2010 Prison Drug Use Survey:

A national survey of drug use and associated high-risk behaviour across the prison population in Afghanistan

FINAL REPORT

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Health Protection and Research Organization (HPRO)

Funded by UNODC
ACKNOWLEDGEMENTS:

UNODC has subcontracted and commissioned the Health Protection Research Organization (HPRO) to conduct a survey of the prevalence of drug use and dependency and associated risk behaviour among Afghanistan’s prisoners. This survey was managed and overseen by the HPRO, a locally registered NGO which specialises in evaluations, operational research and infectious disease control. Founded in 2008, HPRO now has projects from a range of donors and provides support for independent evaluations of programmes, conducts international standard publishable research, and provides technical training and capacity building for infectious disease control to several partners. For more information on HPRO, please contact the lead author of this report.

The survey was conducted in the field by the Agency for Development and Assistance to Afghanistan (ADAA), a locally registered NGO which has been operating in Afghanistan since 2007. ADAA conducts a range of services for a variety of donors, including health programmes, livelihood strengthening, gender based programming, vocational training and agricultural support.

ACKNOWLEDGEMENTS:

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SUMMARY:

Three methods were used to conduct the survey which aimed to assess the drug use and associated high-risk behaviour amongst inmates in Afghanistan’s prison system. A survey of inmates equating to 10% of the prison population (~13,000 at the time of the survey), focus group discussions with prison staff and inmates and thirdly a survey of services and policies was undertaken. Random sampling was conducted in 22 male provincial prisons, one female prison (in Kabul) and one women’s wing (of Herat province). Sampling was in proportion to the inmate population of the target prisons.

RESULTS OF THE SURVEYS

The survey amongst 1,225 individual male and female (n=123) inmates in 23 provincial level prisons and one women’s wing in Herat Prison found evidence of regular, active drug use amongst the prison population. Around 5% of the prison population reported use of opium or heroin in the last month. Amongst regular heroin users up to 30% reported injecting drugs in the last year. Evidence of regular drug use was found in all the prisons surveyed, either through interviews with prisoners or through the focus group discussions. The number of regular heroin users in the national prison population was estimated at 750 (range: 570-931) and the number of regular opium users in the prison system was estimated at 514 (range: 475-667). Given these usage statistics and the price of drugs reported by respondents, the value of the annual market for contraband heroin and opium in prisons is estimated at approximately USD 2.9 million. Evidence of practices which may increase risk of HIV transmission was also found, with tattooing and unprotected sexual intercourse with multiple partners being evident within the sample. Knowledge of HIV amongst the prisoners was low with only 42% having heard of the disease, although amongst those who had heard of the disease, it was equated with injecting drug use. Most did not equate condom use with protection against HIV.

There was anecdotal evidence from prisoners and prison staff that drugs are smuggled in by inmates’ families, friends and by prison staff themselves. However access appears not to be widespread – those who used drugs in the last month were more likely to have been in prison for >5 years, suggesting a hierarchy of access amongst the population. Those who had been in prison for shorter periods (less than one year) had much reduced access to drugs once they were in the prison system. In many of the prisons the presence of any drug use or risk behaviours for HIV/AIDS are denied by the prison staff.

Service provision within the prisons was inadequate both for basic services (such as food, water and clothing), health services, and in particular for drug treatment and harm reduction; none of the prisons surveyed provided regular services which equate to best-practice guidelines, although a pilot programme for health and drug treatment services is now under progress in Kandahar prison (which was not included in this survey). One third of the population was incarcerated for drug related crimes (a significant proportion of which are regular users) yet there are no facilities for providing withdrawal under medical supervision. The UNODC 2005 and 2009 National Drug Surveys showed an “alarming” rise in drug use amongst Afghanistan’s general population which is likely to translate to an increase in the problem of drug use in prisons as higher numbers of drug users, dealers and smugglers are arrested and processed through the penal system.

CONCLUSIONS AND RECOMMENDATIONS

Some important limitations of the study are likely to lead to an underestimate of the true picture of drug use and risk behaviour; firstly, the nature of the subject matter will lead to under reporting, secondly, some questions had a low response rate and thirdly, there were some instances of deliberate attempts by prison staff to bias the answers of respondents.

Despite these limitations, there is certainly an appreciable amount of regular drug use in Afghanistan’s prisons. This can be seen against the lack of service provision for drug treatment and harm reduction in almost all of the prisons. Despite
the findings of this survey, few of the prison staff members were willing to admit that there was any use of drugs in the prisons. Bringing the problems of drug use to the surface and including it as a component of programmes to improve the prison system in Afghanistan will be harder if it is not discussed openly between all stakeholders.

Drug use is one of many pressing needs within the prison system of Afghanistan. A holistic approach to improving health and welfare is required, and interventions which focus on these aspects of basic care are likely to reap greater gains than vertical programming aimed just at drug use. The recent addition of the prisons into the formal health service system (the BPHS) to provide preventative and curative services presents a strong opportunity to improve health and welfare amongst Afghan prisoners but its effects on improving services for drug treatment, harm reduction and prevention is not known and steps are needed to ensure that this important component of HIV control is not neglected by policy makers and planners.

Systematic approaches to provide standard drug treatment and harm reduction services in the prison system are therefore recommended. Our data suggests that drug use is a problem in a small and hard-core group of users. These need to be identified and provided with treatment. Detection of drug users in the prison system could be conducted by using simple screening procedures and those found to be persistent users could be referred for drug treatment. Because drug use is persistent in a minority of the population who are hard-core users, treatment could be provided at regional locations which may be more cost-effective than providing treatment services in all prisons. Harm reduction services could be provided at all prisons and voluntary participation in treatment services made available to prisoners.

Drug use in Afghanistan is on the rise, according to the UNODC national drug surveys of 2005 and 2009. This will lead to an increase in drug users in the prison population as those increased number of drug users are picked up within the penal system. The scale of the problem in prisons is therefore likely to rise in parallel to national trends and preparations to meet the rising demand are required. Further evaluation of the prison health system after two to three years of implementation is required to examine the level of further programming that is required for drug treatment and harm reduction. Future studies on drug use should also include a biological measure of drug use, for example, using a simple urine screening component. This can easily be anonymous and will identify drug users more accurately than through self-reporting which has been the preferred method used on almost all of the drug use surveys recently conducted. One criticism of drug use surveys (including this one) is that they consistently underestimate the scale of the problem because the subject matter promotes responder bias and underreporting — to correct this error, biological measurement will assist in identifying the scale of underreporting and the true scale of the drug use problem.

There are no easy or quick solutions to the problem of drug use in any population, and the population of prisoners is no different. Drug use occurs in most penal systems across the world, whether well resourced or under resourced. Sustained approaches to improving prisoner health and welfare are required as well as specific interventions for provision of drug treatment, harm reduction and prevention services within prisons.
**ABBREVIATIONS:**

**ART** - Anti-Retroviral Therapy (treatment for HIV/AIDS)

**BBV** - Blood Borne Virus

**BPHS** - Basic Package of Health Services

**HBV** - Hepatitis B

**HCV** - Hepatitis C

**HR** - Harm Reduction

**Ibn Sina** - Afghan NGO providing HIV/AIDS programme in Kandahar Central Prison since 10 January 2010 funded by GTZ and the Global Fund

**INL** - US State Department Bureau for International Narcotics and Law Enforcement Affairs

**OST** - Oral Substitution Therapy – substitute prescribing of Methadone, Buprenorphine to problem opiate users

**PHS** - Prison Health Strategy

**MdM** - Medicins du Monde - a French NGO in Afghanistan (Kabul) contracted by the Global Fund to provide capacity building in HR, HIV / AIDS and OST

**MSM** - Men who have Sex with Men

**NSP** - Needle / Syringe Programme

**STD** - Sexually Transmitted Disease

**Tx** – Treatment

**VCCT** – Voluntary Confidential Counselling and Testing (for HIV)
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INTRODUCTION

DRUG USE IN AFGHANISTAN

The role of Afghanistan in the supply of opium worldwide has been a major concern for the past decade. Drug use in Afghanistan is now widely acknowledged to be a serious problem for the country as well. A drug use survey carried out in 2009 by the United Nations Office on Drugs and Crime (UNODC) and the Ministries of Counter-Narcotics (MoCN) and Public Health (MoPH) documents a major increase in the use of drugs in comparison to a similar UNODC survey carried out in 2005. It is estimated that 8% of the population between 15 and 64 years old now use drugs. This equates to almost one million Afghans. Around 150,000 – 230,000 Afghans are regular opium users, an increase of 53% since 2005, while approximately 120,000 people now use heroin, an increase of 140%.1 The main types of problem drug users in the country include those using heroin and opium and a disturbing detail is that in families where the adult uses opium the children are also likely to be given the drug. Other problem users include those who misuse tranquillisers or pharmaceutical painkillers and those who use more than one drug concurrently.

The increase in drug use is thought largely to be due to the continuing instability in the country alongside the relatively easy access to low-cost drugs. The 2009 drug use survey found that there is a link between drug use and the geographic areas of drug production and trading. The southern and northern regions are associated with the production and trading of cannabis and opium and the highest prevalence of drug users is found in these regions.

A serious concern about the widespread use of drugs in Afghanistan is the link between drug use and associated risk behaviours, such as injecting drug use and sharing of injecting equipment that can lead to the spread of communicable diseases such as HIV and Hepatitis B and C. A recent survey in three cities in Afghanistan found that amongst injecting drug users there was an HIV prevalence of 1% in Kabul, 3% in Herat and 18% in Mazar-I-Sharif. HIV prevalence in Afghanistan is still low but the increased trend in injecting drug

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1 UNODC Afghanistan Drug Use Survey 2009

A typical drug user in Afghanistan:

“The archetypal Afghan drug user is a 28-year old father of three, married but not cohabiting with his wife, who resides with his extended family in a self-owned house or apartment. He is also probably unemployed, cannot read or write and has little if any education. If he is employed it is likely in private business or works as a farmer or unskilled worker. Like most Afghans, he is poor.”

(2009 UNODC Drug User Survey)
use suggests that there is a real threat of an epidemic in Afghanistan. The 2009 drug use survey estimated that six percent of drug users had injected at least once in their lifetime and approximately two thirds of these injecting drug users had injected in the past 12 months. The survey also found worrying evidence of high-risk behaviours amongst the injecting drug users such as sharing needles, multiple usage of needles and syringes, and a lack of needle sterilization.

Drug use though is not just a concern from a disease control stance. The impact of drug use on the individual, their families, and on the welfare of Afghanistan as a country, is well known. The 2009 drug use survey highlighted that drug use is associated with mental, physical and social problems such as family difficulties and employment problems. Meanwhile, there is very little support available for drug users. There are 40 structured drug treatment services across 21 provinces which mostly provide low intensity support, usually based on residential and home-based approaches. Only 11% of drug users reported receiving any kind of treatment for their drug problem yet more than 90% of drug users expressed a desire for help.

