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AFGHANISTAN DRUG INSIGHTS VOLUME 3

MAPPING OF FACILITIES FOR TREATMENT OF SUBSTANCE USE DISORDERS: ADDRESSING SERVICE PROVISION CHALLENGES IN A HUMANITARIAN CRISIS



VOLUME 1: OPIUM POPPY
CULTIVATION 2024



VOLUME 2: 2024 OPIUM PRODUCTION
AND RURAL DEVELOPMENT



VOLUME 3: MAPPING OF FACILITIES FOR TREATMENT OF
SUBSTANCE USE DISORDERS: ADDRESSING SERVICE PROVISION
CHALLENGES IN A HUMANITARIAN CRISIS

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Glossary of terms

ANPASH: Afghanistan National Program for Control of AIDS, STIs and Hepatitis

CDC: Communicable Disease Control Programme

CSOs: Civil Society Organizations

DfA: De Facto Authorities

DDR: Drug Demand Reduction Department

DICs: Drop-in Centres

DM-CNP: Deputy Ministry of the Counter Narcotics Police

DTCs: Drug Treatment Centres

MoI: Ministry of Interior

MoPH: Ministry of Public Health

MMRCA: Medical Management and Research Courses for Afghanistan

NGOs: Non-Governmental Organizations

OAT: Opioid Agonist Therapy

PTSD: Post Traumatic Stress Disorders

SUD: Substance Use Disorders

STIs: Sexually Transmitted Infections

UNDP: United Nations Development Programme

UNICEF: United Nations Children's Fund

UNODC: United Nations Office on Drugs and Crime

WADAN: Welfare Association for the Development of Afghanistan

WHO: World Health Organization

YHDO: Youth Health and Development Organization

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Key points

This is the first comprehensive survey on the availability of capacity and resources for substance use disorders (SUD) treatment services in Afghanistan, emphasizing the need for an improved and systematic approach to address the pressing health challenges posed by drug use and its consequences in a rapidly shifting drug landscape.

The survey identified **82 operational treatment facilities**, predominantly residential Drug Treatment Centres (DTCs), serving mainly male patients. Despite the availability of treatment services in 32 out of 34 provinces, significant disparities exist in service distribution, accessibility, and gender representation, particularly affecting female patients.

In 2022, UNODC and UNDP partnered to conduct a survey to capture critical data regarding the capacity of SUD treatment services through direct outreach to identified operational facilities across Afghanistan. The approach included interviews and on-site evaluations conducted to gather quantitative and qualitative information.

73.2% of the total operational facilities identified are DTCs providing residential in-patient care. The remaining facilities offer low-threshold services such as outreach services and drop-in centres (DICs). The Ministry of Public Health (MoPH) primarily funds DTCs under public administration, while facilities run by non-governmental organizations (NGOs) are supported by international agencies. This distinction underscores the collaborative effort in addressing substance use in Afghanistan.

The primary objective of this mapping is to provide a clear picture of the treatment capacity and services available for individuals with SUD in Afghanistan. It aims to inform policy decisions and improve resource allocation for more effective interventions.

17.1% of the facilities offer services for female patients only, while nearly two thirds of the facilities provide service exclusively for men. Furthermore, among the 32 provinces with operational facilities, only slightly over one-third of the provinces have services available for women, emphasizing a significant gap in support for female patients.

Facilities face numerous obstacles in providing effective treatment, including shortages of qualified healthcare professionals and insufficient infrastructure. Additionally, issues such as inadequate facilities and lack of access to basic necessities hinder service delivery.

Opiates remain the most prevalent primary substances leading to treatment admissions in Afghanistan. This is followed by a significant demand for services addressing stimulant use, particularly methamphetamine and amphetamines, indicating a diversity in substance-related issues.

72% is the overall bed occupancy rate among facilities offering in-patient treatment, indicating the level of demand for residential treatment. Facilities administered by the government report a higher occupancy rate compared to NGO and private-run establishments. An average of **48 beds** are available in facilities providing in-patient treatment, with a higher capacity for female attendance observed among privately and NGO-funded facilities compared to those under public administration.

