



UNODC
Afghanistan

**Drug Demand
Reduction
information,
advice and
training service
for Afghanistan
AFG/G26**

**United Nations Office
on Drugs and Crime
(UNODC)**

**Country Office for
Afghanistan**

**UNDP Compound
Shah Mahmood Ghazi
Watt, Shahr-e-Naw
Kabul, Afghanistan**

**Tel: 0093202101994
Fax: 00873763467626**

AFGHANISTAN

COMMUNITY DRUG PROFILE #5 An assessment of problem drug use in Kabul City



July 2003

Acknowledgements

The following individuals contributed to this assessment of problem drug use in Kabul city, and to the preparation of the present Community Drug Profile:

The fieldwork was directed by David Macdonald, Senior Advisor for Drug Demand Reduction (UNODC Kabul) and coordinated and supervised by Mohammad Naim, National Project Officer (UNODC Kabul) who also collected the secondary data. The field interviews were conducted by: Setara, Shah Begum, Hanifa, Sayed Ali and Mohammad Aman Raufi of Nejat Drug Treatment Centre, Kabul; Naseema of DOST Welfare, Peshawar; and Abdul Habib, Khair Mohammad Neekyar. Mirza Mohammad, Abdul Saboor Popal, Mohammad Karim and Shabirullah of the Government's Drug Dependency Treatment Centre (DDTC), Kabul.

The data was translated and hand-collated by Najibullah and Zohal

The report was written by David Macdonald and reviewed by the following: Dr.Kakar (DDTC); Dr.Mohammad Zafar (Counter Narcotics Directorate, National Security Council, Transitional Government of Afghanistan); Stefano Berterame, Chris van der Burgh, Hakan Demirbuken and Riku Lehtovuori (all UNODC Vienna); Mohammad Amirkhizi, Adam Bouloukos, Barbara Bruckmoser, Jamie Gairns, Mohammad Naim and Richard Will (all UNODC Kabul).

The Community Drug Profiles Series

Between 1998 and 2001, the UNDCP¹ Afghanistan programme, at that time based in Islamabad, Pakistan, developed a drug control strategy and an integrated programme of development assistance for Afghanistan consisting of capacity building, drug control monitoring, poppy crop reduction and demand reduction. The drug demand reduction support project had the objective of establishing community based drug prevention, treatment, rehabilitation and social reintegration capabilities in selected target areas in Afghanistan and Afghan communities in refugee camps and in Peshawar and Quetta cities in Pakistan where there was an identifiable drug problem.

The Community Drug Profiles Series provides assessments of specific drug problems and at-risk groups within Afghan communities. This provides part of the necessary information and data to plan and develop rational and realistic intervention strategies for drug prevention activities and service delivery for the treatment and rehabilitation of problem drug users. The *Series* also provides useful information for all those government agencies and other organisations involved in development assistance for Afghanistan, in particular for those in the fields of health care, social services, education and community development who work with problem drug users and their families in Afghan communities both inside and outside the country.

The information collection for the first four profiles in the *Series* was undertaken by UNDCP's Drug Demand Reduction Support Project (AFG/C29) in close co-ordination with a wide range of individuals and organisations, including Afghan communities themselves. The series is now being researched and compiled by UNODC's Drug Demand Reduction section (AFG/G26) based in Kabul. Along with the complementary *Strategic Studies Series* on illicit crop reduction, initially developed by UNDCP's Drug Control Monitoring Project (AFG/C27), the Community Drug Profiles Series has recognised that there are inherent problems associated with undertaking research into drug issues in Afghanistan. In such a context the verification of findings through systematic information-gathering techniques and methodological pluralism becomes a priority. As far as possible, the profiles are based on a Rapid Situation Assessment (RSA) methodology that uses a combination of several qualitative and quantitative data collection techniques and draws on a variety of data sources leading to an understanding of the nature and extent of problem drug use and the structures and services that exist, or do not exist, to address drug-related problems.²

Community Drug Profiles (CDPs):

- *CDP#1: Problem Drug Use in Afghan Communities- An Initial Assessment*
- *CDP#2: Opium and other Problem Drug Use in a group of Afghan Refugee Women*
- *CDP#3: A Comparative Study of Afghan Street Heroin Addicts in Quetta and Peshawar*
- *CDP#4: Problem drug use in rural Afghanistan: the Greater Azro Initiative (GAI) project*
- *CDP#5: An assessment of problem drug use in Kabul city*

¹ In 1997, UNDCP combined with the CICP to form the UNODCCP United Nations Office for Drug Control and Crime Prevention). On 1 October 2002, UNODCCP became the United Nations Office on Drugs and Crime (UNODC) including UNDCP

² United Nations Office for Drug Control and Crime Prevention (1999) *Drug Abuse Rapid Situation Assessments and Responses*, UNODCCP, Vienna

1. Introduction

In 1999, UNDCP published an initial assessment of problem drug use in Afghan communities that reported an increase in drug consumption in several areas of the country, including Kabul city. The main drugs reportedly used were hashish, opium, heroin and a wide range of pharmaceutical painkillers and tranquillisers. A report from the Mental Health Hospital in Kabul for the period January to April 1999 showed that 237 drug users were referred for treatment, of which 48 were opium users and 112 were heroin users, including some injectors³. The UNDCP assessment also showed a range of other drugs reportedly used in Kabul, including hashish, alcohol and volatile glues and solvents. In another assessment of problem drug use among Afghan women in a refugee camp outside Peshawar in NWFP (North West Frontier Province) in Pakistan, conducted in 1999, a woman reported that she had started using heroin in Kabul in 1997 when “my husband died and one of my sons lost both his legs due to a landmine explosion”. Other women in the same study also reported starting drug use in Kabul before going to Pakistan as refugees⁴. Two years previously, in 1995, a UNDCP report had stated that in Afghanistan “urban drug use is increasing significantly, with heroin becoming the drug of choice, especially in Kabul⁵. The report also suggested that Kabul likely had the most rapidly increasing population of opium and heroin users in Afghanistan, due mainly to a supply driven market and opium and heroin using refugees and IDPs returning from camps outside and inside the country.

Interviews with police departments in Kabul in early 2003 revealed a concern on the part of police with increasing illicit drug consumption in the city. The Head of the Crime Branch at one city police post estimated that there were 50-60 heroin injectors in his area, and that he personally had arrested 6 heroin injectors who were sharing injecting equipment. At another city police post, the Officer-in-charge estimated that there were “thousands of hashish users and hundreds of heroin and opium users” in his area. The general police department in Kabul produced a list of 114 drug addicts who had been arrested during the last year. This figure only accounts for those in possession of drugs or who are caught actually using drugs, as the police generally do not arrest people who have already used drugs and are in a state of intoxication, primarily as there are not sufficient facilities in Kabul for treatment. In accordance with Article 42 of the Counter Narcotics Law, police present those arrested for using drugs to the court where, if it is their first charge, they are referred to the Government Drug Dependency Treatment Centre (DDTC) in the Mental Health Hospital which has very limited capacity. If they relapse after treatment and are arrested again for drug use, then they are sentenced to between 3-6 months imprisonment.

The Deputy Head of Khair Khana Hospital, also in early 2003, reported that an investigation of patients attending the hospital for respiratory problems showed that 5% of them were hashish users. An average of two cases of alcohol poisoning is registered at the hospital every month. The doctor also suggested that 80% of people in Khairkhana were using tranquilisers, 30% using hashish and around 700 using heroin.

The annual report for 2002 from the Drug Dependency Treatment Centre in the Mental Health Hospital showed that 452 drug users were admitted to either their inpatient or

³ UNDCP (United Nations International Drug Control Programme) (1999a), *Community Drug Profile #1 - Problem Drug Use in Afghan Communities: An Initial Assessment*, UNDCP Programme, Islamabad

⁴ UNDCP (United Nations International Drug Control Programme) (1999b), *Community Drug Profile #2 - Opium and other problem drug use in a group of Afghan refugee women*, UNDCP Programme, Islamabad

⁵ Ulrich Kohler (1995), Report of a drug demand reduction assessment and strategy formulation mission to Afghanistan, UNDCP, Islamabad

outpatient services during the year. This included 339 heroin users (two of which were women), 89 opium users, 23 hashish users and one pentazocine/morphine user. Their figures for the first five months of 2003, which is actually only for 3 months as the Centre was closed for refurbishment for a two-month period during this time, suggests a likely increase for the year as 192 drug users were admitted. This figure included 141 heroin users (three of which were women), 43 opium users, 6 hashish users and 2 pentazocine/morphine users.

Nejat, an NGO that has for several years provided treatment and rehabilitation programmes for Afghan drug users in Badakshan province and Peshawar, opened a treatment centre in south-west Kabul in June 2002. In the month of July 2002 their female outreach workers made contact with over 300 men, women and children who were problem drug users. These included 206 women and 33 children aged between 2 months and 14 years who were dependent on opium, plus 18 women dependent on tranquillisers and 3 women dependent on heroin. In the 11 month period from July 2002 to May 2003, Nejat treated 220 drug addicts, mostly women and children who were dependent on opium.

Clearly such reports as those cited above give a general indication of a serious drug problem in Kabul city. The purpose of this study is to provide a more systematic assessment of the extent, nature and patterns of problem drug use in Kabul, including the types of social, economic and health-related problems for individuals, families and communities resulting from such use. The assessment includes all psychoactive substances, both licit and illicit, including the misuse of pharmaceutical drugs. Alcohol is included because, like all other intoxicants, its use is *haram* (forbidden) in Islam and also contravenes statutory law.

2. Background

2.1 Problem drug use in Afghan communities

During recent years UNODC, other UN organisations, NGOs and Afghan communities themselves have expressed concern about the escalation of problem drug use in communities in Afghanistan and among refugees in both Pakistan and Iran. In particular, concern has been raised about problem drug use among vulnerable at-risk groups such as the unemployed, poppy cultivators, the war-disabled, ex-combatants, IDPs, refugees, women and children. The use of such drugs as opium, heroin, hashish and a wide range of pharmaceutical and other drugs “has led to an increase in social, financial and health-related problems for individuals, families and communities and poses a distinct barrier to human and socio-economic development, further impoverishing an already impoverished people”⁶.

In this context, the term problem drug use is used in preference to drug abuse or misuse, as it encompasses the wide range of problems associated with different types of drug use found in the Afghan context. While using any intoxicating drug is *haram* in Islam, and using such drugs is against the laws of Afghanistan, it serves little purpose to further stigmatise problem drug users who frequently find themselves socially excluded and marginalised in their families and communities by labelling them as ‘abusers’. According to a UK Government Report, a problem drug user is: “any person who experiences social, psychological, physical or legal problems related to intoxication and/or the regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances”⁷.

On a general level, problem drug use in Afghanistan and refugee communities in Pakistan has to be contextualised within the country’s 24-year cycle of almost continuous war, conflict and

⁶ Ibid, p8

⁷ Advisory Council on the Misuse of Drugs (1982), *Treatment and Rehabilitation*, HMSO, London

internecine violence. Indeed it would be hard to exaggerate the continued misery and suffering of the Afghan people. In 2000, an FAO Report⁸, for example, claimed that Afghans, along with Haitians and Somalians, were more ‘chronically hungry’ than any other people in the world. As Mr.Ashraf Ghani Ahmadzai, Minister of Finance, stated in February 2002 at the Afghan Development Forum, “given present levels of aid, the best that the Afghan people can hope for is to move from misery to poverty with dignity”.

In 1996, the UN Human Development Index placed Afghanistan 169th out of 174 countries of the world. Since then Afghanistan has not even been included in the index for lack of accurate data and has become one of the least developed and poorest countries in the world. It has extremely high rates of illiteracy, rural poverty, infant and maternal mortality and an average life expectancy of only 45 years.

