreover, and again not unique to MDM, the organisation's later departure and disengagement has been presented as leaving many programmes to collapse or dimmish significantly with little thought for sustainability and capacity building. Whatever the case, it must be acknowledged, however, that MDM's work definitely created a core team of peers who experienced harm reduction and drug treatment at international standards and that remain influential in terms of direct practice and policy level impact. Nevertheless, beyond the not uncommon problems associated with international organisations and agencies 'parachuting in' and bouncing out, other more systemic challenges existed prior to the Taliban takeover. Key among these was corruption, an apparently endemic aspect of Afghan governance and certainly not unique to drug policy. With civil society playing a large role in the implementation of harm reduction services, the situation has been described in terms of 'different NGO's battling how to survive the system' and navigate a 'fiefdom of interests.' Examples are widespread. For instance, one individual working with people who use drugs pointed out that while funding over the years has come from various sources, including MDM and the World Bank, the GFFATAM had in recent times been one of the only major donors for harm reduction in the country and the government had managed to engineer a situation to permit high levels of corruption and the siphoning of funds. Others with experience of operating in the country described how, as a matter of course, high level officials automatically expected kickbacks from internationally funded programmes and saw them as a prerequisite for operationalisation.

Within this context it is remarkable to see the progress that has been made. Just prior to Taliban takeover, in addition to the limited number of treatment centres offering harm reduction services, programmes were being implemented by several NGOs (for example, Youth Health Development Organization, Organization of Technical Cooperation for Community Development, Medical Management and Research Courses for Afghanistan, and Bridge Hope Health Organization) in fourteen provinces. In Kabul Province, OTCD and Bridge also delivered an MoPH co-financed project. Activities include emphasis on peer education, which is critical given that the awareness of safe use practices has historically been poor. In 2010, for example, the IRIN Humanitarian News agency described HIV awareness among injecting drug users as 'non-existent'[76] and between 2008 and 2011 the prevalence of HIV among injecting drug users is considered to have doubled.[77] Relatedly, Coact, a technical support agency working with Bridge, also identified the cold shake method of preparing brown heroin for injection. This involves injecting a heroin solution without converting it into an injectable form with an acidifier and not heating, sterilising or filtering the drug solution. This practice is driven by the police harassment and corruption that drives a rushed approach to injecting and has underpinned a devastating pattern of injecting related injuries. The OTCD and Bridge projects both also included NSPs (incorporating the distribution of appropriate injecting equipment), wound care and overdose management. Research suggests that Bridge's registration with the Ministries of Economic

Affairs and Public Health as a community-based NGO has facilitated unhindered access to drug-using priority areas within the capital. Another sign of small but significant progress, prior to the fall of the government, was the increased coordination between the programme run by the drug demand reduction department in the MoPH and the harm reduction programme within the National AIDS Control programme (now called Afghanistan National AIDS, STI and Hepatitis C (ANPASH).

(RE)ENTER THE TALIBAN

'Now the uncontested rulers of Afghanistan,' began an Associated Press (AP) article from early October 2021, 'the Taliban have set their sights on stamping out the scourge of narcotics addiction, even if by force. At nightfall, the battle-hardened fighters-turned-policemen scour the capital's drug-ravaged underworld. Below Kabul's bustling city bridges, amid piles of garbage and streams of filthy water, hundreds of homeless men addicted to heroin and methamphetamines are rounded up, beaten and forcibly taken to treatment centers.'[78] The report adds that 'Police roundups of addicts did occur during previous administrations. But the Taliban are more forceful and feared.' The reporters followed several people who use drugs who were rounded up, their possessions burned, and taken to Camp Phoenix, which, as described above, is today Kabul's largest treatment centre. What the 'patients' experienced there appears to be a harsher version of the already degrading treatment that took place prior to the Taliban takeover. Their heads are shaved, they are threatened with beatings and fed meagre amounts, and the 'treatment' is based on abstinence, with no substitution therapy provided to alleviate their suffering. A doctor at the facility provides the following comment: 'We are not in a democracy anymore, this is a dictatorship. And the use of force is the only way to treat these people.' By July 2022, it had become clear that such an approach was ascendant. According to another AP report, on one night during that summer 'Taliban fighters had stormed two areas' where people who use drugs gathered, collecting in total 'some 1,500 people, according to officials in charge or registering them.'[79]

The Taliban's attitude towards drug use certainly does not seem to have changed since the 1990s, when people who use drugs were considered criminals and forced, often via practices akin to torture, to abstain, albeit without the use of official 'treatment' centres. Moreover, if what has been referred to as the Taliban 2.0,[80] were to effectively enforce a ban on the cultivation of opium as it decreed in April 2022,[81] the repercussions for global supply would be enormous. And inside the country it would mean hundreds of thousands, perhaps millions, of people who use drugs would no longer have such easy access to heroin or opium. A supply-side shock could lead users to search for dangerous, lower quality alternatives. A drug related health-crisis, with more cases of overdose, is likely to follow. The economic implications would also be disastrous. A recent RAND Corporation study, which hypothesises the implication of a drastic drop in demand for opium, observes that a sudden reduction in opium cultivation 'could have devastating effects on rural populations and be disruptive to other sectors and actors in the economy. A more gradual decline in demand for Afghan opiates could ease the transition by giving Afghan households and the economy more time to adjust, but it might still result in lower living standards in an already-poor country and add to migratory pressures.'[82]