Overall, this paints a depressing picture of rapidly increasing drug use in Afghanistan, alongside a significant gap in effective treatment options for the drug users. Furthermore, it is likely that the levels of drug use are much larger than those reported in these surveys due to the stigma attached to drug use and to the difficulty of getting information from hard to reach groups such as women and people in insecure provinces. It is therefore widely acknowledged that Afghanistan is a country with very real problems associated with problem drug use. Two major issues contribute to the problem – the availability of drugs at low prices and a lack of adequate programming for treatment of problem drug use.

Amongst the groups that are at particular risk from drug use and its effects are the vulnerable populations of prisons, returning refugees and internally displaced persons. This report was commissioned by UNODC to provide primary data from the former group – those currently incarcerated in Afghanistan’s main prisons. The latter group, returnees and IDPs is being assessed in our partner paper, to be published in accompaniment to this report.

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2 WHO http://www.emro.who.int/afghanistan/programmes_hiv.htm
UNODC RECOMMENDATIONS FOR DRUG PREVENTION AND TREATMENT

The UNODC has developed recommendations for the treatment of drug users. Drug users should have access to both prevention and treatment opportunities. There should be non-discriminatory, comprehensive programmes available that aim to reduce the adverse health and social consequences of drug use. Harm reduction measures should be combined with treatment facilities. This will prevent the immediate adverse consequences of drug use and should also be effective in reducing the long-term adverse consequences of drug use for the individual and society.

Recommended interventions include:

- Reliable information and counselling on the risks of drug abuse
- Low threshold pharmacological interventions
- Adequate social assistance should be provided for marginalized drug dependents
- Vaccination programmes against Hepatitis should be available to all drug abusers
- Medication and emergency kits for management of overdoses in appropriate places should be available
- Needle/syringe exchange programmes for injecting drug abusers may be implemented where appropriate, under sound medical practice
- Voluntary HIV counselling and testing and antiretroviral treatment for HIV-infected drug users
- Prevention and services for the management of sexually transmitted infections have to be accessible to drug abusers
- Availability of measures to prevent acute consequences of stimulants abuse in the outlets of frequent abuse of these substances
- Interventions in emergency rooms have to be guaranteed
- Medical staff has to be adequately trained to engage drug abusers and dependent individuals in need of treatment interventions.

However, despite an overall increase in funding from key donors, it is often difficult to provide this sort of treatment due to resource limitations. This is particularly true in prisons where the treatment of drug use is not usually a priority. The lack of this comprehensive service may lead to the further stigmatization of drug users and exacerbate the risks associated with drug use, for the individual and for the wider community.

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1 UNODC Reducing the adverse health and social consequences of drug abuse: A comprehensive approach. A discussion paper.
THE PROBLEM OF DRUG USE IN PRISONS

Prisoners are a vulnerable population in need of adequate health care, including access to drug treatment and harm reduction services. Not only are these services a part of a prisoner’s basic human rights but they are also important for the community at large to mitigate the social effects of drug use and also to prevent the spread of diseases such as HIV. During the nineties, a series of studies in prisons in the US, UK, Australia and former Soviet countries of Eastern Europe, reinforced the understanding that imprisonment significantly affects the spread of diseases such as HIV and hepatitis B and C. For instance, a study amongst correctional inmates and releases in the US demonstrated that a high proportion of the disease burden was amongst this population: 20-26% of all people living with HIV, 29-43% of all people infected with Hepatitis B and C and 40% of all people with tuberculosis passed through a correctional facility.¹

Prisoners often exhibit a high degree of risk behaviours that are associated with the spread of disease due to the conditions and nature of being in prison. Several studies have demonstrated the high prevalence of drug use and risk behaviours such as needle sharing, tattooing and unprotected sex.⁵,⁶ One study in Glasgow, UK, demonstrated that length of injecting, year of commencing drug injecting and number of times in prison predicted antibody positivity for Hepatitis C.⁷ This type of risk behaviour has driven epidemics of blood borne diseases such as HIV and hepatitis all over the world including New York in the US and other countries such as China, Indonesia, and Kazakhstan.⁸

The better understanding of the linkages and interactions between the penal system, drug use, risk behaviour and blood borne diseases is beginning to encourage policy and decision makers in some countries to change their attitude towards health care and disease control in prisons, and in particular to the politically sensitive topic of drug treatment in prisons. For instance, in 2001 a World Health Organization (WHO) conference in Switzerland called for more to be done in prisons to reduce the harm caused by drug use and to treat drug use amongst prisoners.⁹ Not only are prisons an opportunity to reduce the burden of disease amongst prisoners and the general population but also an opportunity to tackle drug use.

The concept of harm reduction has emerged as a way to effectively treat drug use and to reduce the spread of disease. Harm reduction now refers to a package of treatment and disease control strategies that usually include best-practice interventions such as HIV testing and counselling, needle and syringe exchange programmes, drug dependence treatment such as opioid substitution therapy, condom distribution, prevention of mother-to-child transmission of HIV and STI treatment. Harm reduction packages also take into consideration strategies for effective service delivery, and developing a supportive policy environment that ensures equitable access to care, as well as assuring access to disease information through disease surveillance. This package of care needs to be adapted to the individual country particularly where resources or cultural attitudes might alter the effectiveness of particular harm reduction models.10

**Drug Use in Prisons in Afghanistan**

There is evidence in Afghanistan that there is a significant amount of drug use in its prisons. Some studies have described drug users who report previously using drugs in prison. For instance, a study in Kabul found 57% of male injecting drug users at an HIV Voluntary Counselling and Testing Centre had been in prison and that nearly one third of these had injected drugs whilst in prison.11 There have also been some studies in the prisons themselves which have highlighted the problem. A 2009 study in Pol-i-Charkhi prison estimated that there were 280 drug users within the prison population (approximately 4,500 inmates at the time) and nearly 14% of these were intravenous drug users.12 Again, it is worth noting that this approximation is likely to be an underestimation of the true scale of the problem; drug users are unlikely to accurately report their own drug use for fear of recourse to the authorities.

In general, there is a lack of evidence about the extent to which drugs are used in prisons throughout the country, and the extent to which the prisons are providing health and drug treatment services. To address this issue, the UNODC Penitentiary System Reform Programme commissioned a survey of 22 male prisons, one female prison (Kabul) and one female wing (Herat Prison) in Afghanistan. The aim of the survey is to highlight the current situation in prisons across the country and to provide the evidence to inform the delivery of effective drug treatment and harm reduction services within prisons. The results of the survey will also inform policy makers and donors about where focus should be placed in responding to addiction among the prison population.

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12 Ziaullah, S., Findings from a harm reduction survey carried out in Pul-i-Charkhi prison, Kabul, Sanaye Development Organisation June 2009
A pilot survey was carried out in Kandahar Prison, in 2010.13

Drug use in Kandahar Prison

- Over half of the respondents had tried drugs in their lifetime and 34% were current drug users in the prison.
- Opium and cannabis were the most commonly used drugs.
- There was no self-reported injecting drug use in Kandahar prison.
- 24% of respondents admitted to receiving a tattoo by injection and few were aware of a clean needle being used.
- Less than 5% of respondents admitted to male-to-male penetrative sexual intercourse whilst in custody but over 40% of the respondents refused to answer the question.
- None of the prisoners who used drugs at any time in their life reported receiving treatment whilst in the community.
- There is no structured treatment in place to treat the current drug users in Kandahar prison though a new harm reduction and HIV project has started in the prison since the survey was conducted.

The findings from the pilot survey suggest that drug use is a problem in prisons but it also hints at the difficulties in accessing information on drug use and associated risk behaviours due to stigma and fear of discrimination amongst the prisoners. The study highlights that risk behaviour such as using dirty needles to tattoo are prevalent in this prison, but there is little concrete evidence to indicate whether sexual risk behaviour amongst men is prevalent in this prison.

THE CRIMINAL JUSTICE SYSTEM AND PRISONS IN AFGHANISTAN

After years of war and instability, the formal criminal justice system suffers from many serious problems. Major work still needs to be done to develop a functioning criminal justice system and rule of law within the country. The penitentiary system itself is in need of a large overhaul in order to meet international standards. As such, work is ongoing to try and reform the whole justice system in Afghanistan, with international agencies and donor nations supporting the government to review the penal legislation and to improve the whole process from the judicial system through to the prisons.14

PRISON STRUCTURE AND POPULATION

There are 34 operational prisons and detention centres at central and provincial level and 203 active district detention centres in Afghanistan under the management and stewardship of Ministry of Justice Central Prisons Department. At the time of data collected in mid-2010, the prison population was approximately

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13 UNODC Drug Use Survey, Sarpoza Prison Kandahar, Afghanistan 2010
16,000 inmates.15 This includes roughly 4,000 detainees due to overcrowding at the district detention centres.16 A small percentage of these are women (about 400). Pol-i-Charki prison in Kabul is the largest prison with 5000 prisoners and the next largest prisons are in Herat, Kandahar and Nangarhar with over 1000 prisoners and detainees. As at November 2010, the total prison population stands at almost 19,000.17 The rest of the prisons have a population that varies from anything between less than 10 inmates and less than 500 inmates. The overall prison population has increased massively since 2002, placing a large amount of pressure on the prison infrastructure. There are reports of poor prison conditions as well as human rights abuses such as physical abuse, poorly trained staff and violations of both Afghan and international penal laws.18

**Female prisoners**

Women face a particularly difficult time in prison. Although the numbers are still small the number of female prisoners is on the increase, perhaps because of the increased emphasis on a formal justice system, rather than traditional justice routes.19 Women are often in prison for “moral crimes”. Women face extremely distressing conditions, for instance, many provincial prisons do not have separate female facilities. In prison the physical conditions and psychological distress affect their mental and physical health and they do not receive healthcare specific to their needs. Once they leave prison, they are often not able to return to their homes due to the shame on their family and community. Herat and Kabul have the only separate female facilities that stand apart from their male counterparts. These female facilities are infrastructural and operational models for the imprisonment of women who often have their dependent children with them.

**HEALTHCARE IN PRISONS IN AFGHANISTAN**

Until recently, health care in Afghanistan’s prisons has been neglected. It has lacked a formal system and had no linkages to national health services available in the country. This situation has lead to an almost total absence of primary care which should include preventative healthcare measures, such as basic hygiene education and awareness. Provision of curative services is also lacking, with few of the main prisons having any formal or regular contact with the health system through the Ministry of Public Health. Prior to 2009, the provision of health services in prisons was included in the mandate of the Ministry of Justice. However, in
2009, the MoJ and the MoPH entered a Memorandum of Understanding (MOU) to begin transitioning the responsibility for healthcare in prisons to the MoPH.

Since 2002, the MoPH has been implementing the Basic Package of Health Services (BPHS), to provide basic health care to all resident Afghans including prisoners. The BPHS is the national health system, free at the point of use and is largely funded by support of three main international donors – USAID, European Commission, and World Bank. The BPHS is the primary healthcare system and provides a range of preventative and curative services which ensures that each province has a minimum standard of healthcare, including primary and secondary level healthcare. The BPHS also includes mental health care and psychosocial counselling. The Prison Health Package guides the implementation of the BPHS in prisons. The BPHS is also connected to the Essential Programme of Hospital Services. The level of integration of drug treatment into the BPHS has not yet been fully defined, and a pilot programme is currently in operation in Kandahar Prison. Such health and social welfare services that do exist for the prison population are usually provided or supported by international organisations (e.g., UNODC and ICRC).