Rapid social disruption, breakup of families and communities, destroyed and abandoned physical infrastructure, environmental degradation, prevalence of land mines and other unexploded ordnance, a shattered economy and scarcity of health and educational facilities are still normative in most provinces of Afghanistan. Unemployment rates are extremely high with few non-farm job opportunities for the mainly rural population, and there has been a continuous erosion of civil society and human rights, particularly those of women.

At the same time, over the last decade Afghanistan has become the world’s leading producer of opium, accounting for an estimated 75% of global opium production. In 1999, opium production substantially increased to an estimated 4,581 tonnes⁹, although in 2000 this was reduced to 3,275 tonnes, mainly due to the drought that affected most of the country¹⁰. In 2001 there was “virtually no cultivation of opium poppy”¹¹ in Taliban-controlled Afghanistan, largely as a result of the ban on opium cultivation imposed by the Taliban authorities on 27 July 2000, and the repressive and violent measures they took to impose the ban. In 2002, poppy cultivation rose back again to pre-ban levels of 3,400 metric tonnes.¹²

With increased policing and security operations against traffickers on Afghanistan’s borders, however, it is likely that in such a high-risk environment some traffickers will take the low-risk option and sell at a reduced profit onto the local market. Certainly it was inevitable that increasing opium production since the early 1990’s would result in greater quantities of both opium and heroin becoming available on the local market where there has been a growing demand for such drugs¹³.

In a context of extreme human deprivation and suffering, then, this increased availability of opium and heroin, along with a range of pharmaceuticals and other psychoactive substances, has contributed to an escalation of problem drug use. Over twenty years of war and social disintegration has devastated traditional coping mechanisms and left the population, both inside and outside the country, extremely vulnerable to a range of mental health problems, particularly chronic depression, anxiety, insomnia and post-traumatic stress disorder.

⁸ FAO (Food and Agriculture Organisation of the United Nations) (2000), *The state of food insecurity in the world 2000: when people live with hunger and fear starvation*, FAO, Rome

⁹ UNDCP (1999a) *Annual Opium Poppy Survey*, UNDCP Afghanistan Programme, Islamabad

¹⁰ UNDCP (2000) *Annual Opium Poppy Survey*, UNDCP Afghanistan Programme, Islamabad

¹¹ UNDCP (2001) *Afghanistan: 2001 Opium Poppy Pre-assessment Survey*, UNDCP Country Office for Afghanistan, Islamabad

¹² UNODCCP (2002) *Afghanistan Opium Survey 2002*, United Nations Office for Drug Control and Crime Prevention October 2002

¹³ D.Macdonald and D.Mansfield (2001), *Afghanistan and Drugs, Drugs: education, prevention and policy*, Vol 8, No 1

In the case of Afghan refugee communities, as long ago as 1985 a psychiatrist warned of the likelihood of high incidences of anxiety, depression and drug dependence, and suggested that even after six years of enduring war and conflict, for Afghan refugees “the psychological repercussions and psychiatric illnesses produced as a consequence match no parallel”¹⁴.

Underlying many of these mental health problems is the central problem of loss. Having to cope with the loss of family members, home, job, well-being, personal security and even country, in the case of refugees, has understandably led some people to turn to drugs to cope with the pain, both psychological and physical, of such loss. Although there are no accurate figures, it has been unofficially estimated, for example, that over 2 million Afghans have been killed as a result of the fighting. Very few families have been untouched by the violent death of loved ones. It has also left Afghanistan with an estimated 2 million widows, plus their children, now one of the most vulnerable and impoverished groups in an already impoverished population¹⁵.

2.2 Kabul city

The first census of the population of Kabul took place in 1965-66, and revealed that 435,000 people lived in the city, 243,000 males and 192,000 females. By 1979 the population had more than doubled to 931,000, with 488,000 males and 443,000 females. Seven years later in 1986 the population had risen to over a million (1,301,000). The next census in 1999-2000 showed a population of 1,781,000 with, for the first time, more females than males living in the city (888,200 males: 892,800 females). Since the previous census in 1979, as a result of continued war and conflict, significant numbers of people had been forced out of the city, internally displaced between districts in the city, or moved into the city from peri-urban areas to seek assistance. These social upheavals are mirrored in the changing demographic profile of Kabul over the last two decades. By 2000, 58% of families were displaced or returnee families, children under the age of 15 constituted nearly 57% of the population, the average number of members in a family was 6.42 persons, and 4% of women were classified as widows and “their own family’s leaders”. In other words there were around 18,000 female headed households in Kabul in 2000, when, as the Population Survey of that year stated, “in spite of expansion of urban areas, the essential facilities have stayed limited”¹⁶. Taking a 2% annual growth rate and the large influx of returning refugees in 2002, the population in early 2003, the time of UNODC’s assessment, is estimated to be around 2.5 million people.

During 2002, 1.80 million refugees returned to Afghanistan, mostly from neighbouring countries. The greatest majority, 85% or 1.54 million returned from Pakistan with 14% (n=252,811) returning from Iran. Of those returning to Afghanistan from Pakistan, 52% (n=792,046) were from NWFP. Of the total number of refugees returning, 651,732 (37%) returned to Kabul province, most to the city of Kabul itself. Interestingly, in 2001 UNODC developed and funded a community based drug abuse treatment, rehabilitation, aftercare, social reintegration and prevention programme in Akora Khattak refugee camp outside Peshawar, where an assessment revealed that up to 10% of adults had a drug problem. Even if this percentage is reduced to 5% and applied to all returning adult refugees, then this would mean that, in 2002, it was likely that at least 20,000 new problem drug users arrived in Kabul city.

¹⁴ J.Ahtone (ed) (1985) *Proceedings of a Workshop on the Afghan Refugees Health programme, 19-21 November 1985*, Islamabad

¹⁵ D.Macdonald (2001) *Death, destruction and depression: understanding Afghanistan*, Druglink, September/October 2001

¹⁶ Central Statistics Office (2000) *Kabul City Population Survey*, Islamic Emirate of Afghanistan, Kabul, August 2000, p.iv

According to UN-HABITAT, in 2003 Kabul has around 1,500 families living in ruined buildings, and a further 60,000 families in partially-destroyed houses and apartments¹⁷. It is common for up to 20 members of one family to be living in a house built to accommodate six. Apart from cramped living conditions, many Kabul residents suffer from having to pay rapidly increasing rental costs for housing, and face a severe shortage of basic services such as water, electricity and sanitation. A report from Amnesty International in 2003 states that, for returning refugees, “being unable to afford to rent a room or a house due to spiralling rent prices, many have been forced into dilapidated buildings or unoccupied land” and live under the constant threat of eviction by landowners.¹⁸

3. Methodology

Collecting reliable data about illicit drug use in a city like Kabul is problematic. The use of all intoxicants (*nasha-i-mawad*) in Islam is forbidden (*haram*), and in Afghanistan the Taliban have left a legacy that saw severe punitive measures for those drug users caught by the Department for the Suppression of Vice and Promotion of Virtue. This resulted in drug use becoming an increasingly hidden and secretive activity, and it appears that drug users are still reluctant to disclose information about their drug use to outsiders who might be perceived as untrustworthy or informers. Apart from being scared of arrest by the police, they may also feel that they risk being stigmatised by the community they live in if their drug use is publicly known.

As a result, members of the community may be reluctant to provide information about drug use, as well as other forbidden activities like gambling or prostitution, preferring to keep secret the existence of such social problems in their community, and feeling shamed if such information is publicly disclosed. Community representatives also reported that they were fed up with the UN and NGOs coming to their communities to conduct assessments and take pictures, and then not fulfil their promises of development assistance. Pharmacists were particularly suspicious of interviewers as they were afraid that they would be reported to the Ministry of Public Health for selling pharmaceutical drugs without a medical prescription.

Female interviewers asking questions about drug use were sometimes subjected to harassment, although this was relatively infrequent. On one occasion, a group of female interviewers was told by community members that the area of Kabul they were entering was not controlled by the police and was not safe or secure. On another, a female drug user was being interviewed in her house when her brother-in-law, who suffered from mental health problems, shouted at the female interviewer and threatened her that if she did not leave the house she would be beaten. Two groups of heroin users in the Andrabi and Ghundi-e-quli-Abchakan areas of the city approached by UNODC fieldworkers were told by drug dealers not to talk to UNODC. The heroin users were told that UNODC only wanted their names on forms to show that they had been provided with medicines that, in fact, UNODC were keeping for themselves!

Both primary and secondary data were collected for the assessment. UNODC visited police stations and hospitals in different locations of Kabul, collected any statistics they kept on drug use, and interviewed doctors and police on their perceptions of the nature of the drug problem in their area of Kabul. More formally, 12 fieldworkers were hired and provided with

¹⁷ IRIN (2003) *Focus on Kabul housing shortage*, <http://www.irinnews.org>, 22 May 2003

¹⁸ Amnesty International (2003) *Afghanistan - Out of sight, out of mind: The fate of the Afghan returnees*, Amnesty International, London, 23 June 2003

a 5-day training programme on research methodology before conducting comprehensive interviews with 100 key informants and 200 drug users in Kabul city.



Figure 1: Interview team

The interviewers were selected from the staff of the Drug Dependency Treatment Centre (DDTC) situated in the Mental Health Unit of the Government's Polyclinic and Nejat, a community-based drug treatment and rehabilitation centre based in southwest Kabul. This meant that the interviewers, most of whom were social or community outreach workers or doctors, had an understanding of drug use and professional experience of working with drug users. More importantly, they already had established contacts with drug users in Kabul which made it easier to find drug users who were willing to be interviewed.

Although Kabul has 16 designated Municipal districts, for purposes of conducting interviews it was divided into ten districts that were more geographically distinct, for example, while the Khair Kana district to the north of the city is composed of 2 Municipal districts, it is a separate geographic area distinct from the rest of the city. Another reason for choosing 10 districts was that it facilitated the collection and collation of the data. In each district 10 key informants and 20 drug users were targeted for interviewing.

Within each target area interviewers were instructed to try and collect data from several different sites, using a simple random sampling process to select the key informants and snowball sampling to select drug users.

The interviewers were provided with a list of preferred types of key informants that should have lived in their target area for at least one year. They were, in descending order of importance: doctors; other healthcare staff; NGOs providing healthcare services; Wakili Guzars/Local Government Administrators; mullahs; police; school teachers; pharmacists; taxi drivers; shopkeepers/restaurant owners. Random sampling was then used to select the key informants from these occupational groups.



Figure 2: Interviewing a male drug user

Trying to find drug users willing to be interviewed was more difficult. In each of the ten target sites, Nejat and the DDTC already had contact with drug users who had come to their treatment centres seeking help. This facilitated access to drug users and, once contact had been established, snowball sampling was used to contact other drug users in the area. This meant that once a drug user had been contacted and interviewed, they would introduce the interviewer to other drug users that they knew, and so on. The fieldworkers were instructed to ensure that the 20 drug users interviewed in one target area were not of the same type, for example all heroin users, as this would give a very skewed sample. Interviewing only 200

drug users in a city the size of Kabul, however, is not statistically representative and it should be noted that the drug users that were interviewed are not necessarily representative of all drug users in Kabul, rather they cover the wide spectrum of drug use that reportedly exists and provide indicators of current drug use patterns and trends in Kabul.

Conducting interviews in Kabul in February when it was very cold, and sometimes snowing heavily, meant that it was difficult to establish contact with drug users who usually stayed indoors. Conducting interviews in the summer when some drug users are more likely to use their drugs outdoors in places like parks and graveyards might have resulted in a very different group of drug users being interviewed. When interviewing both drug users and key informants it was often difficult for interviewers to find a dry, warm and safe place to conduct the interviews.