TAKEAWAYS

Synthetic drugs are the second most frequently reported class of substances used by patients seeking treatment

Recent reports indicate a rise in the availability and use of synthetic drugs like methamphetamine alongside traditional opiate use in Afghanistan. This shift seems to be reshaping the treatment landscape, as the characteristics and needs of the patient population diversify and complicate care strategies.

Addressing gender disparities should be a priority

Women face limited geographic access to SUD treatment services. It is essential to expand treatment options for women and ensure gender-sensitive approaches in service delivery.

Community-based treatment is underdeveloped

Community-based treatment remains underdeveloped, yet it offers an effective approach to addressing the varied needs of individuals with SUD, particularly less severe cases. By prioritizing these services, accessibility and overall treatment effectiveness in Afghanistan could be improved.

Urgent infrastructure and resources are needed to improve public health, safety, and social stability in Afghanistan

Facilities urgently require enhanced infrastructure, including nutritious food, hygiene supplies, and medical resources. Addressing these fundamental needs is crucial for improving the quality of care and overall treatment outcomes for people who use drugs.

2. Main conclusions

The evolving drug market landscape in Afghanistan, influenced by recent drug policy changes, may further strain the already limited treatment options for drug rehabilitation, as documented in this report. Most of the treatment services in the country are provided by residential DTCs, which may not fully address the diverse treatment needs and the number of people in need of treatment in the country, which could benefit from integrated community-based services tailored to less severe cases. Additionally, while women make up a substantial proportion of people using drugs in the country, over half of the facilities providing SUD treatment offer services exclusively for men. Moreover, only just above one-third of the provinces have facilities with services available for women.

Furthermore, a shortage of qualified professionals such as medical professionals and a lack of infrastructure improvements to meet patients' needs, including essential items such as clothing and food, were reported during this survey. Most DTCs urgently need enhanced physical facilities and infrastructure. This includes constructing new buildings, upgrading existing ones, and setting up well-equipped laboratories.

Although the capacity levels identified do not suggest a shortage of bed occupancy, with an average occupancy rate of 72% across facilities providing SUD treatment in the country, there is a need for improved services, including better access to medicine and diagnostic offerings. This includes integrating community-based care, which is particularly crucial for the effective provision of Opioid Agonist Therapy (OAT) for the treatment of opioid dependence, and the availability of naloxone for the emergency management of opioid overdose.

Finally, changes in the opiate economy and the rise in the availability of synthetic drugs in Afghanistan could be influencing the demand for drug treatment services in the country. For instance, stimulants drugs such as methamphetamine and amphetamines were the second most frequently reported class of drugs used among the estimated number of annual patients seeking treatment for SUD, with only opiates being more prevalent.

In summary, addressing these complex challenges demands active, collaborative, and coordinated efforts from both the de facto authorities (DfA) and the international community. This includes increasing funding, allocating resources to meet the basic needs of people who use drugs such as improved infrastructure, nutritious food, hygiene supplies, and medical resources.

It is also essential to prioritize a diversified continuum of treatment and care for SUD, incorporating a range of evidence-based interventions and post-recovery programmes of varying intensity, including community-based services, as outlined in the UNODC-WHO International Standards for the Treatment of Drug Use Disorders.¹ These efforts should be accompanied by a thorough integration of pharmacological and psychosocial treatment options across all facilities that support individuals seeking SUD treatment in Afghanistan.

¹ WHO and UNODC. International standards for the treatment of drug use disorders. Revised edition incorporating results of field-testing (2020). Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf

3. Background

The past decades of conflict and instability in Afghanistan have put considerable strain on traditional coping mechanisms and survival strategies among Afghan people. The displacement of populations, both internally and externally, due to conflict over the decades has disrupted extended family structures, rendering the population vulnerable to mental health issues such as anxiety, depression, Post Traumatic Stress Disorders (PTSD) and SUD.²

Afghanistan has been known as one of the largest producers of opium,³ with trafficking and use of opiates directly impacting women, children, and impoverished farmers who rely on the illegal opiate economy. Moreover, the sudden emergence of synthetic drugs is raising concerns about their potential impact on drug use in Afghanistan and neighbouring countries.⁴

Since 2005, four national surveys have assessed the extent of drug use in Afghanistan. Although the findings of these surveys cannot be directly compared due to variations in the population samples and methodologies used, they collectively highlight a concerning public health issue associated with substance use in the country.