**STUDY RATIONALE:**

The study was conducted under the aegis of the United Nations Office on Drugs and Crime (UNODC), Country office for Afghanistan (UNODC COAFG). UNODC COAFG has previously conducted large scale drug use surveys (2005, 2010) in the general Afghan population. The results of these surveys indicated increasing drug use and dependency. However, there was no information about how prisons might be impacted although speculations could be made. The prevalence of drug use, dependency and their corresponding risk factors among the prison population was unknown. This report examines the vulnerable population of the prison population. A companion report on drug use amongst returning refugees and IDPs in Afghanistan has also recently been undertaken to examine drug use amongst this potentially vulnerable group.

The study recognises that the scope of drug use amongst the general Afghan population has been described in detail from previous UNODC reports (see reports from 2005 and 2010), but that inferences and comparisons with specific vulnerable groups are hard to make. This study aims to provide information on the drug use situation amongst prisoners in Afghanistan’s provincial prisons, and examine the access to services which may or may not be available to this vulnerable group.
METHODS

OVERVIEW OF METHODS:

The purpose of the study is to assess the type and level of drug use amongst prisoners in twenty-two male, one female and one female wing (23 facilities in total) from amongst Afghanistan’s 34 provincial prisons. The study also examined the type and level of other risk behaviours practised in prisons and the perceptions of prison staff towards drug use and risk behaviours. The service provision for drug treatment and harm reduction was examined in order to understand what gaps there are in this service.

Three pre-tested and standardised methods were used to survey the prisons; a questionnaire survey of prisoners, focus group discussions with prison staff and prisoners, and a “Prison Audit Tool” which examined the current structure of the services available.

Data was collected by teams of experienced field surveyors who were given access to the prison by prison commanders with permission from the director Central Prisons Department of the Ministry of Justice. Prisoners were screened for the inclusion and exclusion criteria and then randomly selected from the list of current prisoners. Following the receipt of signed informed consent from participants; interviews were conducted in a private space without the presence of prison staff. Focus groups were conducted in a sub-selection of prisons to represent those with high, medium and low occupancy. The prison audit tool was employed in all 22 male prisons, one female prison and one female wing (in Herat Prison). The target sample size for the interview survey was 1,100 male prisoners, and 120 female prisoners. Focus groups were conducted in prisoners at three male and one female facility and amongst prison staff at three male facilities, with groups of size 5-7 participants.

Data was collected on paper pro-forma sheets, cross checked daily by project supervisors and then transported to Kabul for data entry. Data was entered into specially designed databases, and then analysed using statistical analysis software.
**STUDY OBJECTIVES:**

The individual study objectives were:

- To evaluate the extent of drug use and associated high risk behaviours across the adult male and female prison population in Afghanistan in order to accurately inform subsequent treatment and harm reduction intervention planning in prisons and community in the form of prison aftercare:
- Assess the extent of offenders drug use and high-risk behaviours through the development and execution of appropriate quantitative and qualitative research methods in order to collect relevant information relating to drug use / drug related health / drug related risk behaviours: and
- Assess current prison based treatment and harm reduction service provision in custodial settings.

**PRISONER INTERVIEWS:**

Male prisoners were selected from the 22 provinces to cover the main geographical areas in Afghanistan. A total sample size for the questionnaires was $1/10^{th}$ of the country’s prison population and the sample within each prison was based on the proportion of prisoners in each provincial prison.

A total sample size of ~1100 people were selected, in proportion to the number of prisoners in each provincial prison, using a sampling frame outlined in table 1.

**Table 1: Sample selection from the 22 selected prisons (does not include the 2 female prisons).**

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Total Inmates</th>
<th>Proportion of total (%)</th>
<th>Number of interviews to be conducted</th>
<th>Number of interview hours</th>
<th>Number interview days</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kabul Detention</td>
<td>402</td>
<td>3.0</td>
<td>33.0</td>
<td>16.5</td>
<td>2.8</td>
<td>C</td>
</tr>
<tr>
<td>Pol-i-Charkhi Central Prison</td>
<td>4,389</td>
<td>32.8</td>
<td>360.3</td>
<td>180.1</td>
<td>30.0</td>
<td>C</td>
</tr>
<tr>
<td>Parwan Zone Central</td>
<td>283</td>
<td>2.1</td>
<td>23.2</td>
<td>11.6</td>
<td>1.9</td>
<td>C</td>
</tr>
<tr>
<td>Bamyan</td>
<td>129</td>
<td>1.0</td>
<td>10.6</td>
<td>5.3</td>
<td>0.9</td>
<td>C</td>
</tr>
<tr>
<td>Nangarhar Zone (East)</td>
<td>992</td>
<td>7.4</td>
<td>81.4</td>
<td>40.7</td>
<td>6.8</td>
<td>E</td>
</tr>
<tr>
<td>Laghman</td>
<td>162</td>
<td>1.2</td>
<td>13.3</td>
<td>6.6</td>
<td>1.1</td>
<td>E</td>
</tr>
<tr>
<td>Kunar</td>
<td>78</td>
<td>0.6</td>
<td>6.4</td>
<td>3.2</td>
<td>0.5</td>
<td>E</td>
</tr>
<tr>
<td>Balkh Zone (North)</td>
<td>540</td>
<td>4.0</td>
<td>44.3</td>
<td>22.2</td>
<td>3.7</td>
<td>N</td>
</tr>
<tr>
<td>Faryab</td>
<td>378</td>
<td>2.8</td>
<td>31.0</td>
<td>15.5</td>
<td>2.6</td>
<td>N</td>
</tr>
<tr>
<td>Jouzjan</td>
<td>613</td>
<td>4.6</td>
<td>50.3</td>
<td>25.2</td>
<td>4.2</td>
<td>N</td>
</tr>
<tr>
<td>Kunduz Zone (Northeast)</td>
<td>501</td>
<td>3.7</td>
<td>41.1</td>
<td>20.6</td>
<td>3.4</td>
<td>N</td>
</tr>
</tbody>
</table>
Most prisoners in Afghanistan are male, so the female prisoners were selected using a separate sample size. Approximately 25% of the total female prison population, 120 inmates, were interviewed as shown in Table 2 below. Over half of the female prison population resides in Kabul and Herat so interviews were conducted in these two prisons.

Table 2: Sample selection amongst the two women’s prisons.

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Total Inmates</th>
<th>Proportion of total (%)</th>
<th>Number of interviews to be conducted</th>
<th>Number of interview hours</th>
<th>Number interview days</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFPDC</td>
<td>130</td>
<td>56.0</td>
<td>67.2</td>
<td>33.6</td>
<td>5.6</td>
<td>C</td>
</tr>
<tr>
<td>Herat Zone (West) هرات</td>
<td>102</td>
<td>44.0</td>
<td>52.8</td>
<td>26.4</td>
<td>4.4</td>
<td>W</td>
</tr>
<tr>
<td>Sub Total</td>
<td>232</td>
<td>120</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Selection criteria:**

Participants, both male and female, were included if they matched the following inclusion criteria:

- Listed in the current prison population (i.e. not in detention awaiting trial)
- Been in prison for more than 3 months
- Be willing to participate and give informed consent

The following exclusion criteria were also applied in order to ensure safety and ethical approaches to the research:

- Prisoners deemed to be dangerous or a threat to study staff (or themselves)
- Those convicted of terrorism crimes or crimes related to the ongoing armed conflict
• Foreign prisoners
• Incompetent or otherwise deemed unable to give informed consent

**Selection of Subjects:**

A complete list of prisoners was provided by each prison and reviewed to match criteria for selection (as above). Those individuals who remained on the list of prisoners were included on a selection list. The selection list was then assigned sequential numbers up to the total of the eligible population. Sequence numbers were then randomly generated using MS Excel to provide a sample of 10% of the total list, matching the overall sampling structure (table 1).

Each selected participant on the list was brought to the interview room. Selected participants were then screened a second time for the selection criteria and if eligible were asked to provide informed consent. Once informed consent was received, the interviewer commenced the interview. If a participant was ineligible for participation based on the inclusion/exclusion criteria (including refusal of informed consent), the next prisoner on the list was selected. The process continued until the required sample size for the prison was reached.

**Questionnaire Tool:**

The questionnaire tool was developed by UNODC COAFC and UNODC Office in Vienna and was piloted, pre-tested and validated for use prior to the survey in Kandahar Prison (see separate report by UNODC). The questionnaire consisted of 231 questions, divided into 8 sections. These sections covered:

- **Section A – Background Information**
  Demographic details; penal status; employment and accommodation status before prison
- **Section B – Drug use**
  Knowledge of people using drugs; type of use and impact of drug use if a user of opium, heroin, hashish, tranquilizers, opiates, alcohol, cocaine, amphetamines, inhalants and insolvents or a combination of drugs
- **Section C – Drug-injecting and risk behaviour**
  Injecting drug use; sharing needles; tattooing
- **Section D – Blood borne and other infections**
HIV, Hepatitis C, Tuberculosis testing; knowledge and attitudes towards HIV and other blood borne infections, knowledge and attitudes towards treatment and testing for blood borne infections in prison setting

- **Section F – Sexual behaviour**
  Sexual behaviour in prison

- **Section G – Health and treatment**
  Self-rating of health; drug treatment services in prison

- **Section H – Drugs and Crime**
  Current penal status and criminal history

**QUALITATIVE/component – Focus Groups:**

**Focus Groups with Prison Staff**

Prison officers and medical staff were interviewed using focus group discussion techniques. These were conducted in small groups within the prisons (male and female with a maximum group size of 5). The focus groups were conducted in one small prison (bottom 33%), one medium sized prison (middle 33%), and two from larger prisons (top 33%).

The topic guide for the FGD consisted of three main topics, including:

- **Drug use**
  Perception of drug use in the prison; type of drugs used; patterns of use; understanding of withdrawal symptoms

- **Risk behaviours**
  Injecting drug use and other types of drug use; sharing needles; men who have sex with men (MSM), awareness of blood borne infections; training in blood borne disease awareness and prevention

- **Drug treatment and harm reduction service delivery**
  Drug treatment and harm reduction services available in prison; understanding of need for prevention programmes; recommendations for improvements and new services; policies in place for drug treatment and control of blood borne infections; understanding of drug law; knowledge of community support for discharged drug users; quality of health care in prisons (staffing levels, equipment available, voluntary HIV testing)

**Focus Groups with Prisoners**

Prisoners were interviewed using focus group discussion techniques to discuss drug use in prisons. The discussion groups were located in the prison, one in a small prison, (bottom 33%), one in a medium sized
prison (middle 33%) and two from larger prisons (top 33%). One of the focus groups was with female prisoners.

The prisoners were asked to discuss similar topics to the prison staff in order to compare their responses. The topic guide for the FGD consisted of three main topics, including:

- **Drug use**
  Perception of drug use in the prison; type of drugs used; patterns of use

- **Risk behaviours**
  Injecting drug use and other types of drug use; sharing needles; men who have sex with men (MSM); awareness of blood borne infections

- **Drug treatment and harm reduction service delivery**
  Drug treatment and harm reduction services available in prison; recommendations for improvements and new services; understanding of need for drug treatment in prisons; understanding of drug law; knowledge of community support for discharged drug users

**Prison Audit Tool:**

The review of the health service provision in prisons was carried out in all 22 prisons. Key staff within the prison, such as the prison commander and prison staff with responsibilities that included health were interviewed using a structured audit checklist.