Figure 3: Interviewing a female drug user

Most importantly, in terms of the reliability of the results of the assessment, both key informants and drug users consistently gave estimates of number of drug users only for the particular locale they lived in and **not** for the total target area as described to them by the interviewers. This was not surprising given the size of the areas concerned, which covered large geographical spreads with populations of up to a quarter of a million people. It can be safely concluded that **these estimates provide figures for the minimum number of drug users in each target area, and therefore Kabul city as a whole.**

Perhaps it was unrealistic to ask people to supply estimates for large areas of the city that they were perhaps not too familiar with, and it is to the credit of both key informants and drug users that many only provided estimates for the locales they were personally familiar with and where they felt they could give realistic estimates. Because of this, **it is important to emphasise that the estimates presented in Tables 3 and 4 are likely to indicate the minimum estimated numbers of drug users in Kabul. As such, these figures should be interpreted in absolute terms, in other words as the lowest estimated numbers of drug users in the city, and not as percentages per head of population.**

In any case, the estimated figures presented clearly show that Kabul has a serious drug problem, with tens of thousands of problem drug users requiring assistance with the social, financial and health-related problems resulting from their drug use that affects not only themselves, but their families and the communities they live in.

Profile of key informants

The majority of the 100 key informants interviewed were professionals living and working in Kabul. They included 15 doctors and other healthcare staff, 15 school teachers, 12 pharmacists, 10 police, and 10 Government employees. There were also 12 shopkeepers, 5 community leaders and 5 taxi drivers represented, as well as a range of other occupations including motor mechanic, tailor, hotel worker and army officer. There were 87 males and 13 females in the group, with 79 being married, 17 single and 2 widowed. Fifty seven had been educated to college or university level, 29 to high school level, 8 to primary level and 6 had no formal education. Thirty-six were aged over 40 years, thirty-three between 31 and 40 years, and twenty-nine between 21 and 30 years. Seventy nine of the key informants had lived in Kabul for over 10 years, with 30 of this group having lived there for over 30 years.

Profile of interviewed drug users

The occupational status of the drug users covered a wide range of work activities: 28% were unemployed; 19% housewives; 10% Government employees; 8% general labourers; 8% tradesmen such as carpenters, barbers and carpet weavers; 5% shopkeepers; 5% drivers; 2% professionals; and other activities such as “selling medicine at the side of the road”, peddler and farmer. Three of the drug users were currently in the army, two were police officers and several were ex-combatants. Fifty percent of the drug users were uneducated, 20% had attended primary school, a further 25% had attended secondary or high school and 5% had been to college or University.

There were 51 women and 149 men in the sample, ranging in age from 12 to 73, with 38% between 21 and 30 and 39% between 31 and 40. The majority were married with children, only 20% were single and a further 9% (n=18) were widowed. Most had more than 3 children, and twelve had more than seven. Sixty-one percent had lived in their current area of Kabul for more than 5 years, with 28% living there for more than 20 years. Before moving to Kabul, 26% had lived as refugees in Pakistan and 10% in Iran. Nineteen percent had lived in other provinces in Afghanistan, while 44% had always lived in Kabul.

A third had no personal income and relied solely on family income. The general level of reported income ranged from no income at all to over 10,000Afs (US\$200) per month. Twenty-four percent claimed a monthly income of between 1,000 and 2,000Afs (US\$20-40), with a further 21% claiming between 2,000 and 5,000Afs (US\$40-100) per month. Nine percent reported an income over 5,000Afs (US\$100) per month.

While this may not be a representative sample of all drug users in Kabul, it illustrates that drug users cover a wide spectrum of occupations, ages, education levels and income levels, as well as including both males and females. Drug use is not the prerogative of any one group in Afghan society, although some groups may be more at-risk of particular types of problem drug use than others, for example women, youth, the unemployed, the war-disabled, refugees and those who live in opium cultivation and opium and heroin production areas.

4. Estimates of the extent of problem drug use in Kabul

Table 1: Key Informants - Do people in your locality use the following drugs?						
Drug	Yes	No	Don't know	No response	Total	Percentage 'yes' response
Hashish	100	0	0	0	100	100%
Opium	85	2	12	1	100	85%
Heroin	77	6	16	1	100	77%
Alcohol	54	13	31	2	100	54%
Pharmaceuticals	53	9	37	1	100	53%
Other drugs	10	16	68	6	100	10%

Table 2: Drug users - Do people in your locality use the following drugs?						
Drug	Yes	No	Don't know	No response	Total	Percentage 'yes' response
Hashish	154	1	32	13	200	77%
Opium	127	3	53	17	200	64%
Heroin	113	1	70	16	200	57%
Alcohol	69	2	97	32	200	35%
Pharmaceuticals	50	0	135	15	200	25%
Other drugs	11	3	157	29	200	6%

It is interesting to note that when both key informants and drug users were asked if people in their locality used drugs, both groups generally responded in a similar way, with the percentage that answered 'yes' to each type of drug following a similar pattern. Hashish was reported as being most commonly used, followed by opium, heroin, alcohol, pharmaceutical drugs and other drugs, in that order. While the pattern was the same, however, the key informants consistently answered more positively when asked "Do people in your locality use drugs". Many more drug users than key informants answered that they 'didn't know' if people in their locality used drugs or not. There were also more 'no response' answers from the drug users, which may have been due to the fact that their questionnaire was much longer than the key informants and some were too tired or cold, or lost concentration, to answer all questions.

Table 3: Lowest estimated number of drug users in 10 target sites in Kabul city as reported by key informants

Target site	Type of drug				
	Heroin	Opium	Hashish	Pharmaceutical drugs	Alcohol
1	315	2,136	1,960	1,650	160
2	93	482	950	861	0
3	228	245	564	141	0
4	690	998	3,704	1,076	1,546
5	300	850	3,175	1,904	470
6	1,380	1,974	2,490	2,371	720
7	526	772	5,230	2,366	1,025
8	1,529	1,200	1,840	1,677	1,815
9	809	1,380	3,365	2,070	1,442
10	156	220	3,407	1,410	950
Kabul Total	6,026	10,257	26,415	15,526	8,128

Table 4: Lowest estimated number of drug users in target sites in Kabul city as reported by drug users

Target site	Type of drug				
	Heroin	Opium	Hashish	Pharmaceutical drugs*	Alcohol
1	208	1,170	1,101	650	0
2	658	834	2,067	1,295	525
3	32	615	523	2,500	0
4	873	783	2,100	573	290
5	568	1,846	4,224	300	366
6	1,232	916	2,423	0	601
7	1,236	1,480	2,403	2,371	780
8	1,203	1,356	1,800	1,750	725
9	994	1,170	2,504	2,390	848
10	985	1,120	2,426	1,240	462
Kabul Total	7,989	11,290	21,574	13,069	5,007

* In target sites 1-6 the great majority of drug users replied that they didn't know whether people in their areas used pharmaceutical drugs or not and did not provide an estimate. The figures for these areas are therefore not reliable estimates as they are based on too few responses.

Tables 3 and 4 above provide estimates of the lowest numbers of drug users in Kabul city as reported by key informants and drug users. The pattern of these estimates is remarkably consistent, with both groups reporting that hashish is the most commonly used drug in Kabul, followed by pharmaceutical drugs, opium, heroin and alcohol. Some other drugs were also reportedly used in Kabul, but these were very small numbers. A report on these other drugs

can be found on page 24. If the average is taken of the two sets of figures given by key informants and drug users, then the following table represents **the estimated lowest numbers of drug users in Kabul in early 2003:**

Type of drug	Lowest estimated number of drug users
Hashish	23,995
Pharmaceuticals	14,298
Opium	10,774
Heroin	7,008
Alcohol	6,568

As already mentioned in the Methodology section, these are reliable “lowest estimate” figures because many of those interviewed realistically only gave estimates for the locality where they lived and not for the larger target area. If they had been able to provide an answer for the whole target area then it can be assumed that their estimates would have increased, in some cases substantially. Some of these estimates may, of course, represent polydrug users who use more than one drug, for example opium **and** hashish. This would mean that they would be included in both the figures for opium use and hashish use, thus reducing the total number of all drug users.

In absolute terms this presents large numbers of drug users living in Kabul city who have problems relating to their drug use. The majority of these drug users were perceived as having financial, social and/or health-related problems related to their drug use by both key informants and drug users. In the case of the 200 drug users interviewed, the vast majority reported a wide range of problems relating to their own drug use, irrespective of the drug used, and in the case of the heroin users almost all of them reported problems.

Drug	Location				
	Kabul	Other Afghanistan	Pakistan	Iran	N/R
Hashish (n=99)	57	19	6	1	16
Opium (n=128)	48	21	32	17	10
Heroin (n=74)	26	3	17	17	11

5. The nature and patterns of problem drug use in Kabul

This chapter provides data on the nature and patterns of the different types of drugs used in Kabul as reported by key informants and drug users. Although the sample of drug users is not necessarily representative, it provides valuable insights into the reasons why they started to use different drugs, the reasons for their continuing drug use, methods of drug use, how often drugs are taken, and the problems they experience as a result of their drug use (this latter point will be discussed in Chapter 6).

In terms of giving estimates and profiles of problem drug users, the 100 key respondents were asked substantially more questions than the 200 drug users who were asked instead a set of in-depth questions about their own drug use. Containing over 130 questions, the drug user questionnaire was already too long to retain the attention of many of the drug users, so it was not possible to ask them exactly the same set of questions given to key informants **and** ask the substantial set of important questions about their own drug use.

Each section below firstly provides information from the drug users about their own patterns of drug consumption. This is followed by information from the key informants and all the drug users regarding their estimates and profiles of the users of that particular drug.

5.1 Heroin

Responses from heroin users

Over a third of the 200 drug users (n=74) had used heroin, including 3 women. Nearly 50% of this group (n=34) had started their heroin use in Iran (n=17) or in Pakistan (n=17), with 35% starting in Kabul and a further 3 people starting elsewhere in Afghanistan, two of these in Qandahar. Forty percent had been using heroin for between 3 and 6 years, with a further 21% (n=16) using for more than 7 years. Five of these people claimed to have been using heroin for over 20 years. The majority used heroin 2-3 times daily, with 6 people claiming that they used it more than 4 times daily. Apart from one man, **all** those who had started to use heroin had continued to use it, although over 50% had given it up at some point but had started again.



Figure 4: Taking heroin by ‘chasing the dragon’

Nearly half had started to use heroin due to the influence of friends, family members, roommates or workmates. Such ‘influence’, however, covered a wide range of behaviour including being forced, being persuaded, being encouraged and being offered free heroin. One user reported that “I came from Muqur to Kabul once and the weather was very cold on the journey. I went into a restaurant where there was a heroin user and he encouraged me saying that heroin was good to keep out the cold, so I started using it.” Another said, “I had a friend who was disabled, and one day he sent me a little packet of heroin. On the packet it was written that this was a gift, and he continued to send me free heroin for one month”.

The main other reasons given for starting heroin use were for medical purposes and because of ignorance, people simply didn’t know what it was they were using and had no knowledge

of the negative effects and addictive properties of the drug. Other reasons cited included sadness, loss of a relative, 'to help me work better', for sexual reasons and to become intoxicated.

When I was in Iran my neighbour encouraged me, he said 'smoke heroin to know the taste of life'. I found it was more powerful than opium and started using it instead. At first I felt ecstatic, now I have been using it for five years and am addicted, and use it for body pains and diarrhoea.