The dire state of the economy may push the regime to adopt alternative, practical measures. Following the removal, at best suspension, of international funding after August 2021 the situation for people who use drugs is unlikely to improve, and the economic depression will exacerbate the causes of drug use. The finance shortfall facing the

regime will also limit its ability to pay staff in treatment centres, something that is already reported to be taking place, while the withdrawal of many international aid agencies will reduce the availability of care and training. The economic crisis also means rural people will increasingly need to rely on opium for a cash crop, particularly as demand in the local market for licit products decreases; the external demand for opium may be one of the illicit 'lifelines' upon which the economy is increasingly dependent.[83]

Recent data suggests that as of August 2022, only eight NSP and nine OAT sites (including four in prison) remained operational.[84] Despite such a downward trend, the ongoing existence of harm reduction services can be seen as representing a pragmatic response from sections of the Taliban across the country. For instance, doctors in three cities are being allowed to continue providing methadone to people with opioid dependence. Moreover, since August 2021 Bridge has been able to continue its harm reduction services and provision of OAT, despite some initial disruption from frontline Taliban security. To be sure, the ability of Bridge to adapt and tailor international practice to the Afghan context and to mediate with the Taliban around the boundaries of accepted practice highlights the importance of Afghan NGOs in future advocacy and practice development. As Afghanistan enters the proposal development phase for the next funding round of the Global Fund, the potential to drive up quality and expand access to harm reduction investment will require culturally sensitive negotiations around the delivery of international standards within an Afghan context. All that said, there is compelling evidence to show that the Taliban continue to crack down on areas known for drug dealing.[85] This may be the beginning of a new pattern: despite the official cultivation ban, a blind eye turned to the opium market – a source of revenue and rural employment – while harsh methods are used to try and reduce local consumption of a variety of drug types. It should be noted that UN figures suggest the cultivation of opium increased by 32 percent over the previous year, making the 2022 crop the third largest area under cultivation since monitoring began.[86]

It is not impossible to imagine a scenario in which much-needed finance and aid is tied to better drug treatment – assuming, that is, that aid agencies are willing to cooperate with the Taliban to some degree. There remains much debate within the international community regarding the best approach towards dealing with Taliban authorities, especially within the context of an increasingly uncompromising stance on human, particularly girl's and women's, rights.[87] However, it should be remembered that, during two decades of foreign occupation, the form of drug treatment supported by the international community was, as outlined above, largely abstinence-based and often in violation of international treatment norms, with the US supporting the initiatives of the Colombo Plan. The critical situation for people who use drugs and the country as a whole is one of the legacies of the foreign invasion now left to the Taliban regime.

CONCLUSIONS

For a long time, the deficits in drug treatment in Afghanistan have been accompanied by a knowledge deficit. The 'silent tragedy' was very real, and it was ignored. Before and since 2013 when the phrase was first uttered, there have been few concerted efforts to understand the true scale, complexities, and implications of the drug use problem in the country. The overthrow of the government and the installation of the Taliban in Kabul has shrouded the future in uncertainty. For now, it has also made access to information even more difficult and an already complex picture more confusing and apparently contradictory. For instance, while both the use and cultivation of illicit drugs are considered *haram* (forbidden by Islamic law), this is yet to result in a concerted

effort to stop opium cultivation. Moreover, in some instances, elements in the Taliban appear to be facilitating a health oriented approach to drug treatment; an unexpected but positive development. For example, in January 2023 ANPASH supported the UNODC to deliver in-country training with harm reduction NGO's in Kabul. Linked to the UN Technical Guide on *HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs*,[88] the Taliban Director of ANPASH introduced and endorsed the course and other team members were active participants in discussions about enhancing the response to the growth of 'shisha' (crystalline methamphetamine based synthetic drug) use in Afghanistan.

One thing is clear, however. The occupation of Afghanistan, and the two decades of warfare it caused, created a social catastrophe. An often overlooked aspect of this has been skyrocketing levels of drug use and substance use disorder. Addressing Afghanistan's drug use epidemic now falls to the Taliban. Yet this reality is accompanied by a (geo)political environment where international aid has largely dried up and the new regime's access to finance is being severely restricted by the West. Where drug treatment is concerned, the evidence so far suggests an official continuation of the main tenets of the occupying powers, albeit a harsher version. What the future holds for the provision of drug treatment in Afghanistan is difficult to say. Yet, within the context of what has been discussed here, several questions appear particularly pertinent. First, recognising that it is not a monolithic political movement,[89] it is important to ask whether it will be those within the Taliban committed to international relations and standards or those committed to dominating their people with force that come to prominence? As Saad Mohseni has put it in reference to broader relations with the international community, will it be the 'preachers' or the 'pragmatists'?[90] A coalition of different groups loyal to different leaders with varying values and objectives, it is becoming increasingly clear that how the Taliban's internal struggles for power play out will inform who defines policy. Second, will, in the face of increasing disregard for the rights of women and girls,[91] international organisations be willing to return to the country? And if so, on what terms? And finally, can the Taliban be encouraged to see the problems with drugs being faced by their people as part of the legacy of war, trauma and oppressions that need to be addressed using harm reduction and humane drug treatment measures over the degrading, abstinence-based model that has been dominant thus far? This is clearly an enormous challenge. Nonetheless, it is one that cannot be ignored.

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