Prison commanders, staff, representatives from the Ministry of Justice Central Prison Department and Ministry of Public Health Prison Health Department were interviewed to ascertain existing treatment and harm reduction service delivery in each facility. This provided a needs assessment for the provision of a package of services aimed at providing treatment and harm reduction services within prisons.

The prison audit tool recorded details of prison services available. The tool consisted of seven sections, covering:

- **Section 1 – Strategic Management**
  Prison strategies for drug treatment, HR and Prison Health Strategy (PHS)
  Communication strategies for drug treatment and harm reduction
  Personnel involved with drug treatment and HR strategy
  Reports on drug treatment and HR strategy
  Local information sharing across all agencies

- **Section 2 – Blood-borne Virus (BBV) Infections and MSM**
  Access to specialist services
  Access to HR equipment
  Access to counselling and advice
Testing for blood-borne infections
Knowledge of community services with BBV services
Awareness of MSM

- **Section 3 – Needle Exchange**
  Access to needle exchange equipment
  Access to information on HR community services
  Strategies in place for reducing drug-related litter in prisons

- **Section 4 – Preventing Drug Related Deaths**
  Information campaigns on preventing drug-related deaths
  Discharge protocols in place
  Local training provided on overdose prevention
  Prison protocols for drug overdose
  Medical equipment available in prison for drug overdose
  Access to Opiate Substitution Therapy (OST)
  Recording of drug-related deaths and inquiries into deaths

- **Section 5 – Drug Treatment**
  Screening and assessment process
  Detoxification services
  Counselling services and relapse prevention services
  Other treatment services and advice
  Information on drug treatment services in the community

- **Section 6 – Workforce**
  Staffing of drug treatment and HR services and/or generic health services
  Training, knowledge and skills of staff on health risk assessments, treatment, HR and prevention of drug-related deaths
  Staff access to HBV immunisation and Post-Exposure Prophylaxis (PEP)

- **Section 7 – General Health Care**
  Availability of relapse prevention and BBV education in generic treatment programme
  Individual care plans for primary healthcare needs, drug-related and BBV treatment needs
  Dental health referral mechanisms
  Sexual health promotion, screening and materials available
  Mental health provision

**DATA QUALITY AND MANAGEMENT:**

Detailed Standard Operating Procedures (SOPs) were developed and translated. All surveyors were selected based on prior experience in conducting surveys. All surveyors were local to their regions. The surveyors attended two training workshops in Kabul. The first gave them the full overview of the project, tools, and procedures, including training in the SOPs. This training covered all aspects of the survey, including the approach to the prison, participant selection, consent, form filling, and cross checking. The second training
was conducted following delays in implementation due to delay in receiving permission letters and served as a refresher to the earlier training.

Surveyors were supervised by monitors who observed some of the interviews and also examined the questionnaires and topic guides following completion. Data collected on paper forms was stored in individual packages and sent to Kabul for further processing. Data was then translated and entered into MS Excel databases used for analysis.

ETHICS AND APPROVALS STATEMENT:

The study was reviewed and approved by the Institutional Review Board of the Ministry of Public Health, Islamic Republic of Afghanistan. It was also reviewed and approved by the Central Prison Department of the Ministry of Justice, who gave their permission to access the sites, staff and inmates of Afghanistan’s prisons. All participants (including prison staff) gave voluntary informed consent to participate. Because of the subject matter of the survey, all interviews with prisoners were conducted in private space outside the earshot of prison staff. Participants were informed that it was voluntary and their identity could not be ascertained and would not be disclosed. They were also advised that they could refuse to answer any individual question and to terminate the interview at their own discretion.
RESULTS

PRISONER SURVEY

SAMPLE CHARACTERISTICS:

A total of 1,225 individuals in 24 provincial prisons were selected for the survey, which approximates to around 10% of the total Afghan prison population. The number selected in each prison was in proportion to the total prison population, reflecting some prisons (e.g. Pol-i-Charkhi, Kabul) which had a high number of participants, whilst smaller prisons (e.g. Kunar) had a small number.

Most of the sample were male (89%) representing the sample conducted in male prisons, and 10% of the sample being from female prisons. The mean age of the sample was 33 years (inter-quartile range: 24-39 years). Five minors (aged 15-17) were also included in the study. Most of the sample (58%) had no education, and of the remainder 17% had only completed primary school. Only 19% had completed a secondary or high school education.

Most of the participants (89%) were currently serving their sentences with the remainder on remand and awaiting sentence. Length of stay prior to the interview is illustrated in figure 1. Reasons for imprisonment varied greatly with 356 (29%) serving sentences for using (n=109) or supplying drugs (n=247) and one for cultivating drugs. Of the female prisoners (n=123), 36 were in prison for “prostitution” and 24 for “escaping from home”.

![Figure 1: Length of stay in prison (% of the sample in each group)](image)
**Drug Use in Prison:**

The proportion of respondents who self-reported use of different drugs is illustrated in figure 2. Hashish was the most frequently used drug (17%) with opium also at relatively high levels (14%). For comparison, these figures are in the same realm as the usage of the general Afghan population\(^{20}\), and the population of another vulnerable population, those who are returned refugees\(^{21}\).

Amongst the sample, an appreciable proportion had used these drugs in the last year and last month (figure 2). For example, around 10% of respondents reported using opium in the last year and 5% in the last month; and around 12% reported using cannabis in the last year and 6% in the last month.

![Figure 2: History of drug use in the prison sample, detailing “ever use”, use in the 12 months prior to the survey and use in the month prior to the survey.](image)

Amongst those who reported ever using any of these drugs, the majority had used in the last year (figure 2). Amongst those who reported use in the last year, around 50% report that they have used in the last month;

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\(^{20}\) UNODC: Drug use in Afghanistan

\(^{21}\) HPRO: Drug use in returnees.
drugs are certainly available in prison – almost all the prisoners had been imprisoned for more than 6 months.

Most of those who reported ever using drugs did not have their first use in prison. Opium was predominantly started in Iran, while cannabis was predominantly started in Afghanistan. Heroin first use was equally likely in Afghanistan and Iran. Pakistan did not feature highly in this analysis.

![Figure 3: Place of commencement of drug use amongst those who had ever used drugs, by drug type.](image)

Age group was not related to drug use history – there was no difference in the frequency of one-month or one-year drug use between age groups. There were associations between drug use and gender. In the female prison population, use of opium in the last month was more frequently reported by females (12/118, 10.2%) than males (52/1072, 4.9%). Use of heroin in the last year was more frequently reported by male prisoners (93/1101, 8.5%) than female prisoners (4/122, 3.3%), but there was no difference in the reported use of heroin in the last month, both being close to 3.5%. Amongst female prisoners, none reported hashish use in the last year or the last month.

Length of stay in prison was related to drug use history (Table 3). Those who had been incarcerated for more than 5 years were more likely to have used opium, heroin and hashish in the previous year and in the
previous month. There was also a hint of this relationship with tranquillisers, opioid painkillers, alcohol and cocaine\textsuperscript{22}, although the number of users in each group is too low to draw a firm conclusion.

<table>
<thead>
<tr>
<th>Length of Stay:</th>
<th>% with a history of use in the last year</th>
<th>% with a history of use in the last month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1 year (n=461)</td>
<td>1-5 years (n=623)</td>
</tr>
<tr>
<td>Opium</td>
<td>11.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Heroin</td>
<td>11.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Hashish</td>
<td>12.1</td>
<td>9.3</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>4.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Opioid Painkillers</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.5</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Table 3: Relationship between drug use in year before or month before the survey and length of stay in prison.

Use of opium, heroin and hashish in the last year was common (>10% of the sample) amongst those whose stay had been less than one year, probably because this reflected their use prior to imprisonment. Use of these drugs in the last month was markedly lower, suggesting a restriction of access once they begin their time in prison.

The pattern of use in those with the longest length of stay may reflect a hierarchy of inmates in prison with the longer serving prisoners having greater access to contraband goods, whether through wealth or influence. It could also reflect a greater degree of response to the question amongst this group which may have been more forthcoming with their answers. Either way, drug use in prison appears to be a persistent problem.

**Drug Use and Location and Type of Prison:**

Reported drug use differed by region, with the West and South Regions of the country having higher rates of drug use than other areas. The West region prisons report the highest use of opium and heroin, but the South region also reports considerable use of these two drugs although more frequent use of cannabis as well.

\textsuperscript{22} It is unknown whether this is genuinely cocaine, or (perhaps more likely) a colloquial term for white heroin.
Reported drug use also differed by prison size with drug use being more frequent in prisons with between 100 and 500 prisoners than either very small prisons (with 0-100 inmates) or larger prisons (with population greater than 500) (figure 5). Because these are based on proportions, the true number of users may still be higher in the larger prisons because of their high populations. The relationship between prison size and drug use frequency remains the same regardless of region.
**Frequency of Use and Use of More than One Drug:**

Drug use in the month before the interview was self-reported by the participants, with 5.4% reporting opium use, 3.7% reporting heroin use, and 5.9% reporting use of hashish in the last month (figure 2). Amongst those who had used the drugs in the last month, use was frequent, with more than 80% of users reporting that they use their drugs “about every day”, regardless of drug type. Use of multiple drugs was evident amongst the sample, with 12/61 (19.6%) of opium users also reporting using heroin.

**Injecting Drug Use:**

Injecting drug use in the last year was reported by 15.3% of opium users, and 19.6% of heroin users. This was higher amongst those who had used in the last month, with 21.9% reporting injecting opium and 26.7% reporting injecting heroin in the last year. The figure of 26.7% IDU amongst heroin users is comparable to the proportion of heroin users in the returnee population who report injecting drugs (27%)\(^2\).

These figures did not triangulate well with the specific questions on injecting drug use and risk behaviour, where only 15/1,225 (1.2%) of the sample reporting injecting drug use so the picture is somewhat cloudy.

However there is evidence of injecting drug use in prison, and this could be up to 20-30% of those who regularly use heroin or opium. There was also evidence of injecting equipment sharing – six respondents reported having shared a needle/syringe with another person and a single respondent reported this happening while in prison.

**Cost of Drugs:**

Respondents who used drugs in the last month were asked to provide information on price for a daily “fix” of each drug. Most (>80%) of those who used drugs in the last month reported that they used them every day. The mean cost of a daily dose of opium was AFA 200 (approx USD 4.4); AFA 250 (USD 5.5) for heroin, and AFA 80 (USD 2.0) for hashish.

**Population Projections:**

The estimates for monthly use of opium and heroin have been used to make projections for the estimated number of regular drug users within the prison population. A measurement error (the 95% confidence

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\(^2\) HPRO: UNODC report.
interval) was applied to the proportions who reported use of either opium or heroin in the last month to provide an upper and lower estimate of the total number of regular users (Table 4).

There are up to 930 regular opium users in the provincial prison system, and up to 700 regular heroin users. Amongst these groups, injecting drug use was reported by around 20% of opium users (suggesting around 180 in total) and by 27% of heroin users (suggesting around 190 in total).