When asked why they now used heroin, the vast majority replied that they had become habituated or addicted to heroin and if they tried to stop they would experience withdrawal pains, "if I don't use heroin I become nervous and my body hurts". Others reported that they used it for "medical reasons", such as aches and pains and diarrhoea, although this also referred to withdrawal pains. Most importantly, nearly 7% (n=5) said they used heroin by injecting it dissolved in water and lemon juice. The rest took heroin by the method known as 'chasing the dragon', where the drug is heated on a piece of tin foil and the fumes inhaled into the mouth through a narrow tube. Based on the estimated figures of 7,008 heroin users in Kabul given on page 13 it can be calculated that there is an estimated minimum of 470 drug users who inject heroin in Kabul city. Drug treatment centre staff in Kabul verifies that some groups of heroin injectors are sharing injecting equipment, raising the spectre of IVDU (Intravenous Drug Use) as a means of transmission of HIV/AIDS, Hepatitis B and C, and other blood borne diseases in Afghanistan.

Heroin users reportedly spend between 30 and 250Afs (US\$0.60 and US\$5.00) per day on the drug, the variation most likely depending on the size of their habit, although it may also reflect different prices for the drug at different retail outlets throughout the city. This is a considerable amount of money to be spent on drugs for low income impoverished families. Weights and measures of heroin provided by drug users are not reliable and vary considerably, for example, one gram was cited as being equivalent to 5 poris, 8 poris, 10 poris and 20 poris by different users. Most users worked at various jobs to earn money to pay for their heroin, although stealing from family members, stealing from the bazaar, begging and being given money by relatives were also cited.



Figure 5: A Kabul heroin user 'flushing' his syringe

When asked if there were times when they would use more or less heroin, the majority stated that this depended on how much money they had. The more money they had the more heroin they would use, the less money the less they would use. Others used more if they experienced body pains, if their sleep was disturbed, if they felt sad, if they had time off work or if they had to go on a long road journey. The reported fact that the amount of money available to these users determines the amount of heroin they consume has implications for any cash-based development initiative they are part of – the more cash they have, the more likely they are to spend on heroin rather than the necessities of life for themselves and their families.

It should be noted that without analysis of street samples of heroin taken from different sites in Kabul it cannot be assumed that what people are being sold as ‘heroin’ contains heroin as the main psychoactive constituent. Pharmaceutical additives known to be added to heroin in Afghanistan include paracetamol, phenobarbitol, valium and quinine. If a substance sold as heroin contains a higher percentage of another psychoactive substance then it is not technically heroin. It makes no sense to call a drug containing 20% talcum powder, 5% heroin and 75% phenobarbitol ‘heroin’, since the main effect of the drug will come from the phenobarbitol not the heroin. This has been acknowledged in neighbouring Pakistan where the treatment of ‘heroin’ addicts has been complicated because of the various adulterants added to the drug, including lethal or poisonous substances as well as psychoactive ones¹⁹.

Responses from key informants

Seventy seven of the 100 key informants reported that people used heroin in their area of the city, with 16 saying they didn’t know if heroin was used or not and only 7 saying that there was no heroin use. The majority said that heroin users were exclusively male and youths under the age of 25 years, although 28 said that they were both male and female with perhaps 5-10% being female. While most respondents (n=68) claimed that heroin users in their area were both returning refugees and local residents, 55 of this group stated that they were mostly refugees. Almost two thirds of the key informants knew about heroin use in their area through knowing heroin users personally and also second-hand through other people. The key informants who knew heroin users personally tended to know them because heroin users had visited their clinic/hospital for treatment, were neighbours, or had been seen in public places like the street, graveyards or parks using heroin.

In terms of methods of use, 40% reported that heroin was smoked, mainly by the method known as ‘chasing the dragon’ where heroin is placed on a piece of tin foil, a flame held underneath, and the resultant fumes drawn into the mouth through a thin tube. More disturbingly, a third reported that heroin was both smoked and injected. Two people claimed that users were moving from smoking to injecting, including the sharing of needles and syringes, because it was a more ‘secret’ and less socially obvious method of use, thus minimising the risk of being traced by the police through the smoke or smell of burning heroin. A few mentioned that heroin was also sniffed directly through the nose or taken by a method known as *sekhi sang* where a metal spike or thin knife blade is heated in a flame until very hot, then applied to a small quantity of the drug. The resultant fumes are then inhaled through a narrow tube. One person mentioned that he had seen a man with a head wound rub heroin into the wound until it was absorbed.



Figure 6: ‘Cooking’ heroin prior to injection

Several key informants claimed that people first started using heroin for enjoyment, then later became addicted to it. Others thought that those who were involved in the production and trafficking of heroin became addicts themselves. General reasons given for starting to use heroin were unemployment – “they are passing time as they are jobless”, depression, sadness and “unaware of the dangers of heroin”.

¹⁹ UNODCCP (United Nations Office for Drug Control and Crime Prevention), 2002, Drug Abuse in Pakistan: Results from the year 2000 National Assessment Study, United Nations, New York

All key respondents reported that heroin users have financial and family problems and that many engage in criminal activities such as theft and prostitution in order to pay for their drugs. Most of them are perceived as having poor health and are generally stigmatised and distrusted by the community as *poderi* (heroin addicts). Two thirds of key respondents claimed that there had been an increase in the use of heroin in their area over the past 5 years mainly because of an increase in the population, due to returning refugees from Iran and Pakistan, and the increased availability of the drug.

Responses from drug users

Just over half of the 200 drug users (n=113) reported that heroin was used in their area. Only one person said that there were no heroin users in their area with 16 not responding to the question and a further 70 saying that they didn't know whether heroin was used or not. This rather large number of 'don't knows' likely reflects the fact that users of different drugs, such as opium, hashish and pharmaceuticals constitute separate groups that may not know about each others drug using habits. Heroin use was overwhelmingly seen to be a male drug habit, although 18 respondents said that both males and females used heroin, but predominantly males. While 27% (n=31) reported that heroin was used by youths, another 68% (n=77) claimed it was used by both youths and adults, although mostly by youth. Heroin users were also perceived as being both residents and returning refugees, with slightly more respondents citing 'mostly refugees'. Around 40% claimed that some heroin users were ex-combatants.

Nine percent (n=18) of all the drug users, including 4 heroin users, reported that they had a family member who used heroin. These family members included grandfathers, fathers, uncles, nephews, sons and daughters.

5.2 Opium

Responses from opium users

Sixty four percent (n=128) of the interviewed drug users had used opium, comprising 91 men and 37 women. While the majority had started opium use in Afghanistan, 48 in Kabul and 21 in other provinces, nearly 40% (n=49) had started in neighbouring countries, 32 in Pakistan and 17 in Iran. Over 70% reported that they eat opium, while the rest smoke it. As children, some had been given opium dissolved in water. Sometimes opium is sucked in the mouth on its own, placed under the tongue to slowly dissolve, a pellet-sized piece is swallowed like a pill, or it is taken with tea or food. Those who smoke opium do so mixed in a cigarette, in a *chillum* (a straight stemmed traditional water pipe), or by the method referred to as *sekhi sang* described on page 19. One woman reported that, "my husband was a hashish addict and always beat me, so I lost two of my children before birth and this caused me great physical pain. I mixed opium with water and massaged my body with it, and I also ate it".

Significantly, nearly 40% reported that they first started taking opium for 'medical reasons', citing ailments as diverse as back pain, toothache, typhoid fever, cough, tuberculosis, asthma, colds and influenza. The next most frequently cited reason was for sadness and sorrow, particularly the loss of a relative, usually due to the war and armed conflicts that have ravaged Afghanistan for over 20 years. As with reasons cited for heroin use, although reported much less frequently (n=18), was the influence and encouragement of others. Eight people reported that they used opium to alleviate tiredness and to help them work better, particularly carpet weavers. One man said, "my friend who was with me in the same military post used opium, so he gave me some to be brave and to fight well, and to keep out the cold".

Fourteen others started to use opium for enjoyment. One significant feature of the reasons cited for starting opium use, was that a combination of several life factors were often involved, as in the box below.

Our house was destroyed by the Taliban and my husband was martyred. One side of my face was completely burned and when we took refuge in Peshawar no one assisted us. I had too many problems and became nearly mad, on one side I had immigration problems, on the other financial problems. One day I went to the old camp to beg and told an old woman my story and that I was in pain. She gave me a little drug, it was opium, and I have used it ever since.

Twenty three percent (n=29) have stopped using opium, with nearly half of these now using heroin instead. Several reported that heroin was cheaper to buy than opium. Most of the others stopped because of family pressure, lack of money, or because they couldn't find opium - in other words not through their own choice. One woman stopped because she had been told of the dangers of using opium when pregnant. The 77% of people who had ever used opium and who continued to use it, did so mainly because they had become habituated and couldn't stop otherwise they would suffer from withdrawal pains, or for medical reasons such as cough, headache, insomnia, fatigue and body pains. The majority of this group used opium 2-3 times a day, with some others using only once a day or more than three times a day.

Trying to estimate the amount of opium that users consume on a daily basis is problematic as they frequently cite different types of weight measurements such as 'pea', 'chick pea', 'gram', 'mesqual' and 'mung bean'. The majority typically take one of these measures each day in 2 or 3 different doses, and spend an average of 20 to 50Afs (US\$0.40 to US\$1.00) daily on purchasing opium. Some reportedly spend as much as 200Afs (US\$4.00) per day or as little as 40Afs (US\$0.80) per week. Most people said that they worked at a job to obtain money to purchase opium, although others begged, stole or were given money by their family. One man said, "I get the money with a lot of lamentation from my family, otherwise I rob and steal. I used to buy the opium from a shop in Deh Afghanistan but it was closed by the Taliban. Then the man reopened it and told me 'put your money in that hole in the wall and take the opium from the hole' and that is what I do".

One third said that they used less opium if they didn't have the money to buy it, while the majority used more if they were sick (n=31) or if they felt very sad or depressed (n=27). Others reported that they took more opium if they had more money, without specifying any other reason. A few recognised that they had to consume more, as with the development of tolerance to opium they had to increase the dosage to maintain the same effect.

Responses from key informants

Eighty five of the key informants reported that opium was used in their area, while 12 said they didn't know whether opium was used or not. Nearly half of this group said that opium was used by males, while the rest said that it was used by both males and females, with 23 saying it was 'mostly males' and 9 'mostly females'. Two thirds claimed that both adults and youth used opium, although most emphasised that it was mostly adults. Interestingly, 13 key informants specified that children also used opium, in reference to reports that opium is frequently given to children as a painkiller, a pacifier, or a means of control, in several areas of Afghanistan.

The majority reported that both local residents and returning refugees used opium, with equal numbers reporting that it was mostly residents or returning refugees that took the drug. Only 6 said that opium was used exclusively by residents. Four said exclusively by refugees. Sixty nine of the group said that they knew opium users both personally and through other people.

The two main reasons given why people used opium was because they were habitual users and addicted, so had to continue to use opium to avoid the pains of withdrawal symptoms, and for medical reasons such as TB, insomnia, body pains and bad coughs. Eighteen informants also mentioned that people took opium for recreational purposes. Some others mentioned specific reasons such as unemployment, sadness, tension and 'to work harder and longer', particularly in carpet-weaving communities. These were also given, along with the medical reasons cited above, as explanations why those who were addicted had started to use opium in the first place. As one man said, "Migration, poverty and sadness led people to use opium, then it became habitual. Some refugees used opium to make their life easier as they were away from their family and country".



Figure 7: Women opium users

The two main methods of opium use reported was ingestion, often with tea, and smoking. The *sikh sang* method, as with heroin, was also reported. Six informants reported that opium was injected, presumably referring to 'blackwater opium', an opium preparation made specifically for injecting and used in both Iran and Tajikistan. The majority of key respondents claimed that there had been an increase in opium use in their area over the past 5 years.