In 2005, UNODC jointly with the Ministry of Counter Narcotics of Afghanistan, carried out a drug use survey in 32 provincial capitals, 30 districts centres and 152 villages to estimate the prevalence of drug use in the population. The survey revealed that there were 920,000 people using drugs for non-medical purpose in Afghanistan or the equivalent of 3.8 per cent of the population.⁵

Another survey conducted in 2009, also implemented by UNODC in collaboration with national partners, was based on interviews with people using drugs and key informants. This survey estimated that between 660,000 and 940,000 people (between 5.4 and 7.7 per cent of the adult population of that time) were using drugs regularly.⁶

² Alemi Q, Panter-Brick C, Oriya S, et al. Afghan mental health and psychosocial well-being: thematic review of four decades of research and interventions. *BJPsych Open*. 2023;9(4):e125. Available at: <https://pubmed.ncbi.nlm.nih.gov/37424447>

³ UNODC. Afghanistan Opium Survey 2023.

Available at: https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_opium_survey_2023.pdf.

⁴ UNODC. UNODC Drugs Monitoring Platform Brief on Afghanistan and neighbouring regions: Update on patterns and trends in heroin, methamphetamine and opium trafficking from 2020 to 2023, before and after the April 2022 Afghanistan Drug Ban. Available at: <https://dmp.unodc.org/brief6-public#:~:text=The%20Drugs%20Monitoring%20Platform%20and%20its>

⁵ UNODC. Afghanistan Drug Use Survey 2005. Executive Summary (November 2005).

Available at: <https://www.unodc.org/pdf/afg/2005AfghanistanDrugUseSurvey.pdf>.

⁶ UNODC. Drug Use in Afghanistan: 2009 Survey. Available at: <https://www.unodc.org/documents/data-and-analysis/Studies/Afghan-Drug-Survey-2009-Executive-Summary-web.pdf>

In 2015, an Afghanistan National Drug Use Survey was implemented by the Colombo Plan for Cooperative Economic and Social Development in Asia and the Pacific, in collaboration with local partners. The survey collected biological samples (hair, urine and/or saliva) from individuals from randomly selected households in urban and rural areas. The survey found that 12.8% of the adult population tested positive for exposure to drugs, including alcohol. Of these, 9.5 per cent of women vs. 16.1 per cent of men had exposure to any drug.⁷

Lastly, a national survey conducted in 2018-19 among young people aged 13-18 years (both in and out of school) by UNODC and the United Nations Children's Fund (UNICEF), in collaboration with national partners, found that 12 per cent of respondents reported using any substance, including alcohol, in the past 12 months.⁸ Despite the differences in methodology and scope, most surveys have shown that opiates (primarily opium and, to a lesser extent, heroin) and cannabis are the most used substances in Afghanistan. Opium consumption is especially widespread among the rural population, and heroin use is much higher among male adults than females. For instance, in 2009, around 1.6 per cent of males had regularly used heroin, compared with 0.2 per cent of females. The non-medical use of pharmaceutical opioids and tranquillizers has also been commonly found among adults in general, with women using these substances more often than men.⁹

Of particular concern in Afghanistan is the extent to which people using opium also report giving this substance to their children. In 2009, for example, nearly 80 per cent of women who had used opium also reported giving opium to their children.¹⁰ Moreover, biological samples from 7.5% of children in rural areas involved in the survey conducted in 2015 contained traces of opioids (metabolites), suggesting they had either been administered the drug or were subject to an environment where the substance was being used.¹¹ This kind of exposure to drug use among children in Afghanistan often results from second-hand exposure when smoke is breathed in by children for medicinal or calming purposes, or when they are passively exposed to opium smoke in the home.¹²

⁷ US Bureau of International Narcotics and Law Enforcement Affairs. Afghanistan National Drug Use Survey 2015. Available at: <https://colombo-plan.org/wp-content/uploads/2020/03/Afghanistan-National-Drug-Use-Survey-2015-compressed.pdf>.