Around 80% of those who reported use of heroin or opium in the last month used these drugs on a daily basis. The average price of a daily dose of opium was given as 4.4 USD, suggesting an annual market for opium worth in the region of USD 1.5 million within the inmate population. The average price of a daily heroin dose was given as USD 5.5, suggesting an annual market for heroin worth in the region of USD 1.4 million within the inmate population. Not including the sale of other drugs and contraband, this is a considerable incentive for smuggling of contraband – a market for opium and heroin worth in the region of USD 2.9 million per year.

Other studies on drug use have reported evidence of reporting bias leading to an underestimate of drug use in the population. This is attributed to the subject matter of the questionnaire, which would tend to result in under reporting. This effect is likely to be as valid in the present study as in studies in other populations; prisoners are likely to be reticent to admit illegal acts for fear of self-incrimination or possible ramifications from other prisoners. It seems likely, therefore that the estimates set forth in this report are underestimates. It is impossible to say how much of an underestimate there is, but anecdotal reports based on the focus group discussions suggest that drug use is even more widespread than this data suggests (see next section).
### Table 4: Projected total number of opium and heroin users in Afghanistan’s prison population based on self-reported use in the survey

<table>
<thead>
<tr>
<th>Total Prison Population(1)</th>
<th>Opium 1 month users (%) (2)</th>
<th>Projected number of “1 month users” (4)</th>
<th>Heroin 1 month users (%) (2)</th>
<th>Projected number of “1 month users” (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Middle</td>
<td>Upper (3)</td>
<td>Lower</td>
</tr>
<tr>
<td>All prisons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td>5.4</td>
<td>6.7</td>
<td>570</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.8</td>
<td>3.6</td>
<td>6.1</td>
<td>644</td>
</tr>
<tr>
<td>Female</td>
<td>4.6</td>
<td>10.1</td>
<td>15.7</td>
<td>22</td>
</tr>
<tr>
<td>Prison Size:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-100 inmates</td>
<td>0</td>
<td>2.8</td>
<td>8.7</td>
<td>0</td>
</tr>
<tr>
<td>100-500 inmates</td>
<td>6.1</td>
<td>9</td>
<td>11.8</td>
<td>208</td>
</tr>
<tr>
<td>500-1000 inmates</td>
<td>2.8</td>
<td>5.7</td>
<td>8.7</td>
<td>85</td>
</tr>
<tr>
<td>&gt;1000 inmates</td>
<td>1.2</td>
<td>2.5</td>
<td>3.9</td>
<td>81</td>
</tr>
<tr>
<td>Region:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>3.1</td>
<td>5</td>
<td>7</td>
<td>180</td>
</tr>
<tr>
<td>East</td>
<td>0</td>
<td>3</td>
<td>6.4</td>
<td>0</td>
</tr>
<tr>
<td>North</td>
<td>1.2</td>
<td>3.4</td>
<td>5.7</td>
<td>34</td>
</tr>
<tr>
<td>South</td>
<td>1.2</td>
<td>5.8</td>
<td>10.4</td>
<td>21</td>
</tr>
<tr>
<td>West</td>
<td>5.4</td>
<td>9.1</td>
<td>12.9</td>
<td>122</td>
</tr>
</tbody>
</table>

**NOTES:**

(1) From Central Prisons Department, November 2010.
(2) Proportion of respondents who reported use of opium or heroin in the month prior to the interview
(3) Lower and upper estimates are the 95% confidence interval for the sample estimate
(4) Estimates extrapolated from sample estimates.
**OTHER HIV RISKS:**

**Tattooing:**

Tattooing while in prison worldwide is reportedly a common practice and is reportedly no different in Afghan prisons. This practice makes use of a sharp implement (needle, pin or similar) which is used to puncture tattoo ink (henna, or other forms of rudimentary dye) under the skin. As such, it represents a potential source of transmission of blood borne infection, (e.g. HIV or hepatitis).

Around 10% of respondents reported having a tattoo in prison. This proportion is higher amongst those who reported use of opium in the last month (19% vs. 9%), but not amongst those who used heroin. The tattoo was given with a new needle in 90% of those who had had a tattoo, according to respondents.

**Sexual Behaviour:**

Few of the respondents reported having penetrative sexual intercourse while in prison - only 14/1,224 (1.1%) responded affirmatively. There were more individuals who refused to answer the question (93 respondents, 7.6%). The very low reporting rate is likely to reflect under reporting because of the stigma associated with sexual acts of this type. It is worth emphasising that the question posed was specifically worded for the act of “penetrative sexual intercourse”. Non-penetrative sexual acts are not included in this definition, and there may also be some responder confusion over the term. Even with the specific or confusing nature of the question, this estimate seems implausibly low.

Of those 14 individuals who reported sexual intercourse, five reported multiple partners (>1) in the past month and seven of the individuals reported never using a condom. Two respondents also reported use of heroin in the last month.

Few firm conclusions can be drawn from this limited response, but the responses suggest than sexual risk factors for HIV (i.e. unprotected penetrative sexual contact with multiple partners, including drug users) are evident amongst the prison population.

**ACCESS TO PREVENTATIVE AND HEALTH SERVICES:**

The survey examined some aspects of access to services which are used for harm reduction and HIV prevention, as well as the general health system available in prisons.
**HIV testing:**

Of 878 respondents, 21% reported having had an HIV test. A higher proportion those who reported using opium in the last month had had an HIV test than non-users, but there were few heroin users who responded to the question.

Amongst those who had had an HIV test, >90% had had it in the last two years (2008-2010) reflecting the increase in HIV testing service availability in prisons provided by a variety of donors and partners. In 2009-10 (1388), 11 out of 23 prisons had prisoners who had an HIV test. 89% of those tested said that they had been tested within the prison.

This data suggests that HIV testing has recently become available for prisoners although it is not clear under what circumstances these tests are performed or by whom. Of 179 respondents, 5 (2.7%) reported that they were given a positive test result.

Hepatitis testing was reported by 15.7% of the respondents and a TB test was reported by 11.1% and again, most of these tests were performed in the prison in the last two years.

**HIV/AIDS Knowledge and Attitudes:**

Forty-three percent (536/1224) of respondents had heard of HIV. This proportion was lower amongst those who reported opium or heroin use in the last month. A series of knowledge questions about HIV were asked of the respondents, and their answers are detailed below:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Don’t know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can people protect themselves from HIV by using a condom correctly every time they have sex?</td>
<td>49%</td>
<td>9%</td>
<td>42%</td>
</tr>
<tr>
<td>Can people protect themselves from HIV by having one uninfected faithful sex partner?</td>
<td>73%</td>
<td>7%</td>
<td>20%</td>
</tr>
<tr>
<td>Can people protect themselves from HIV by abstaining from sexual intercourse?</td>
<td>66%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>Can a person get HIV by sharing a meal with someone who is infected?</td>
<td>33%</td>
<td>42%</td>
<td>25%</td>
</tr>
<tr>
<td>Can a person get HIV by getting injections with a needle that was already used by someone else?</td>
<td>74%</td>
<td>7%</td>
<td>19%</td>
</tr>
<tr>
<td>Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?</td>
<td>35%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?</td>
<td>59%</td>
<td>10%</td>
<td>31%</td>
</tr>
<tr>
<td>Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?</td>
<td>60%</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>
breastfeeding?
Can a person get HIV by drinking from the glass of someone who is infected? 39% 34% 27%
Can a person get HIV by kissing someone who is infected? 39% 35% 26%
Can a person get HIV from mosquito bites? 51% 22% 27%
Can someone get HIV by injecting drugs with a needle/syringe that has been used by someone else? 76% 3% 21%
Can someone get HIV by using a spoon, or filter or water when injecting has been used by someone else? 48% 24% 28%
Can someone get HIV by shaving with the razor blade of someone who is infected? 77% 4% 20%
Can someone get HIV by having a tattoo with a needle that has been used by someone else? 78% 2% 19%

General level of knowledge of HIV was poor, with only 42% having heard of HIV. Amongst those who had heard of the disease, detailed knowledge was mixed. Most recognised the risk of injecting drug use for transmission of HIV, but only 50% responded that a condom should be used to prevent HIV. There is a need for greater available of clear information amongst prisoners.

A series of questions on prevention of HIV transmission were put to respondents, whose answers are summarised below (total number of respondents was 552):

Questionnaire, section D10: “People can do different things to try to protect themselves from getting HIV, which of the following do you think is effective or ineffective:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Effective</th>
<th>Ineffective</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>To wash yourself after having sex</td>
<td>76%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>To have sex with only one partner</td>
<td>88%</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>To use a condom</td>
<td>65%</td>
<td>9%</td>
<td>26%</td>
</tr>
<tr>
<td>To use contraceptive pills</td>
<td>56%</td>
<td>14%</td>
<td>30%</td>
</tr>
<tr>
<td>To have an HIV blood test regularly</td>
<td>89%</td>
<td>1%</td>
<td>10%</td>
</tr>
</tbody>
</table>

More respondents wrongly thought that post-sex washing was a preventative measure for HIV than correctly thought that using a condom was a preventative measure. The majority also correctly thought that maintaining one regular sexual partner was a suitable prevention method.

A series of questions were asked to assess prisoners' general attitudes towards HIV and they were asked to signal their agreement or disagreement with a series of statements. Responses are summarised below:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>An inmate with HIV should not be allowed to take part in sports activities</td>
<td>49%</td>
<td>41%</td>
<td>10%</td>
</tr>
<tr>
<td>in prison.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An inmate with HIV should not be allowed to prepare/cook food in prison.</td>
<td>57%</td>
<td>33%</td>
<td>10%</td>
</tr>
</tbody>
</table>
An inmate with HIV should not be allowed to take part in general work activities in prison. | 50% | 41% | 9%  
Inmates with HIV should be housed in a separate building away from the rest of the prisoners. | 76% | 17% | 7%  
HIV positive inmates should be treated the same way as other prisoners | 81% | 12% | 7%  
HIV positive inmates need medical assistance and general support | 90% | 4% | 6%  
The guards should be informed about inmates’ HIV status | 90% | 4% | 6%  
It is too risky for a non-infected prisoner to share a cell with an HIV positive inmate. | 80% | 11% | 9%  

Significant and unjustified stigmatisation was evident in the sample with the majority of respondents agreeing to restrictions on HIV infected individuals, for example, 76% agreed that HIV infected inmates should be separately housed, and 80% that it was too risky to share a cell with an HIV infected person. However, the overwhelming majority also felt that HIV infected individuals need medical assistance.