Responses from drug users

Nearly two thirds of the drug users (n=127) reported that opium was used in their area, with a further 25% stating that they didn't know whether it was used or not. Only 3 people categorically stated that opium was not used in their area. Of the 67 who said that both males and females used opium, 39% stressed 'mostly males' and 48% stressed 'mostly females'. A further 59 claimed that only men used opium and 4 said only women. While most respondents thought that both youths and adults took opium, the emphasis was on youths. Ten respondents reported that children also took opium. Both residents and returning refugees were seen as taking opium, although 10% stated that it was only residents.

Nearly 25% (n=49) of the 200 drug users reported that a member of their family used opium, this included mothers, wives, sisters, brothers, husbands, cousins, fathers and uncles.

5.3 Hashish

Responses from hashish users

Almost 50% (n=99) of the drug users had used hashish. It may be significant that only 9 of this group were women, hashish is perceived as a 'male' drug consumed mainly by men. Most of the hashish users started to use the drug in Kabul (n=57) or in other provinces of

Afghanistan. Only 7 people started outside the country. A third had used hashish for over 10 years, some for over 20, with a further third using for 7-10 years. Almost all smoked the drug in a cigarette rather than through a *chillum*. One man reported that he used it by a method called *paingaky* where a small piece of hashish is placed on a needle, heat applied, and the smoke inhaled.

Nearly half had started to use hashish for enjoyment, such as going to parties with friends or to watch films. Eleven people said they had started using because of sadness and sorrow, with another 11 saying they had been encouraged by friends. Eight individuals cited that they started to use it when they were ‘soldiers’, often to keep out the cold, but also just for enjoyment and to “be free from fear during the war”.

Over a third of the hashish users had stopped using it, the majority because they had started using other drugs such as heroin (n=14), opium (n=13), alcohol (n=2) or tobacco (n=1). Hashish users that had switched to opium and heroin often qualified their answers by saying that they would sometimes smoke hashish if they had no opium or heroin. Most of those who had continued to use hashish said they did so because it had become a habit, some saying that without it they would become nervous, impatient, get a headache, couldn’t sleep or wouldn’t be able to work. Three people said they used it in combination with opium or heroin to increase the intoxicating effects of these drugs.

Once I was in Shohada and I ate some opium. There were two persons there smoking hashish and they said ‘you use opium but you don’t use hashish, why not?’ So I took the hashish cigarette from them and smoked it and it had a good effect after the opium so I used it again.

Hashish users reported their daily consumption of the drug in measures like *tolas*, *paltas*, grams and beans which varied between different users. This makes it very difficult to estimate exactly how much hashish is consumed on a daily basis, for example, these were some of the individual responses: “I use one *tola* which is equivalent to 2 grams”, “one *tola* is equal to a bean”, “I use one and a half *tolas* daily which is equivalent to half a gram”, and “I use half a *tola* a day which equals half a gram”. Whatever quantity is smoked on a daily basis, many users said that they smoked 2-4 times every day, with a few reporting that they smoked more than ten times a day. In a country like Afghanistan where hashish is frequently smoked and shared with others it is always difficult to assess individual consumption rates.

Twenty-eight of the 61 who provided information about how much they spent on hashish daily said between 10 and 20Afs (US\$0.20 and US\$0.40), with a further 20 saying between 30 and 40Afs (US\$0.60 and US\$0.80). While these are still significant sums of money in an impoverished country like Afghanistan, the price of hashish for these users is clearly significantly lower than for opium and heroin. A few claimed that they spent between 100 and 200Afs but this may have been for a weeks supply or to share with others.

Compared to heroin and opium users, the great majority of hashish users who reported using more or less of the drug depending on circumstances did not factor money into their decision making. Only 10 users reported that they would smoke more if they had more money. For most it depended on how they were feeling, “I take more if I feel sad”, if friends were available to smoke with, “when I meet my friends I can smoke 8 times in a day”, or if they had work to do, “when I am at home I use more, when I am at work I smoke less”. Inevitably, a few said that they smoked more if they didn’t have access to opium or heroin.

Responses from key informants

All key informants reported the use of hashish in their area. The vast majority (n=82) stated that only males used hashish, with only 9 people saying both males and females used. The same majority said that both adults and youth used hashish, with 50 of these specifying mostly youth, and that both residents and returning refugees used hashish. Unlike heroin and opium use, they claimed that it was mostly residents rather than returning refugees. Seventy respondents reported that ex-combatants used hashish, as one respondent, himself an ex-combatant claimed, “In military bases the use of hashish was common, the commanders gave hashish to men to encourage them to join. This happened during the regime of Dr.Najibullah, the Mujahideen and even the Taliban”.

Three quarters knew hashish users both through others and personally, with 15 saying they knew them only through other people and 12 saying they only knew them personally. Three quarters of the key informants said that hashish was mainly used for recreational purposes, such as at weddings or parties, while two thirds also said it was used because people became habituated to it. Nine also claimed that people took it for medical reasons, such as abdominal pain and insomnia, with other reasons cited such as unemployment, sadness, lack of information about dangers of the drug, and that it was cheaper than other drugs like heroin and opium.

All respondents reported that hashish was commonly smoked either in a cigarette or *chilum* while 13% also said that it was eaten either on its own, in soup, with meat, or as the drink *bhangawa* which is made with milk, almonds and pistachios. The many problems faced by regular hashish users was encapsulated by one key respondent who said, “the hashish user is weak, tense, irritable, talkative, has red eyes, no money and fights with family and friends. No one trusts him, he is stigmatised as a *charasi*”.

Three quarters reported that there had been an increase in hashish use in their area over the last 5 years, with only 20 citing a decrease because there had been a strict ban on hashish by the Taliban and because people had moved from using hashish to opium and/or heroin.

Responses from drug users

Over three quarters of the drug users (n=154) reported that hashish was used in their area, with 32 reporting that they didn't know whether it was used or not and one person saying it wasn't used. None of the drug users mentioned that only females used hashish and 9 of the 10 that said both females and males used said “mostly females”. With the vast majority reporting that only men used hashish it can reasonably be assumed that, in Kabul at least, hashish is perceived as a ‘male’ drug. Both adults and youth were seen as using hashish, with the emphasis on “mostly youth”. In terms of residency, most drug users said that it was mostly residents who used hashish, although 27 said that it was ‘mostly refugees’. Just over 50% said that ex-combatants used hashish.

Over 25% of the 200 drug users reported that a member of their family used hashish, this included a wide range of male relatives such as brothers, fathers, cousins, nephews and brothers-in-law, but, unlike opium and heroin, no female relatives.

5.4 Pharmaceutical drugs

It should be noted that there are over 5,000 registered pharmacies in Kabul, as well as unregistered pharmacies and other retail outlets, selling a range of psychotropic drugs, such as tranquillisers and painkillers. These drugs should only be sold with a medical prescription but are frequently sold over-the-counter without one. Some of them are also very cheap to purchase, a month's supply of valium, for example, costs less than one US dollar, making it accessible to even the poorest person. As a UNDCP report from 1999 stated, "In the case of both Afghanistan and refugee communities in Pakistan, there is substantial evidence that a wide range of pharmaceutical drugs is available over-the-counter, without a medical prescription, from 'pharmacies', other retail outlets and even roadside stalls. Many of these drugs are adulterated, spurious, outdated, unregistered and illicitly manufactured in Pakistan and India and then illegally imported into Afghanistan"²⁰. In June 2003, in Dara Adamkhel in North West Frontier Province in Pakistan, close to the border with Afghanistan, several heroin addicts died as a result of taking a locally-produced sedative drug sold as a replacement for heroin²¹.

Responses from pharmaceutical drug users

Forty percent (n=80) of the drug users had taken pharmaceutical drugs, 52 men and 28 females. This means that 56% of all the female drug users interviewed and 35% of all the men had used pharmaceutical drugs. By far the most common drug cited was diazepam (valium), a benzodiazepine tranquilliser that should only be available on prescription provided by a medical doctor. Almost three quarters (n=59) of the drug users who had taken pharmaceuticals had taken diazepam. Other drugs cited were mandrax (methaqualone), sosegon (pentazocine), hyoscine, lorazepam (ativan), and non-prescription painkillers such as paracetamol and brufen. It is worth mentioning that methaqualone, a barbiturate drug much favoured by users of illicit drugs and once seen as safe, effective and non-addictive, has been banned in most western countries.

When I lost my second husband, so I had a lot of sorrow. On the other hand my father-in-law beat me and said that I was unlucky and didn't let me see my daughter who lived with my mother and was injured when the rocket crashed into her house. Because of these problems I started using these tablets (valium). I used to take two a day, but now I just take one at night otherwise I can't sleep. I started taking them 10 years ago when a doctor prescribed them for me, but then I just started buying them in the bazaar

The vast majority cited a wide range of 'medical reasons' for taking pharmaceuticals, but particularly insomnia or 'sleep disturbances' and anxiety disorders caused mainly by the social upheavals related to war and conflict. One woman said, "my husband died 10 years ago and my children and I moved to Kachagari refugee camp. One son came to Kabul and then went to Iran. I had no information about him so I started to use valium to sleep well at night and forget my sorrow". Eleven respondents reported that they used valium when they couldn't find hashish, opium or heroin. Some of these tried to stop their heroin use by self-medicating with valium to ease withdrawal pains.

Just over 50% (n=42) of the people who had ever used pharmaceutical drugs had stopped using them, primarily because they had moved on to taking other drugs, with 16 now taking heroin, 11 taking opium and one taking hashish. One man said, "heroin is available

²⁰ UNDCP (1999a), op cit, p9

²¹ The News, 2 July 2003

everywhere and it is cheap, so I don't use painkillers now", while another said, "I only use valium now if I can't get heroin, they don't work so well". Of the 38 still taking pharmaceutical drugs, the majority (n=25) were taking valium, 13 men and 12 women. It is of great concern that these people have been self-medicating with the drug for an average time of over 5 years with five taking it for 10 years or over, 4 of these being women. Three of those who still use pharmaceuticals inject pentazocine, hyoscine and valium respectively.

The reasons why pharmaceutical drugs are still used mirror the original reasons for starting to take them, predominantly insomnia and other medical conditions, usually phrased as 'body pains'. Eleven respondents said they were now habituated and couldn't stop even if they wanted to. Compared to illicit drugs like heroin, opium and hashish, many pharmaceutical drugs, particularly valium, are extremely cheap. Almost all the respondents still using valium said that they took the drug without a doctor's prescription.

Unlike with illicit drugs, those respondents who sometimes use more of the drug report that money is not a variable in their decision-making. The majority who still use pharmaceutical drugs reported that they used more if they felt very sad or nervous, felt sick or couldn't fall asleep. One woman said, "I take one tablet every night, but sometimes I take two if I don't feel calm".

Responses from key respondents

Just over half of the key respondents reported the use of pharmaceutical drugs in their area, with most of the others saying they didn't know whether such drugs were used or not, suggesting that the use of such drugs is less 'public' and unlikely to be consumed in the company of others, as is often the case with hashish and heroin. One key informant said that "people are now educated through the media and health education in clinics not to use medicine without a medical prescription", although evidence would tend to suggest that this is not the case and that many people self-medicate with a range of pharmaceutical preparations without consulting a doctor. Another informant claimed that "some heroin users keep valium under their tongue to increase the effect of heroin".



Figure 8: A Kabul pharmacy

The majority of the key respondents suggested that both males and females take pharmaceutical drugs, with 17 saying mostly females and 14 mostly male. Sixteen said that only males took these drugs with one person saying only females. Adults and youths were both seen as using pharmaceuticals, while 10 people mentioned that they were also given to children. While 42 said that both residents and returning refugees used, 25 stipulated mainly residents, with a further 10 specifying it was residents only. Twenty seven respondents also mentioned ex-combatants.