⁸ UNODC and UNICEF. Study on Substance Use and Health among Youth in Afghanistan 2018 (April 2021). Available at: https://www.unodc.org/documents/data-and-analysis/statistics/Drugs/Drug%20use/Study_on_substance_use_and_health_among_youth_in_Afghanistan_2018.pdf.

⁹ UNODC. Drug Use in Afghanistan: 2009 Survey (see footnote 6).

¹⁰ Ibid.

¹¹ US Bureau of International Narcotics and Law Enforcement Affairs. Afghanistan National Drug Use Survey 2015 (see footnote 7).

¹² UNODC. Drug Use in Afghanistan: 2009 Survey (see footnote 6).

In recent years, the trafficking and use of synthetic drugs such as methamphetamine has been increasingly reported in Afghanistan.¹³ Notably, during the latest national survey among young people conducted in 2018-19, past-year use of methamphetamine (1.3%) was at the same level as heroin. The self-reported prevalence of “tablet K”¹⁴ use was even higher, at 1.8%.¹⁵

Due to the lack of adequate healthcare services, particularly in rural areas of Afghanistan, some individuals resort to using drugs as a form of self-medication for physical ailments such as coughs, colds, and both acute and chronic pain. Additionally, drugs are sometimes used also non-medically to address psychological issues like stress, anxiety, depression, and trauma.¹⁶ At present, there is no available data on the prevalence of drug dependence nationwide.

In 2022, UNODC and UNDP partnered to address the critical need for an updated survey on substance use and its consequences in Afghanistan. A range of studies have been planned and conducted to have a comprehensive understanding of drug use in the country and the accessibility of dedicated health care services. This first report looks into the capacity of treatment services provided to individuals with SUD in Afghanistan.

The findings presented in this report are based on a study conducted in December 2022, with additional updates on facilities identified after the initial survey, extending through May 2024. The methodology applied was based on the WHO/UNODC substance use disorder treatment facility survey global questionnaire,¹⁷ which has already been used by UNODC in other countries.¹⁸ As the country continues to experience shifts in drug trafficking and usage trends, it is crucial to have a clearer picture of the capacity of health services available for treating SUD in Afghanistan.

¹³ UNODC, World Drug Report 2024 (United Nations publication, 2024).

¹⁴ Tablet K is commonly found in a wide range of colours and shapes, resembling ecstasy tablets. It may contain MDMA, but also a variety of other stimulant drugs, such as opioids and methamphetamine (<https://www.unodc.org/LSS/announcement/Details/66069555-1009-4f55-8a33-f992ea49fbc4#:~:text=Three%20different%20types%20of%20tablet,a%20type%20containing%20mainly%20MDMA>).

¹⁵ UNODC and UNICEF. Study on Substance Use and Health among Youth in Afghanistan 2018 (see footnote 8).

¹⁶ UNODC. Drug Use in Afghanistan: 2009 Survey (see footnote 6).

¹⁷ WHO/UNODC Substance use disorder treatment facility survey.

Available at: https://www.unodc.org/documents/WHO_UNODC_Facility_survey_Draft_for_field_testing_March_2018.pdf.

¹⁸ More examples are available at: UNODC. Cartographie des structures de prise en charge des troubles liés à l'usage des substances dans les pays francophones de l'Afrique de l'Ouest. Available at: https://www.unodc.org/documents/Cartographie_des_structures_de_prise_en_charge.pdf. Treatment Services for Substance Use Disorders in Latin American Countries.

Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC_QALAT_mapping_report_ENGLISH.pdf; UNODC. Drug treatment systems in the Western Balkan.

Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/EMCDDA_UNODC_Publication.pdf.

4. Treatment Options

Different institutions address various aspects of SUD treatment in Afghanistan. The MoPH is the primary responsible authority for leading, implementing and overseeing drug-related harm reduction¹⁹ and treatment programmes from de facto authorities in Afghanistan. Services like overdose management, OAT, and outreach are overseen by the Afghanistan National Program for Control of AIDS, STIs, and Hepatitis (ANPASH) under the MoPH, led by the Communicable Disease Control Programme (CDC). Drug treatment services, especially residential DTCs, for men, women, and children are overseen by the national Drug Demand Reduction Department (DDR).