Finally, a series of statements about strategies to improve the healthcare situation with regard to drug use and prevention of HIV were put to the respondents. Respondents were asked to signal their agreement or disagreement with each statement:

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>
| Provide long-term visiting rooms for conjugal visits | 80% | 11% | 9%  
| Make condoms available in the long-term visiting rooms for conjugal visits | 45% | 27% | 29%  
| Make condoms easily available for the inmates in the prison | 38% | 32% | 30%  
| Make sterile syringes and needles available for the prisoners injecting drugs | 49% | 40% | 11%  
| Provide sterile needles for tattooing | 49% | 39% | 12%  
| Provide the prisoners with information/educational materials (leaflets, booklets) on HIV/AIDS and Hepatitis B/C prevention, risky behaviour, safe sex etc. | 82% | 3% | 14%  
| Train educators among the prisoners to disseminate information on HIV/AIDS and Hepatitis B/C prevention | 84% | 2% | 14%  
| Train educators among the prisoners to provide information on prevention of drug use | 85% | 2% | 13%  
| Systematically test inmates for HIV | 86% | 1% | 12%  
| Systematically test inmates for Hepatitis B/C | 87% | 1% | 11%  
| Systematically test inmates for drug use | 88% | 1% | 11%  
| Provide prison staff with information on infectious diseases | 88% | 2% | 10%  
| Vaccinate inmates against Hepatitis B | 89% | 1% | 10%  
| Vaccinate prison staff against Hepatitis B | 90% | 1% | 9%  
| Provide drug dependence treatment to prison inmates with drug problems | 92% | 1% | 7%  
| Provide counselling and other psycho-social support to inmates with drug problems | 91% | 1% | 8%  

HRPO Report: A national evaluation of drug use and associated high-risk behaviour across the prison population in Afghanistan
Most respondents agreed to provision of visiting rooms, and greater education, testing, vaccination and treatment for drug addiction in the prison. Less than half of inmates agreed that condoms, needles and syringes or sterile tattooing needles should be made more freely available within the prisons.

Most respondents agreed that they would like to be tested for HIV, TB and hepatitis (85%).

RESULTS FROM PRISON STAFF FOCUS GROUPS

Focus groups were conducted in each region to assess the knowledge, attitudes and thoughts of prison staff regarding drug use. Responses were evaluated by the principle researchers and analysed for thematic trends, for example on drug use in prison, types of drugs used, etc. The primary data is summarised in a series of statements which are detailed below.

Four focus groups were conducted with prison staff, in Bamyan, Farah, Herat and Nangarhar with a group size of between 4 and 7 consisting of prison officers and health staff of the prisons (health workers). The FGDs were conducted by trained surveyors who used a topic guide. Due to the sensitivity of the topic, and in an attempt to induce the participants to react freely and openly to the questions, no additional information on positions or demographic factors was collected.

The results presented in this section were recorded during the FGDs and therefore represent the opinions of the respondents, as recorded by the surveyors.

COMMENTS ON DRUG USERS IN PRISON:

Bamyan
There is no reported drug use inside the prison.

Farah
Drug use is prevalent in prison. The drugs are supplied by the drug mafia and they are smuggled into the prison via products such as oil, shampoo, and food cans.
Herat
60% of prisoners are drug users and it is widespread in general society as well. Immigration has lead to an increase in drug use, but in Herat [general population, as opposed to the inmate population], drug use is less than in other provinces. The staff also identified poverty, unemployment, illiteracy and war as the cause of drug addiction. The drugs are smuggled into the prison through the relatives and the drugs are found in the prisoners’ cells. All drug users are put into a separate block.

Nangarhar
There is no reported drug use in this prison as the prisoners cannot use drugs here [editors comment – this is an example of denial by the prison staff – contrary reports were evident in the drug user survey and in the following focus group].

**COMMENTS ON THE TYPES OF DRUGS USED**

Farah
Opiates, hashish, pills and heroin are used in prison. The prisoners use the drugs alone. The drugs are smoked, injected and taken orally.

Herat
Opiates are very common because it is possible to take orally and to get it in the prison. It is unlikely that the prisoners take the drugs in groups because it is forbidden by the prison.

**RISK BEHAVIOURS WITHIN PRISONS:**

Bamyan
There is no reported drug use in this prison.

Farah
The prison staff has observed prisoners injecting drugs and they have seen the signs on the prisoners’ hands/arms. They are not aware where the needles and syringes come from.

Herat
There is no [reported] smoking or injecting of drugs in the prison.

Nangarhar
Prisoners [reportedly] cannot obtain injecting equipment or drugs in the prison.
**BLOOD-BORNE VIRUSES**

**Bamyan**
Staff is unaware of HIV/AIDS and they state that MSM does not occur in this prison.

**Farah**
Staff is aware of HIV/AIDS and that it can be spread through injecting. There are no HIV tests in the prison. The staff is not aware of MSM in the prison. HIV can be prevented if there are the proper resources available.

**Herat**
Staff is aware of HIV/AIDS and HIV can be spread through injecting and sharing needles. Surgical procedures may also spread HIV. Other transmission routes include sexual relations and using prostitutes. They are not aware of MSM in this prison. World Vision provides some treatment services for prisoners and confidential HIV tests are available for prisoners.

**Nangarhar**
Staff is aware of HIV but they state that MSM does not occur in the prison. HIV tests have been done in the past. There is no treatment available for BBVs.

**WITHDRAWAL FROM DRUG USE**

**Bamyan**
Symptoms include yawning, sleeping more than usual and “low morality”.

**Farah**
Symptoms include pain, itching, abdominal pain, vomiting.

**Herat**
Prisoners are provided with advice and information. They are given cold water treatment and put into isolation.

**MOTIVATIONS OF PRISONERS TO CHANGE THEIR DRUG ABUSE BEHAVIOUR**

**Bamyan**
There is no reported drug use in this prison.

**Farah**
They are motivated but sometimes it is difficult to motivate the prisoners because they are criminals. However, there is nothing available for the prisoners to help them change their behaviour – no doctor, medicines or other resources.
Herat
The drug users, the prison staff and the families are motivated to reduce drug use. There is a lack of resources to tackle drug use, but it is difficult for drug users to take drugs in prison anyway.

Nangarhar
The drug users are cooperative and willing to give up the use of drugs.

SERVICES AND FACILITIES IN THE PRISON

Bamyan
There is a lack of basic health care facilities in the prison. The prison has one nurse and there is no medical equipment and few medicines. There is a health shura in place that does carry out some prevention activities. Prison staff has not received training on BBV awareness and prevention. There are no drug treatment and harm reduction policies or strategies in place in the prison.

Farah
“Farah prison has only a surrounding wall and not anything else”. The prison is over-crowed with 400 prisoners when it was designed for 80 prisoners. Water and electricity is not available in the prison. There are no health workers in the prison. There are no medicines or equipment for health care. The Provincial Public Health Office also does not have adequate medicine or equipment. There are not enough resources and information on how to treat drug use. There are no drug treatment and harm reduction policies or strategies in place. The staff has not been trained in BBV awareness and prevention.

Herat
The prison is over-crowed with 2000 prisoners in a prison with a design capacity for 700 prisoners. The prison provides medical treatment but there is only one doctor for 2000 prisoners. They do not have specific treatment services or medicines for drug users. Staff has participated in several workshops on the spread of HIV and other BBV diseases, but they have not had specific training on prevention. There is a health education team who provide information to drug users and inform them about the risks of drug use.

Nangarhar
There are qualified doctors and nurses in the prison and there is a health shura which provides prevention activities. The prison staff has not been trained in BBV awareness and prevention.

SERVICES AND FACILITIES OUTSIDE OF THE PRISON

Bamyan
The community should accept and respect drug users but they are not well-treated in the community, “they are not part of the community”.

Farah
No services are available for prisoners as the community reject prisoners. The prisoners will revert to begging, robbery and other crimes.

Nangarhar
There is no support for prisoners in the community. Drug users have a bad reputation but if prisoners were able to get support, this would be a good and humanitarian action.

UNDERSTANDING OF THE POLICY AREA

Bamyan
Drug use is a crime and forbidden in Afghanistan. There is a lack of awareness about drug treatment strategies and BBV treatment and prevention policies.

Farah
Drug use, smuggling and cultivation is forbidden in Afghanistan. They think that drug abuse treatment is very important for prisoners but they have little understanding of substance abuse programs or harm reduction approaches. Justice police officers salaries are very low and other police salaries are higher.

Herat
Drug use, smuggling, trafficking and cultivation is forbidden in the country. The staff does not know about the BBV prevention or the drug treatment policies and strategies that may be in place. To reduce drug use, the staff thinks that there should be adequate living spaces for the prisoners and that there should be assignments and activities organised to distract the drug user from their addiction. They also think there should be sufficient food, medication, and recreational facilities for the drug users.

Nangarhar
There is a lack of knowledge about BBV, drug treatment and prevention strategies. They think that drug treatment programs are very important, “lifesaving”.

RECOMMENDATIONS FROM THE RESPONDENTS

Bamyan
- Health workers, health facilities and medicines
- Build a standard prison
- Provide training and education to prisoners and staff
Farah
- Health facility and clinic
- Reasonable and separate places for drug users and other types of criminals
- Medicines
- Health workers
- Education and vocational trainings
- Recreational facilities for prisoners
- Food and clothing for prisoners

Herat
- Clinic with medicine, skilled health workers and specialist doctors
- Medicine for drug users
- Medical equipment and supplies
- Enough food for drug users and prisoners
- Sufficient accommodation for drug users
- Places for sport and recreation
- Joint-working with the families, community and government is important to reduce drug use and its risks
- More support from the government
- Raise awareness about this issue with the community through the media (radio and TV)

Nangarhar
- Provide more health workers
- Improve existing health facilities
- Increase equipment and medicines available
- Provide more training for health workers
- Provide health education for drug users and prisoners
- Specialist doctors for BBV treatment and prevention

**Conclusions from the FGD amongst Prison Staff:**

Several anecdotal conclusions can be drawn from this focus-group data. Firstly, most members of the prison staff deny the existence of drug use, while others estimate a much higher proportion of drug users than revealed by the inmate data. Focus group participants mentioned relatives of inmates as the main route of entry of illegal drugs, but none mentioned prison staff as being complicit in such actions. In Nangarhar, drug
use was entirely absent from the responses of participants as well as almost entirely absent from the inmate data – but this is because we were refused access to any drug users during the survey (see notes from the surveyors). The main drugs of abuse were identified by some staff as opiates (opium and heroin) and hashish. Knowledge of withdrawal symptoms was not well defined, and few comments were received on this topic – this being in line, perhaps, with the general state of denial amongst prison staff.

Injecting drug use was referred to by respondents in one prison, but denied by all others. All prison staff denied the existence of sexual activity in the prisons. Some staff was aware of HIV, and that it is transmitted by injecting drug use, but this knowledge was not universal.

The main problems with service provision was lack of availability – although there is some link with the health system, this does not extend to preventative or primary care and is usually only on a referral basis. The second main problem identified was overcrowding in the prisons. None of the prisons provided services for treatment of chronic infections. Herat prison seemed to be the best served of the prisons.

All prisons recommended a clinic, health workers and medicines as a recommendation. There were also pleas for such basic needs as enough food for prisoners [and drug users] and clothing.

This anecdotal data collected from prisons strongly suggests a policy of denial by many of the prison commanders and staff, which must be overcome if progress is to be made. Lifting the lid on the true picture inside Afghanistan’s prisons is the only way of providing adequate services for health (and indeed basic needs and human rights such as food and clothing).

**Results from Prisoners Focus Groups**

Focus group discussions were also conducted in Nangarhar, Baghlan, Herat womens prison, and Paktiya prisons. The group size was between 4 and 6 individuals who were selected from the interviews conducted during the survey. Participants were also selected based on recommendations of the prison officers.