The main drugs reportedly used were valium, mandrax, librium, diazepam and pentazocine (sosegon), with brufen a non-prescription analgesic drug also frequently cited. One respondent also claimed he knew some drug users who injected ketamine, an anaesthetic with analgesic and hallucinogenic properties. Indeed, 35 of the key respondents claimed that pharmaceutical drugs were both taken orally and injected. If true, this is disturbing information as it means that not only are some people self-medicating with pharmaceutical

drugs, they are also injecting them. Pentazocine, available in ampoule form from pharmacies, was the most commonly reported injected pharmaceutical drug.

The main reason for taking such drugs was both medical and habitual. Typically it was reported that some people would go to the doctor and get a prescription, then when it was finished just go to the pharmacy and buy the drugs over-the-counter, eventually leading to dependence on the drug and eventual addiction. Others claimed that some people were too poor to go to a doctor so just went to the pharmacy and bought the drugs. The main reasons given for using these drugs were body pain, insomnia, tension, sadness, sexual problems and depression. Most informants reported an increase in the use of pharmaceutical drugs over the past 5 years, mainly as a result of people displaced by war and conflict returning to the city.

Responses from drug users

Twenty five percent (n=50) of the drug users reported that tranquillisers and painkillers were used in their locality, although most of the drug users (n=135) said that didn't know whether these types of drugs were used or not, reflecting the 'private' use of such drugs. Twelve said that these drugs were used by men, while 39 said both men and women, with 26 of this group saying 'mostly women'. Both adults and youths were seen as taking such drugs, with 11 also reporting children. It is, of course, normal for children to be given painkillers if there are medical reasons and the drugs are prescribed by a doctor, but potentially dangerous for parents or others to give prescription drugs to children without medical advice. Residents were seen as using these drugs more than returning refugees, with 39 respondents saying 'mostly residents'.

Nearly 20% (n=38) of all the drug users reported that a member of their family took tranquillisers or painkillers, with most of these citing female relatives such as wife, mother, sister, aunt, daughter and mother-in-law.

5.5 Alcohol

It should be noted that Kabul, as the capital and cosmopolitan centre of Afghanistan, has always had a reputation as a place where various types of alcohol were available and consumed. The patterns of alcohol consumption found in Kabul are unlikely to be replicated in most other parts of the country.

Responses from alcohol users

Nearly 20% (n=39) of the drug users reported having taken alcohol. Most (n=25) started to drink alcohol in Kabul, with a further ten reporting that they started in Pakistan, Iran or other countries. The majority started to use alcohol for enjoyment and recreational purposes such as wedding parties and picnics with friends. A few had used it because they were ignorant of its effects or because they were curious. One man said, "I used it because everyone in my family drinks it except the children".

The majority (n=22) of those who had tried alcohol, however, claimed that they had stopped using it, particularly because it was often unavailable or expensive. Three said that they now used heroin instead. Of the 17 who continued to take alcohol, 4 said that they were now habituated to it and 10 said that they only took it for recreational purposes. This was also reflected in how often alcohol was actually consumed, ranging from "once or twice a week" to "five times a day, thirty five times a week", and how much alcohol was consumed, from "a bottle between 3 or 4 friends at a party" to "four glasses or a plastic bag every day".

Compared to other drugs, alcohol is reportedly expensive with the average price of ‘a bottle’, depending on type and quality, ranging between 400 and 800Afs (US\$8.00 and US\$16.00). People tended to use more if they went to parties or visited friends.

Responses from key respondents

Just over half of the key respondents reported that people in their area used alcohol. One third said that they didn’t know whether people used it or not and 13 said that no alcohol was used. In target areas 2 and 3 there were no reports of any alcohol use. Alcohol users were seen as predominantly male, although there were a few reports of women using it as well as men. While both adults and youths were reported as using alcohol, youths were seen as the main users and most of these were residents rather than returning refugees.

Alcohol was reported as usually being consumed with soft drinks like coca-cola and fanta and seen by almost all key respondents as being mostly used for recreational purposes, especially at birthdays, weddings and parties. Over half also suggested that alcohol use became habitual and people became dependent on its use.

Alcohol was reported as harming the health of the user, giving them nausea, liver problems and stomach ulcers. Alcohol users were also seen as creating problems for their family, were not trusted, and were hated because alcohol use is forbidden in Islam. Most reported that alcohol use had increased over the past 5 years and was “easy to buy from the bazaar”. One person claimed that it was bought from foreigners who had easy access to imported alcohol in Kabul.

Responses from drug users

Thirty-five percent (n=69) of all the drug users reported that alcohol was used in their area, almost exclusively by males and mainly by youths. The majority claimed that it was mostly residents rather than returning refugees who used alcohol. Fifteen (8%) of all the drug users reported that other members of their family used alcohol, exclusively male members such as brothers, husbands and brothers-in-law

5.6 Other psychoactive substances

Responses from drug users

Five percent (n=10) of drug users also reported that people in their area used other drugs, although it was difficult for them to estimate numbers. Fifteen drug users claimed that they also used other drugs, although this was mainly various preparations of hashish and/or opium such as *bhangawa* and the boiled juice from poppy pods. Three reported using cough syrups that they purchased from the pharmacy. One man said that he had been sniffing cologne for the last 5 years, “Every morning I take a bottle of cologne and sniff the fumes for half an hour”. Another person reported smoking dried scorpions mixed with hashish in a chillum.

It should be noted that the use of tobacco was not included in this assessment as the focus was on illicit and illegal drugs. However, tobacco products such as cigarettes and *naswar* can contribute to a wide range of serious health problems, particularly in a country like Afghanistan where an impoverished population already suffers from high levels of respiratory and other endemic diseases.

Responses from key respondents

Only 10% of the key respondents reported the use of any drug other than those already mentioned in their area. The great majority didn't know whether other drugs were used or not. The 10 key respondents who reported other drug use tended to be very specific and mentioned the use of substances such as petrol, shoe polish, glue, acetone (found in nail polish remover), Datura, also known as *Dantoorah* or *Gul-e-Khampiray* (a plant of the *Solanaceae* family that grows wild all over Afghanistan), and *mufara*, a preparation made from opium, hashish and sugar and eaten like chocolate. One key respondent said that "an oil seller in Chaman Babarak market told me that there were 5 or 6 persons there who smelled petrol and sometimes drank a small glass of it". Another reported that, "I knew someone who sucked the petrol from his motorcycle into his mouth, now he does this many times a day".

6. Drug-related problems

The drug-related problems experienced by the great majority of the 200 drug users in Kabul who were interviewed for this assessment are compounded by their general lack of accurate,

practical and realistic information about drugs. Misconceptions and misinformation about the nature of drugs and their effects are common, and there is often little understanding of the potentially harmful effects of drugs like heroin, opium and valium, particularly relating to the risk of dependency and addiction. Many people who start using these drugs do not know that in the long-term they run the risk of becoming addicted to them and the problems that this inevitably brings, particularly to an impoverished population with very limited access to suitable treatment and rehabilitation services.

6.1 Health

All but one of the heroin users reported that they experienced health problems related to their heroin use. In the text box below, the health problems typically relate to a state of addiction and are symptomatic of someone undergoing withdrawal from heroin. From the addict's perception, the only thing that will 'cure' these various ills is another dose of heroin or a substitute drug like methadone.

I have a lot of health problems due to heroin, such as coughing, body weakness, diarrhoea and asthma. I am pale and I have poor hygiene. My tears fall down and also my body itches. Usually my family doesn't allow me to come into my home, so I sleep in the mosque and people call me 'poderi'. They don't trust me.

Many opium users, as well as heroin users, reported that they had become dependent on these drugs and if they stopped regular daily use they would experience a range of 'body pains'. However, apart from the obvious withdrawal symptoms, these pains may be partly attributable to the original physical pains that led to drug use in the first place and/or the psychosomatic expression of current mental health problems.

The health-related problems of opium users were similar to those of heroin users, with only 3 opium users reporting that they experienced no problems. Many of the opium users reported

a wide range of withdrawal symptoms if they didn't take opium, for example, nervousness, dizziness, palpitations and shaking, feeling cold and mood swings. One man said "if I don't use opium I get a headache, I become nervous and I am always constipated. I get a backache, can't walk, and my mouth has a bad smell".

By contrast, 9 of the hashish users claimed that they had no problems related to their drug use, although one man said, "hashish is not problematic for me, but for someone who does not eat good food it causes weakness, irritability and tension". Another said, "I have no problem with hashish generally, but sometimes without reason I beat my children due to tension and anxiety". A third of the 63 men who still used hashish specifically mentioned that smoking hashish contributed to a range of respiratory complaints like coughing, asthma and breathlessness.

Five of the 38 drug users who still used pharmaceuticals said they had 'no problems' with taking these drugs, although 2 qualified their answer, by saying, "I don't have any problems because valium is available at pharmacies and I have the money to buy it", and "the only problem is that my children might find these drugs, swallow them and die". The people who had problems related to their use of pharmaceuticals were more likely to report problems they experienced if they **didn't** take the drug, such as becoming nervous and not being able to sleep, rather than those resulting from taking the drug. The most commonly reported health-related problem due to taking pharmaceuticals was reportedly 'dizziness', while some respondents said gastritis, nausea, and general forgetfulness. One woman claimed that "right now my menstrual periods are irregular", but this was more likely due to her consumption of opium than of pharmaceuticals.



Figure 9: An abscess caused by injection

Seven of the 17 people who continued to take alcohol said they experienced no problems, probably due to the fact that most were not regular users of the drug. Few specific health problems due to alcohol consumption were cited, although one respondent mentioned typical signs of alcoholism, cirrhosis of the liver and kidney problems, and another said that alcohol use had given him a peptic ulcer.

One compounding effect in trying to determine cause and effect with regard to the relationship between drug use and reported problems, not only health problems but also economic and social ones, is polydrug use, that is a pattern of drug use where two or more drugs are taken either in combination or in rapid sequence of each other. Over half of all the heroin users were polydrug users, with 14 also taking hashish, 10 taking opium, 10 taking hashish and opium, and 5 taking pharmaceuticals and hashish. A third of current opium users also took hashish. Many of the opium and heroin users also reported that if they couldn't find these drugs then they would take hashish instead.

6.2 Economic

Over 50% of the heroin users reported having financial and economic problems relating to their use of the drug. Indeed, most related their present state of poverty directly to spending all their money on heroin, even those who worked 'from morning til night' to get money to buy heroin. Several specifically mentioned stealing both money and goods from their family home, as well as from the bazaar. One man tried to force money from his family to buy

heroin, “I tried to get money from my mother but she was unwilling, so I started to break glasses and dishes to try and force them to give me money”.

Two thirds of the respondents who still used opium cited a range of financial and economic problems, such as not being able to work if they were suffering from opium withdrawals, stealing from family members, selling family assets (including land), and spending other family members money on opium. One woman said, “I spend my son’s salary on opium and this is affecting family income, as 50% of family money goes on opium”, while another reported that, “I use opium and my husband uses heroin so we have a lot of financial problems, the family only eats once a day and when I quarrel with my husband over money I beat the children”.

Despite the relatively low cost of hashish compared to opium and heroin, nearly 50% of hashish users reported financial and economic problems related to their consumption of the drug. Most claimed that they spent a lot of their money on hashish and as a result were now poor. Some reported that they robbed and stole to obtain money to buy the drug, while others said that they spent a lot of their wages on it.

I have financial problems and the money that I spend on opium should be used to buy fruit for my children, so really I am using their money. I am afraid that one day my husband will be informed about my opium habit.