No personal information was collected during the FGDs to attempt to induce the participants to talk openly and honestly about the subject matter.
**Drug Users in Prison**

Baghlan
Drug use is reduced in the prison. When addicts are jailed, they withdraw from drug use because it is difficult to access drugs in prison. However, some continue to use drugs in secret. The prison staff introduces drugs into the prison as well as new prisoners. Families also supply drugs for pain relief.

Herat Female
A reported 70% of prisoners use drugs. There is too much drug use inside and outside of the prison. The drugs are brought in by family and by staff. It is hidden inside food.

Nangarhar
Some prisoners think that drug use has increased but some think that drug use has decreased. During the Taliban times, the drug users were not allowed to use drugs on the street, but now this has started to happen and drug use has increased. Drugs are used outside the prison but it is forbidden inside the prison. It is difficult to use drugs as drugs are not easily available. However, when relatives come to visit they bring drugs and the users take the drugs in the toilet or bathrooms.

**Type of Drug Use**

Baghlan
Heroin, hashish and pills are used in the prison. Hashish is very common and opiates are used for pain relief. The drugs are taken in the toilets, in groups or alone. If drug users have money they will use alone, but if they do not have enough money they will use in groups. First, drug users use hashish, and then they begin to use other drugs to reduce their unhappiness.

Herat Female
Most of the drugs users use opium but hashish and heroin are also used.

Nangarhar
Hashish is very common and alcohol is also used. Heroin and opiates are taken as well.

**Risky Behaviours**

Baghlan
Some injecting drug use exists outside the prison but inside smoking is more common and needles are not available here. Injecting drug use can spread diseases from one person to another.
Herat Female
Some of the group was aware of injecting drug use in the prison. The injecting drug users are separate from the other prisoners. The group was not aware of sexual activity in the prison.

Nangarhar
The prisoners are not aware of injecting drug use in the prison, though they stated that sharing needles caused the spread of HIV/AIDS. Needles are not available in the prison. The prisoners were not aware of MSM.

WITHDRAWAL FROM DRUG USE

Baghlan
Symptoms include not sleeping well and pain. They make a noise and disturb other prisoners. If a prisoner is a drug user, the prisoners identify him and put him “under treatment” so that he withdraws from the drugs.

Herat Female
Symptoms include pain, irritation, abdominal pain and headache.

Nangarhar
Symptoms include severe pain and “they cannot live without drugs, because they are addicted and must use it”.

BLOOD-BORNE VIRUSES

Baghlan
The prisoners are aware of BBVs such as HIV/AIDS and that HIV is a disease that can spread from one person to another. People should be tested for it so they can know if they need treatment. The prisoners had received a talk from a doctor about HIV. The prisoners were not aware of MSM in the prison.

Herat Female
The prisoners were aware of HIV/AIDS and said that BBVs were spread through sex and contact with patients. Sex workers spread the disease as well. If someone had HIV the group said they should be quarantined.

Nangarhar
The prisoners were aware of HIV/AIDS and that it was a fatal disease. The prisoners had received a talk from a doctor about HIV.
SERVICES AND FACILITIES IN THE PRISON

Baghlan
There are few treatment facilities and equipment available in the prison. The existing prison doctor is not able to treat the prisoners regularly and there is a limited amount of medicine available for prisoners. The group did mention a commission, made up of prison staff and prisoners that have been established to oversee drug related problems in the prison. However, the prisoners also stated that they were not aware of any measures in place to reduce risky behaviours associated with drug use or to prevent the spread of BBVs. The prisoners receive medical health care from their families.

Herat Female
There is little basic health care available to the prisoners. The prisoners were not aware of any measures in place to prevent the spread of BBVs. They were also not aware of any drug treatment and harm reduction services.

Nangarhar
There is some basic health care provided to the prisoners. Sometimes a doctor comes from outside the prison and provides treatment. The prison clinic does not regularly provide medicines or treatment but the prisoners think the service is good. There are no harm reduction and drug treatment facilities in the prison. There is a separate block called Guantanamo where the drug users are held until they have withdrawn from the drugs. The prisoners were not aware of any measures in place to prevent the spread of BBVs.

SERVICES AND FACILITIES OUTSIDE OF THE PRISON

Baghlan
The prisoners were not aware of any community programs for drug use but they thought that the prisoners should be supported and not disturbed – “they made a mistake and did a crime and now they are released”.

Herat Female
The group was not aware of any facilities or services outside of the prison for drug treatment.

Nangarhar
The prisoners were not aware of any facilities outside of the prison but they thought this was a good idea.

MOTIVATIONS OF PRISONERS TO CHANGE THEIR DRUG ABUSE BEHAVIOUR

Baghlan
If there is treatment available for drug users, then they will change their behaviour. Also, prisoners “help each other”.

UNDERSTANDING OF THE POLICY AREA

Baghlan
The prisoners think that drug abuse treatment is very important and that with a good health clinic and medication there will be no drug users. If the correct medical treatment is not available, then the drug users will die, but if they do receive the correct treatment then they will improve and “become a good man”. The prisoners think that drug law should be enforced to decrease the use of drugs and that drug cultivation should be controlled.

Herat Female
The prisoners think that drug abuse treatment is very important while the drug user is in prison. The consequences if no treatment is available include poor health and suffering. In Afghanistan, drug use is forbidden and a crime.

Nangarhar
The group thought that drug control and the control of risky behaviour that causes HIV are very important. The consequences of not controlling this behaviour and of not implementing drug treatment is “death”. Drug use is illegal in Afghanistan.

RECOMMENDATIONS

Baghlan
- Provide better medical facilities, treatment and medicine
- Provide more regular treatment
- Provide more medical professionals
- Provide better accommodation
- Provide more toothpaste and other useful personal hygiene products
- Strong management from the prison staff

Herat Female
- Equip the prison clinic with medical supplies and medication
- Regular check-ups and treatment for prisoners
- Good quality medicines
- Education and vocational training for prisoners
- Those who have not done a crime should be released.

**Nangarhar**
- Drug suppliers should be arrested
- Drug users should be treated
- Prison clinic should be well equipped
- Drug addicts should be provided with clothes and washing materials when they withdraw
- Provide better health care services

**CONCLUSIONS OF THE PRISON FGDs:**

Drug use within the prisons was reported by all the focus group participants. Visitors and staff were implicated in smuggling drugs into the prisons, with opium, hashish, heroin and even alcohol reportedly available.

Interestingly withdrawal from drugs was alluded to by prisoners as being administered by prisoners – “prisoners put him under treatment” – providing a potential avenue for improving drug withdrawal treatment in the prisons. Prisoners appear to help each other with health problems, including drug treatment. Some health education was evident amongst these groups with most of the groups being aware of HIV. Most prisoners indicated that provision of health services and drug treatment services are necessary for their prisons.

**RESULTS FROM PRISON AUDIT TOOL**

The results of the audit tool indicate that amongst the provincial prison leadership there is a lack of understanding about drug use, harm reduction and drug treatment. There is a lack of knowledge about the current policies that are in place and the policies that are under development and there is a lack of understanding about the effective management of drug use and drug treatment services in prison. During the interviews, although the prison governors often answered yes to the questions about their facilities and policies, it is clear from their answers that the prison commanders often did not fully understand the policy area, or they were perhaps unwilling to answer the questions openly. There was a reluctance to speak openly about drug use in the prisons. Nearly all the prisons stated that drug use did not occur in their prison at this
time, despite information that contradicts this from the inmate data, prison focus groups and the surveyors themselves.

**Strategic management**

There is a lack of understanding about drug treatment strategies and protocols that are in place amongst the prisons. While some prisons mentioned the strategy agreed between the PPHOs, MOPH, MOI and MOJ, most of the prisons did not seem to be aware of the strategy. Often, despite answering yes to the question, it is clear from their answers that the prison commanders do not thoroughly understand the policies, strategies and protocols that are needed for the treatment of drug users.

The management of drug treatment services is very poor in nearly all of the prisons. The prisons do not have a designated person who is in charge of the delivery of drug treatment services and there seem to be few reporting mechanisms in place to ensure that accurate information on drug use is collected or to ensure that action is taken. There is also a lack of information on the services that are available for drug users outside of the prison, and a lack of communication and co-ordination with services outside of the prison.

One issue for the prisons is the lack of resources available. For this reason, the prisons often state that they are unable to provide effective health care treatment and drug treatment.

**General health facilities in place**

Most prisons seem to be able to refer their prisoners to the provincial hospital and within the prison they have access to a medical professional on a weekly or daily basis, though many prisons said that there was only one doctor or nurse for the whole prison. The health services usually provide basic primary health care and for serious cases the prisoner can be referred to the provincial hospital. Nearly all the prisons have a referral system in place for dental care but few prisons had services available for mental health or treatment of disease (including STIs).

**BBV treatment facilities in place**

The majority of prisons do not seem to have a comprehensive service in place for the treatment and prevention of BBVs. Although the prisoners have access to the hospital for serious cases, it is not clear if the prisoners are screened, vaccinated or treated for BBVs. There is probably no injecting equipment made
available for drug users in prisons (although 7 prisons stated that this was available, including Pol-i-Charkhi). The counselling and advice provided on this subject is likely to be basic, as most prisons said that this service was available, but for general information only.

**Drug Treatment Facilities in Place**

The drug treatment facilities in place are poor within the prisons. Several prisons separate drug users from the rest of the prison population and the treatment is basic, usually involving cold showers. Nearly all the prisons state that they do have counselling and advice services for the prisoners, provided by the prison health staff, mullah or health shura. For injecting drug use, there is little evidence that the prisons have any policies in place for reducing the harm caused by sharing needles. Most prisons do not think that injecting drug use is prevalent in their prisons. There was a poor understanding of Opiate Substitution Therapy treatment and it does not appear to be available in the prisons.

Kabul prisons have the best healthcare and drug treatment provision in place. Pol-i-Charkhi prison states it will provide OST treatment in the future. Several prisons in the south of the country are able to refer prisoners to the Narcotics Centre.

**Support Organisations**

Several of the prisons work with local and national NGOs to provide health services and some drug treatment services to the prisoners. For example, Agha Khan, Red Cross, SAF, GTZ, RELIEF, HNI and UNODC are some of the organisations that are involved in providing or funding services to prisoners.

**Summary of the Surveyor’s Feedback**

The surveyors themselves also provided their impressions of the survey and acted as reporters. They were asked to provide information on the state of the prison, their impressions of the access to prisoners, responses of prisoners and staff. The information from the field workers also provides a useful insight and is summarised below.

The feedback from the surveyors who conducted the prison survey highlights a conflict between the information provided by the prison commanders and the direct observations and information collected by
the surveyors. Although nearly all the prison commanders state that there is no drug use in the prisons, several surveyors got the impression that drug use was a problem. This is based on their experience inside the prison. They also noticed several prisons where the reported treatment of drug users was cruel and even the most basic health care was limited.

For some prisons, the surveyors thought that they had good access to the prisoners and that the prison commanders supported them in conducting the study. For other prisons, the surveyors had difficulty getting free and unhindered access to the prisoners.