Perhaps surprisingly, given their low cost, 22 of the pharmaceutical drug users reported financial and economic problems related to their drug use. In many cases, as with many users of the other drugs cited above, however, there was a general feeling that they were ‘just wasting money’ irrespective of whether they could afford to buy drugs or not. A few people said that they were unable to work due to the effects of the drugs they were taking and this obviously affected their income level. One woman said, ‘it doesn’t affect my finances as I only spend 6Afs on each packet of these tablets”. Only a few of the alcohol users reported economic problems, one man said, “alcohol is expensive compared to other narcotics so I have a financial problem”. Most users of alcohol probably don’t have financial problems relating to the drug as they are not regular users and presumably only buy alcohol when they can afford it.

6.3 Social

There was a wide range of reported social problems related to drug use, in particular the various negative ways that drug use impacts on the social relationships between the user, their family and the community. Most heroin users reported that their drug use had led to fights, arguments and disintegrating relationships with other family members, particularly their wives. Many opium users reported the same type of problems, with a few saying that arguments sometimes led to violence, one man said, “some time ago my wife tried to stop me from taking opium and she took the opium from my clothes, but I beat her and she gave me the opium back”.

Once I didn’t have any money to buy hashish and I was tense and irritable so I broke all the windows and set my wife’s clothes on fire. As a result they informed the police and I was arrested and put in prison for a day. Now the children call me by the name of charasi

Arguments were commonly about the individual's use of drugs and the use of family money to pay for them. Such arguments also took place between other family members, as one opium user reported, "I spend my son's salary on opium so it affects our economy, and always my daughter-in-law fights with my son because of my opium use". Female opium users reported similar problems, one woman recounted that, "I can't work very well right now and my relationship is not good with my husband as it was before, so he says that he is going to marry someone else". Around half of the hashish users also reported family relationship problems, with several saying that they became irritable and argued with family members.

Many of the heroin and hashish users reported that they were not trusted, and even disliked and hated, by other people in their community. Many also understood that they were frequently stigmatised as a *poderi* or *charasi* which led to feelings of isolation and low self-worth. One man said that, "there is no place for me in the community, in society I don't have honour", while another recognised his ineffectiveness as

a parent, "I cannot even think about my children, I am useless". It is such feelings of exclusion from the family and society that often leads drug users to seek company with other drug users, increasing the risk that they may be introduced to new drugs and methods of drug use. One hashish user said that, "hashish has damaged my memory and I forget everything and also become irritable. My manner is not good with my family and I become very impatient. Even in my shop I don't really have a relationship except with those who also use hashish".



Figure 10: A pre-treatment motivational counseling group at Nejat Centre

The few alcohol users who reported problems all emphasised a lack of control and propensity to violence when they were intoxicated, as one man said, "Whenever I am intoxicated with alcohol I don't know what comes out of my mouth. I can't control myself and one time I broke down a door and some windows. The people in the community don't like me and call me a drunkard. My father always tells me that the use of alcohol is forbidden in Islam"

6.4 Legal

Apart from social exclusion, drug users also run the risk of being legally excluded from society as consumption of all intoxicants in Afghanistan is banned under statutory law. Nearly 12% (n=23) of all the drug users had been arrested by the police at some point in their drug-using career. Six had been arrested outside the country, mainly in Iran, with a further 15 being arrested in Kabul. One man had been arrested for hashish use during the time of King Zahir Shah and had been imprisoned for 9 months. Seven of the 15 arrested in Kabul had been arrested during the reign of the Taliban and imprisoned for periods that ranged from 24 hours to 6 months.

While drug use is against the law, however, it is important to recognise that people with drug problems should be given the opportunity for treatment and rehabilitation. Imprisoning the consumers of illicit drugs is likely to make drug use an even more hidden and less socially

visible activity, thus making it more difficult for addicts to seek help with their problems as this might increase the risk of arrest and imprisonment.

Note: It should be noted that many of the drug users interviewed are aware that their drug use is causing the types of problems outlined above, both for themselves and their families. Sixty percent of those using heroin had tried to stop, as well as 40% of those using opium and 40% of those using hashish. In fact, many had stopped their drug use on several occasions but had restarted due to a wide range of social factors and personal circumstances, for example the inability to deal with withdrawal symptoms, illness, relapse after treatment, pressures of life, and encouragement from friends to take drugs. One man said, “5 years ago I went to Peshawar to get treatment in a hospital, and after treatment I stopped using heroin for 6 months. Then there was a problem in my family so I started again”. While another reported that, “I went to the mental health hospital 3 months ago and was admitted. I stopped using hashish for 15 days but then met some bad friends and started again”.

7. Key findings and issues

The key findings presented here are derived mainly from the data collected from face-to-face in-depth interviews with 100 key respondents and 200 drug users living in Kabul city during the period February-March 2003. While this sample of drug users may not necessarily be representative of all drug users in Kabul, as far as possible they represent the views and experiences of a wide range of different users of psychoactive drugs such as heroin, opium, hashish, alcohol and pharmaceuticals. As such, the data provides valuable insights regarding trends and patterns of drug consumption, not only in Kabul but also in other parts of Afghanistan. This includes the types of drug-related social, economic and health-related problems for individuals, families and the communities that were reported by drug users themselves.

The figures presented here are reliable estimates of the minimum number of drug users in Kabul in early 2003. With more qualitative data from the assessment, they represent general patterns and trend in problem drug use in Kabul. More in-depth assessments of particular vulnerable and high-risk groups, for example drug injectors, would provide the more detailed information necessary to develop appropriate and specific drug prevention programmes and necessary treatment modalities for these groups.

- The lowest estimated numbers of drug users in Kabul as reported by both key informants and drug users were: 23,995 hashish users; 14,298 users of pharmaceutical drugs such as tranquillisers and painkillers; 10,774 opium users; 7,008 heroin users; and 6,568 alcohol users. In absolute terms, rather than per capita, this represents large numbers of drug users living in Kabul who have problems related to their drug use. In the case of the 200 drug users interviewed, the great majority reported a wide range of problems relating to their own drug use, irrespective of the type of drug used. It should be emphasized that the actual number of drug users in Kabul is likely to be considerably higher than these minimum estimates.
- The following percentages of key informants and drug users who were interviewed reported drug use in their area of Kabul: 85% said hashish was used in their area; 71% said opium was used; 63% said heroin was used; 41% said alcohol was used; 34% said pharmaceutical drugs were used; and 7% said other psychoactive substances were used. Many key informants and drug users

displayed a detailed knowledge of the types of drugs used in their communities, although this was not always accurate with respect to the effects of different drugs.

- A major concern is the reporting of drug injecting in Kabul, particularly among heroin users. While only 7% (n=5) of the 74 heroin users interviewed reported that they injected heroin, a third of key informants claimed that heroin users both smoked and injected the drug. A third of the key respondents also reported that pharmaceutical drugs like painkillers were self-injected, as well as taken orally. Reliable reports from drug treatment centres in Kabul suggest that some drug injectors are also sharing needles and syringes, thus increasing the risk of transmission of blood-borne diseases such as HIV/AIDS and hepatitis B and C into the general population.
- While women constituted only 4% (n=3) of the heroin users and 9% (n=9) of the hashish users interviewed, they constituted 29% (n=37) of the opium users and 35% (n=28) of pharmaceutical drug users, particularly the benzodiazepine tranquilliser valium. This means that 56% of all the female drug users interviewed had taken pharmaceutical drugs. Key informants estimated that 5-10% of heroin users in their area were women and half of the key informants estimated that both men and women used opium, although mostly men. By contrast, almost all the key informants estimated that it was only men that used hashish, and that it was predominantly men who used alcohol. The majority of key informants estimated
- that both men and women used pharmaceutical drugs. Such findings suggest that although women take a range of different drugs, they predominantly take opium and pharmaceutical drugs like tranquillisers and analgesics.
- Fifty-three percent of the heroin users were polydrug users - that is a pattern of drug use where two or more drugs are taken either in combination or in rapid sequence of each other. Of the 39 heroin users who were polydrug users, 14 also took hashish, 10 took opium, 10 took hashish and opium, and 5 took pharmaceuticals and hashish. A third of current opium users also took hashish. This pattern of drug use presents a particular challenge to healthcare and other workers providing services to such a group. It is generally recognised, for example, that polydrug users are likely to have more physical, psychological and social needs than mono-drug users.
- Nearly 50% of heroin users interviewed had first started to use heroin in either Iran or Pakistan. Twenty five percent of opium users had first started opium in Pakistan and a further 13% had started in Iran. Of the pharmaceuticals drug users who reported where they first started to use these drugs, nearly 25% said Pakistan. By contrast, only 7% of hashish users had started to use hashish outside Afghanistan. While most of the key informants (n=68) claimed that heroin users in their area were both returning refugees and local residents, 55 of this group stated that they were mostly refugees. The majority also reported that both local residents and returning refugees used opium, with equal numbers reporting that it was mostly residents or returning refugees that took the drug. Unlike heroin and opium use, however, key informants claimed that it was mostly residents rather than returning refugees who used hashish, thus confirming the data provided by the drug users. Overall, such data illustrates

very clearly the importance of drug abuse prevention programmes for the returning refugee population who constitute a particular at-risk group for problem drug use.

- While several key informants believed that people started to use heroin for enjoyment, then later became addicted, nearly 50% of the heroin users interviewed had started due to the influence of friends, family members or workmates. Such ‘influence’ can refer to coercion, persuasion, encouragement or the provision of free drugs. Medical reasons for taking heroin, as well as opium, included insomnia, TB, cancer, toothache, body pains and influenza. The main ‘medical’ reason for continuing to take these opiate drugs, however, was to avoid the physical discomforts and pains of withdrawal symptoms when drug use was stopped. The use of these drugs was also underpinned by a range of social and personal problems resulting from the violence and conflict that has plagued the country for well over 20 years, for example, loss of a close relative, depression, sadness and sorrow.
- Three quarters of the key informants and nearly 50% of the hashish users reported that hashish was taken for enjoyment. Over a third of the 99 hashish users interviewed had stopped using it because they had started to use other drugs, particularly opium and heroin (n=27). Most of those who continued to use hashish did so because they had become habituated to it. For some Afghans, hashish may be a ‘gateway drug’ to the future use of more powerful and addictive psychoactive substances like opium and heroin.
- Depression, tension, anxiety disorders, stress, insomnia and body pains were the most frequently cited reasons given by both key informants and drug users for people in their area taking pharmaceutical drugs like tranquilisers and painkillers. Over 70% (n=25) of drug users still taking these drugs were taking the benzodiazepine tranquilliser diazepam (valium). It should be noted that quite often these drugs are prescribed by a doctor for genuine medical reasons, then when the prescription is finished the user simply self-medicates by buying the same drugs over-the-counter from a pharmacy or other retail outlet. Such long term use is likely to lead to dependency and addiction.
- Over 50% of key informants and 35% of drug users claimed that alcohol was used in their area. Nearly 20% (n=39) of the drug users had used alcohol, mostly on recreational and social occasions such as weddings, parties and picnics. The high price of alcohol was seen by most as prohibitive, thus reducing the likelihood of regular use.
- While very few key respondents or drug users reported having knowledge of other types of drug use, it is significant that the use of cough syrups, petrol, solvents, acetone, commercial colognes and the plant *Datura* were all cited. Although the use of such esoteric substances was rare, nevertheless it signifies that there is a wide range of psychoactive substances available in Kabul that are potentially problematic, particularly if there is no available information about the risks and dangers of using them.
- Gaining reliable information about the quantity and quality of drugs used by individuals was problematic. Users of heroin, opium and hashish frequently reported inconsistent weights and measures, with no standardisation of such

measurements as grams, poris, tolas and paltas. Drug users frequently referred to weights of drugs in non-standard terms like 'peas' and beans'. Unless samples of street heroin are reliably tested for levels of purity, there is no way of knowing the percentage of heroin contained in any given sample. In terms of daily costs of buying drugs as reported by the users, heroin and opium were significantly more expensive than hashish, while a pharmaceutical drug like valium, at less than one US dollar for a month's supply, was exceptionally cheap.

- The majority of the 200 drug users reported a wide range of problems related to their use of drugs. Nearly all the opium and heroin users experienced typical symptoms of addiction to opiates and the resultant withdrawal pains if they stopped using the drug for any reason. Such pains included shaking, coldness, coughing, physical weakness and aches and pains. Mood swings, tension and anxiety were reported by many users if they were not able to take their daily dose of drugs. This applied as much to hashish and pharmaceutical users as it did to opium and heroin users.
- Many drug users, irrespective of the drug used, saw their present state of poverty as being related to their drug consumption and generally acknowledged that they were 'just wasting money on drugs'. Although many obtained money by working, then spent most of it, or all of it, on buying drugs, others obtained money to purchase drugs by begging, stealing money and/or goods from the bazaar or family members, selling family assets, and spending other family member's money and wages. Most drug users reported social problems related to their use of drugs, mainly arguments, fights and disintegrating relationships with other family members, particularly spouses, and being socially excluded and stigmatised in the community as 'drug addicts' which led to feelings of isolation and low self-worth.
- Preparations of opium were reportedly used as self-medication for a range of illnesses such as flu, cough, headache and general aches and pains. Any reduction in opium supply or a substantial increase in price may lead to an increase in the consumption of substitute drugs, particularly cheaper and more readily available pharmaceutical drugs that, like opium, carry a risk of dependency, addiction and overdose.

8. Annex 1: Interview Checklist

Drug User Profile - Interview Checklist

Problem Drug Use: Kabul

February - March 2003

(UNODC Afghanistan Programme)

Hello, my name is _____ and I am here representing the United Nations Office on Drugs and Crime (UNODC). I would like to ask you some questions about your use of drugs and hope that you will be able to help me. The information that you provide is confidential and will only be used for report writing. This will help UNODC to develop better services for people with drug-related problems in Kabul. Thank you for agreeing to answer my questions. Do you have any questions you would like to ask me before we begin?

Date: _____
Time: _____

Location: _____
Interviewer: _____

KABUL DRUG USER PROFILE

INTERVIEW CHECKLIST

(probes in italics)

1. Age _____
2. Sex _____ Male _____ Female _____
3. Marital Status (single/married/widowed/divorced) _____
4. Number of Children (ages?) _____
5. Ethnic status _____
6. Level of education _____
7. Employment status (current/previous) _____
8. Monthly income (source – own/family?) _____
9. How long have you lived in this area of Kabul? (see area list) _____
10. Where did you live before coming here? _____
11. Where are you originally from? (born/childhood?) _____
12. Have you ever used opium? Yes No (Go to Q25)
13. When did you first start using opium? (method/where?) _____
14. Why did you start using opium? _____
15. How often do you use opium now? (time of day/daily/weekly) _____
(never: when/why/how did you stop?) _____
(If never - Go to Q25)
16. Why do you use opium now? _____
17. How much do you normally use in a day? (method?) _____
18. How much do you pay for your opium/where do you get the money from/
source of opium? _____
19. Are there times when you use more, or less, than you do now? Yes (explain?) No
20. Do you have any problems relating to your opium use? (health/financial/social
relationships – family and community level) _____
21. Are you doing anything about these problems? Yes (what?) No (why not?)
22. Have you ever tried to stop using opium? Yes No
23. If yes: When? Why? Were you successful? For how long? Why did you start again?
24. If no: Any reason why not? _____
25. Do other members of your family use opium? (who?)
Yes (who?) _____ No _____ DK _____
26. Do other people in this area use opium? (habitual/recreational/medical)
Yes _____ No _____ DK _____
(If No or DK, go to Q32)
- Can you now provide us with some information about these people**
27. Are they male or female? _____
28. How old are they?(youth <25 /adults/ children) _____
29. Are they residents or returning refugees? _____
30. Do they belong to any specific group? (ethnic group/ex-combatants) _____
31. How many people would you estimate use opium in this area? _____
32. Have you ever used hashish? Yes No (Go to Q45)
33. When did you first start using hashish? (method/where?) _____
34. Why did you start using hashish? _____
35. How often do you use hashish now? (time of day/daily/weekly) _____
(never: when/why/how did you stop?) _____
(If never - Go to Q45)
36. Why do you use hashish? _____
37. How much do you normally use in a day? (method?) _____
38. How much do you pay for your hashish/where do you get the money from/
source of hashish? _____

39. Are there times when you use more, or less, than you do now? Yes (explain?) No
40. Do you have any problems relating to your hashish use? (health/financial/social relationships family and community level?) _____
41. Are you doing anything about these problems? Yes (what?) No (why not?) _____
42. Have you ever tried to stop using hashish? Yes No
43. If yes: When? Why? Were you successful? For how long? Why did you start again?
44. If no: Any reason why not? _____
45. Do other members of your family use hashish?
Yes (who?) _____ No _____ DK _____
46. Do other people in this area use hashish? (habitual/recreational/medical)
Yes _____ No _____ DK _____

(If No or DK, go to Q52)

Can you now provide us with some information about these people

47. Are they male or female? _____
48. How old are they?(youth <25 /adults/ children) _____
49. Are they residents or returning refugees? _____
50. Do they belong to any specific group? (ethnic group/ex-combatants) _____
51. How many people would you estimate use hashish in this area? _____
52. Have you ever used heroin? Yes No (Go to Q65)
53. When did you first start using heroin? (method/where?) _____
54. Why did you start using heroin? _____
55. How often do you use heroin now? (time of day/daily/weekly?) _____
(never: when/why/how did you stop?) _____

(If never - Go to Q65)

56. Why do you use heroin now? _____
57. How much do you normally use in a day? (method?) _____
58. How much do you pay for your heroin/where do you get the money from/
source of heroin?

59. Are there times when you use more, or less, than you do now? Yes (explain?) No
60. Do you have any problems relating to your heroin use? (health/financial/social relationships – family and community level?) _____
61. Are you doing anything about these problems? Yes (what?) No (why not?) _____
62. Have you ever tried to stop using heroin? Yes No
63. If yes: When? Why? Were you successful? For how long? Why did you start again?
64. If no: Any reason why not? _____

65. Do other members of your family use heroin?
Yes (who?) _____ No _____ DK _____
66. Do other people in this area use heroin? (habitual/recreational/medical)
Yes _____ No _____ DK _____

(If No or DK, go to Q71)

Can you now provide us with some information about these people

67. Are they male or female? _____
68. How old are they?(youth <25 /adults/ children) _____
69. Are they residents or returning refugees? _____
70. Do they belong to any specific group? (ethnic group/ex-combatants) _____
71. How many people would you estimate use heroin in this area? _____
72. Have you ever used pharmaceutical drugs such as tranquilisers like valium or
painkillers? Yes No (Go to Q85)
73. When did you first start using tranquilisers/painkillers? (specify which drug/
method/where?) _____
74. Why did you start using tranquilisers/painkillers? _____
75. How often do you use tranquilisers/painkillers now? (time of day/daily/weekly?) _____
(never: when/why/how did you stop?) _____
- (If never - Go to Q85)
76. Why do you use tranquilisers/painkillers now? _____
77. How much do you normally use in a day? (method?) _____
78. How much do you pay for your tranquillisers/painkillers/where do you get the money
from/source of tranquillisers/painkillers? (specify pharmacist/other retailer?/
whether on prescription or not?) _____
79. Are there times when you use more, or less, than you do now? Yes (explain?) No
80. Do you have any problems relating to your tranquiliser/painkiller use?

(health/financial/social relationships – family and community level?) _____

81. Are you doing anything about these problems? Yes (what?) No (why not?)
82. Have you ever tried to stop using tranquilisers/painkillers? Yes ___ No _____
83. If yes: When? Why? Were you successful? For how long? Why did you start again?
84. If no: Any reason why not? _____
85. Do other members of your family use tranquilisers/painkillers?
Yes (who?) _____ No _____ DK _____
86. Do other people in this area use tranquilisers/painkillers? (habitual/recreational/medical)
Yes _____ No _____ DK _____
- (If No or DK, go to Q92)
- Can you now provide us with some information about these people
87. Are they male or female? _____
88. How old are they?(youth <25 /adults/ children) _____
89. Are they residents or returning refugees? _____
90. Do they belong to any specific group? (ethnic group/ex-combatants) _____
91. How many people would you estimate use tranquilisers/painkillers in this area?
92. Have you ever used alcohol? Yes No (Go to Q105)
93. When did you first start using alcohol? (method/where?) _____
94. Why did you start using alcohol? _____
95. How often do you use alcohol now? (time of day/daily/weekly?)
(never: when/why/how did you stop?) _____
- (If never - Go to Q105)
96. Why do you use alcohol now? _____
97. How much do you normally use in a day? (method?) _____
98. How much do you pay for your alcohol/where do you get the money from/
source of alcohol?
99. Are there times when you use more, or less, than you do now? Yes (explain?) No
100. Do you have any problems relating to your alcohol use?
(health/financial/social relationships – family and community level?) _____
101. Are you doing anything about these problems? Yes (what?) No (why not?)
102. Have you ever tried to stop using alcohol? Yes ___ No _____
103. If yes: When? Why? Were you successful? For how long? Why did you start again?
104. If no any reason why not? _____
105. Do other members of your family use alcohol?
Yes (who?) _____ No _____ DK _____
106. Do other people in this area use alcohol? (habitual/recreational/medical)
Yes _____ No _____ DK _____
- (If No or DK, go to Q112)
- Can you now provide us with some information about these people
107. Are they male or female? _____
108. How old are they?(youth <25 /adults/ children) _____
109. Are they residents or returning refugees? _____
110. Do they belong to any specific group? (ethnic group/ex-combatants) _____
111. How many people would you estimate use alcohol in this area?
112. Have you ever used any other type of drug? (specify: solvents/cough syrups/ other)
Yes No (Go to Q125)
113. When did you first start using these other drugs? (method/where?) _____
114. Why did you start using these drugs? _____
115. How often do you use these drugs now? (time of day/daily/weekly?)
(never: when/why/how did you stop?) _____
- (If never - Go to Q125)
116. Why do you use these drugs now? _____
117. How much do you normally use in a day? (method?) _____
118. How much do you pay for these drugs/where do you get the money from/
source of these drugs? _____
119. Are there times when you use more, or less, than you do now? Yes (explain?) ___ No _____
120. Do you have any problems relating to your use of these drugs?
(health/financial/social relationships – family and community level?) _____
121. Are you doing anything about these problems? Yes (what?) No (why not?)
122. Have you ever tried to stop using these drugs? Yes ___ No _____
123. If yes: When? Why? Were you successful? For how long? Why did you start again?
124. If no any reason why not? _____
125. Do other members of your family use other drugs?
Yes (who?) _____ No _____ DK _____

126. Do other people in this area use other drugs? (habitual/recreational/medical)

Yes _____ No _____ DK _____

(If No or DK, go to Q132)

Can you now provide us with some information about these people

127. Are they male or female? _____

128. How old are they? (youth <25 /adults/ children) _____

129. Are they residents or returning refugees? _____

130. Do they belong to any specific group? (ethnic group/ex-combatants) _____

131. How many people would you estimate use other drugs in this locality? _____

132. Currently do you use your drugs in combination or separately? _____

133. Have you ever been arrested for drug use? (specify: where/when/what drug outcome?) _____

134. Is there anything else that you think we should know about your drug use? _____

Thank you very much for answering the questions

Interviewer: List here any problems with this interview