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<thead>
<tr>
<th>Prison</th>
<th>Surveyors’ observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nangarhar</td>
<td>Poor access to prisoners</td>
</tr>
<tr>
<td></td>
<td>The surveyors had no access to prisoners using drugs. There is a separate wing of the prison where the drug addicts are kept. In this wing the drug users do not receive any drug treatment and they are quarantined from the rest of the prison. When they have finished withdrawal (cold turkey), from the drugs, they are then readmitted to the rest of the prison. These prisoners are not given any medical treatment.</td>
</tr>
<tr>
<td></td>
<td>Health facilities in the prison</td>
</tr>
<tr>
<td></td>
<td>The prison has medical doctors for basic medical care and access to the hospital is very restricted. The prison is concerned about the spread of hepatitis. They do not have any resources to cure or vaccinate the patients.</td>
</tr>
<tr>
<td>Laghman</td>
<td>Good access to prisoners</td>
</tr>
<tr>
<td></td>
<td>The surveyor had good access to the prison through the prison commander No guard was present during the interviews.</td>
</tr>
<tr>
<td></td>
<td>Health facilities in the prison</td>
</tr>
<tr>
<td></td>
<td>Despite restricted resources, the prison refers prisoners to Jalalabad Public Hospital.</td>
</tr>
<tr>
<td>Kunar</td>
<td>Good access to prisoners</td>
</tr>
<tr>
<td></td>
<td>Good access to prisoners, no guard was present during the interviews.</td>
</tr>
<tr>
<td></td>
<td>Health facilities in the prison</td>
</tr>
<tr>
<td></td>
<td>There are few resources in the prison and no standard treatments for drug users or for general health care.</td>
</tr>
<tr>
<td></td>
<td>Treatment of drug users</td>
</tr>
<tr>
<td></td>
<td>The addicted prisoners are treated with water. They are put in a water bath to reduce the pain. The prison commander says “the water is really effective”. The surveyor said that the prisoners also agreed that the water treatment was effective.</td>
</tr>
<tr>
<td>Farah</td>
<td>General prison facilities</td>
</tr>
<tr>
<td></td>
<td>The prisoners did not have good accommodation or food. The prisoners complained that they were living 60 people to 1 room.</td>
</tr>
<tr>
<td>Herat Male</td>
<td>Access to prisoners</td>
</tr>
<tr>
<td></td>
<td>Good access through the prison commander and guards. The prisoners did not seem to have any problem with being open during the interviews. The surveyors think the prisoners answered the questions openly.</td>
</tr>
<tr>
<td></td>
<td>General prison facilities</td>
</tr>
</tbody>
</table>
|          | The prisoners say that there is a separate block, Block 4, where drug use and supply is allowed, as long as the prisoner can afford to pay. Once the prisoner has run out of money, the prisoner is transferred back to the main prison. The surveyors saw Block 4 – it is a long room, nearly 60
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<tr>
<td>Baghlan,</td>
<td><strong>Exposure to research studies</strong></td>
</tr>
<tr>
<td>Kunduz,</td>
<td>The prisoners mentioned that they had often had researchers come and talk to them, but they had not seen any benefits from these studies.</td>
</tr>
<tr>
<td>Takhar,</td>
<td><strong>Prisoner expectations</strong></td>
</tr>
<tr>
<td>Balkh,</td>
<td>Some prisoners expected the surveyors to help treat their illnesses. Some prisoners expected the surveyors to help them get free from jail.</td>
</tr>
<tr>
<td>Faryab, Badakhshan, Jowzjan, Faryab</td>
<td><strong>Confidentiality</strong></td>
</tr>
<tr>
<td></td>
<td>There was good access to the prisoners but the prisoners themselves were concerned about talking freely because they were intimidated by the prison authorities. The guards had been instructed to prevent prisoners from providing information about drug use. The surveyors estimated that 30% of the prisoners had not told the truth during the interviews.</td>
</tr>
<tr>
<td>Kabul Female</td>
<td><strong>Role of the prison staff and drug use</strong></td>
</tr>
<tr>
<td>Prison</td>
<td>The staff in charge of the prison was likely to be involved with drug supply in to the prisons. Many of the prisoners admitted that they pay 350Afs per day to the authorities in order to receive drugs. The prisoners said “if you have money in the jungle, it is soup for you”.</td>
</tr>
<tr>
<td>Drug use in the prison</td>
<td>Around 60 people were drug users or used to be a drug user but during their interview they were not able to freely discuss with surveyors.</td>
</tr>
<tr>
<td>Access to drug users</td>
<td>Access to drug users and prisoners was challenging in the female prison - the prisoners were asked by prison staff not to tell the truth.</td>
</tr>
<tr>
<td>Drug users</td>
<td>Most of drug users were sex workers who used alcohol, sedatives and hashish while they were outside of the prison.</td>
</tr>
<tr>
<td>Health facilities in the prison</td>
<td>The prison was better in term of accommodation and health related facilities.</td>
</tr>
</tbody>
</table>
CONCLUSIONS:

DRUG USE AND RISK BEHAVIOUR IN PRISONS

Regular use of opiate drugs occurs in most of Afghanistan’s prisons to some degree, although in scale, it varies by region and prison size. While the majority of drug use does not involve injecting, there is evidence that injecting drug use does occur; up to 30% of regular heroin users reporting having injected in the year prior to the survey. There is anecdotal evidence that drugs are smuggled in by relatives and friends of the inmates as well as by prison staff to meet an annual market with a potential value in excess of USD 3 million. This is not a unique finding – it occurs even in the best resourced prison systems in the world.

Other risk behaviours, such as unsafe sexual practices and tattooing were also evident in the population. Coupled to this, knowledge of HIV was considerably lower than in the general population and other vulnerable groups (i.e. returnees). There was also evidence of stigmatization of those who may have HIV.

SERVICES IN PRISONS

Service provision for drug users remains poor in Afghanistan’s prison system. There is a lack of preventative health care, and this is reflected in the lack of knowledge of existing policies and practices amongst prison staff. There was, furthermore, evidence of a lack of the most basic of human rights such as food, water and clothing. Efforts to improve the health and welfare of Afghanistan’s inmates are badly needed. Services for assisting drug withdrawal (around 1/3rd of prisoners are incarcerated for drug related crimes) are basic at best and inhumane at worst. Drug withdrawal almost never takes place under medical supervision of any kind. None of the elements of UNODC recommendations for drug prevention and treatment are evident.

Preventative services, not just for drug users and blood borne infection, but for general health and welfare are practically non-existent at present. The prison health system is badly lacking in terms of the need.

STUDY LIMITATIONS:

There are three important limitations to the study, which make interpretation of the data challenging. Firstly, responder biases are likely to make the figures reported in this report an underestimate of the true picture. This is an unavoidable pitfall of the subject matter; respondents (both inmates and staff) are reticent to
report their drug use or opinion truthfully because of the perceived risk of self-incrimination. Although opinions were not consistent between prisons and amongst prisoners and staff there were reports of widespread drug use amongst the prison population – perhaps much higher than acknowledged by respondents in the questionnaire survey. Collecting accurate information on drug use is a challenge in any setting, but is particularly pronounced amongst prisoners and especially those housed in Afghanistan’s prison system. The use of simple and cheap screening methods should be employed in future surveys to provide a biological measure of drug use. These tests are accurate and cheap and require a small urine sample. This would identify the scale of the problem more accurately and allow inferences to be made on the scale of underreporting in previous and future surveys.

The second limitation, related to the first, is the low response rate to some questions – particularly those of a more sensitive nature. It is not necessarily possible to draw firm conclusions from questions with low response rates. For this reason, caution is used in interpreting data where response rates are low.

Thirdly, there were deliberate attempts by prison staff to coerce inmates into not providing accurate or incriminating information to prevent or restrict access to drug users within the prisons. Whether this was to protect the reputation of the prison, or to protect other interests (such as preventing the implication of prison staff in drug dealing) is unknown.

All three limitations would tend to underestimate the true nature of drug use and risk behaviour in prisons. Despite these limitations the study provides robust evidence for the use of drugs in prisons.
RECOMMENDATIONS

Confronting the issue of drug use in prisons firstly requires recognition of the problem. The state of denial that exists amongst prison staff is unlikely to be a positive agent for change. However, the survey also revealed deeper issues at play – overcrowding and the consequent lack of basic services including food, water and clothing, inhumane treatment of prisoners (whether drug users or not) and a lack of knowledge of policies and norms amongst almost all prison staff. Within the context of wider prisoner welfare issues and prison reform, the drug use problem may be seen as but one of a number of competing needs being confronted by policy makers, donors and other officials. The problem, therefore, can best be seen as just one component of the multiple strategies and resources that are needed to improve prisoner welfare in Afghanistan’s penal system.

Providing services for drug treatment, harm reduction and prevention in a purely vertical manner is unlikely to provide the kind of improvements that are required and is unlikely to be cost effective, especially in the context of multiple competing priorities. A more holistic approach to improving health and welfare services in prisons would be a wiser and more sustainable approach. This approach is currently underway, with the new (2010) policy to integrate prison health into the National Health system – the Basic Package of Health Services. Within this system, which already operates in all Afghan provinces (and indeed is centred in the provincial capitals where prisons are located), there are already a range of services available for preventative and curative services available in the general population, but until 2010, prisons were only informally included. In 2010, the prison health programme was added to the mandate of NGOs which provide the local health services through the BPHS and EPHS. This formal inclusion of a prison health programme within the national health system is an encouraging step. The programme has begun as a pilot programme, which includes drug treatment services in Kandahar Prison (funded by UNODC and the Government of Canada). It remains to be seen how the services will perform on a country-wide scale, but evaluation within the first two years of implementation would be a useful measure of effectiveness and could be used to further improve prisoner welfare.

Provision of other, more specialised, health and welfare services to prisons is also not without precedent – several NGOs already provide services within prisons, for example in drug treatment and prevention, and HIV testing. Although simply adding the local prison to the health service roster will not necessarily be the ideal approach for control and treatment of drug use and addiction, specific interventions for prisons can be included in the implementation of health services. This is because drug treatment and prevention services
are not a part of the BPHS – although HIV testing and counselling is. It is clear that further coordination between the Ministry of Justice, Ministry of Public Health, donors and NGOs is required to ensure that drug treatment, harm reduction and prevention services are not neglected in the process of improving prison health. There is a clear need, demonstrated in this survey, for drug treatment, harm reduction and prevention services. Further evaluation of needs within the coming two to three years is required to assess the effect of the new prison health programme on drug use.

The data from this survey suggests that drug use is prevalent in a small but hardcore group of users in almost all prisons. Provision of drug treatment services and withdrawal under medical supervision could be conducted in on a regional basis, with specialist treatment services for rehabilitation provided. This would allow drug users to be referred within the prison service for drug treatment. These services could also be made available if drug screening of prisoners was conducted at the point of entry to the prison if drug use is evident. Those with a positive test can be further screened to identify hard-core users who are in need of treatment services.

There are no easy or quick solutions to the problem of drug use in any population, and the population of prisoners is no different. Drug use occurs in most penal systems whether well resourced or under resourced. Sustained approaches to improving prisoner health and welfare are required as well as specific interventions for provision of drug treatment, harm reduction and prevention services within prisons.