DTCs in Afghanistan are predominantly residential treatment institutions (hospital or non-hospital based) that provide in-patient care for individuals with SUD. Treatment under DTCs from MoPH usually involves a period cycle of 45 days, followed by an “assessment” of drug dependence symptoms by health authorities.

The remaining facilities in the country are defined as providing low-threshold services aimed at ‘hard-to-reach’ and high-risk groups of people using drugs, as well as those engaged in experimental use. Low-threshold services include outreach services and drop-in centres (DICs) providing harm reduction services (see Box 1 for a detailed description of the most common services provided for the treatment of SUD in Afghanistan).

The information gathered through the implementation of the survey described in this report suggests that the Directorate of DDR from MoPH has the responsibility for the national drug treatment response in Afghanistan. Meanwhile, ANPASH focuses on managing harm reduction services, including OAT, which are provided by DICs and mobile outreach teams. Aside from DDR-administered DTCs, NGOs are also engaged in the provision of a wide variety of drug prevention, treatment, rehabilitation, and harm reduction services. NGO-administered facilities rely on financial support from the international community. Although independent in their overall administration and management, NGO-administered facilities are required to be affiliated with DDR from MoPH and must adhere to their standards of drug treatment and prevention.

¹⁹According to the Political Declaration on the Guiding Principles of Drug Demand Reduction adopted by the United Nations General Assembly in 1998, the term drug demand reduction is used to describe policies or programmes directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions. These principles state that activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and the society.

At the time the treatment facility survey was conducted in December 2022, 16 local and/or international NGOs were operating in the field of drug use services in Afghanistan, including harm reduction; however, only eight were providing actual services or activities to their target group.²⁰ In addition to providing harm reduction services such as OAT, distribution of condoms, on-site testing for sexually transmitted infections (STIs), and psychological support for people who use drugs in community settings, some of these NGOs are also engaged in providing treatment and care for SUD within prison settings.

The services provided by NGOs in prison settings focus on harm reduction and SUD treatment interventions, including OAT. For example, YHDO (Youth Health and Development Organization) has established DICs in Kabul, Nangarhar and Herat prisons, while MMRCA (Medical Management and Research Courses for Afghanistan) operates similar centres in Kunduz and Balkh prisons. Other NGOs such as WADAN (Welfare Association for the Development of Afghanistan) offer services targeting individuals with SUD through residential treatment programmes and low threshold services exclusively within community settings.

²⁰ In 2016, eight NGOs grouped together and formed a consortium called CHATAR (“Shelter” in English) to promote cooperation, coordination, and networking between civil society organizations in Afghanistan working in the field of substance use prevention, treatment, recovery, and substance-use related HIV/AIDS prevention. The consortium is still active and led by the WADAN.

Box 1. Definition of facilities for treatment of SUD in Afghanistan used during the UNODC facility mapping exercise (2022).

A **facility**²¹ refers to a distinct organizational entity, such as a medical centre, a department, or a programme, which has its own defined objectives, procedures, rules, and scope of services and interventions. Each facility typically has its own target group(s), a team, and a manager (team leader). These facilities may be standalone entities, such as national addiction treatment centres, or integrated with other healthcare providers, including general healthcare centres, mental health clinics, or hospitals. The survey described in this report considered only those facilities providing treatment for SUD. They were classified as follows:

- **Residential substance use disorder treatment service:** a drug treatment centre (DTC), as described in this report, is either a 24-hour hospital facility that provides nursing and/or medical care for sick or injured, including those with SUD, or a non-hospital residential facility offering SUD treatment to people who use drugs.
- **Low-threshold service:** The term ‘low-threshold’ describes an implementation setting that facilitates drug users’ access to health and social services, in particular those that help to prevent and reduce health-related harm associated with drug use. To encourage drug users to enter into contact, the use of these services typically requires little bureaucracy, often no payment, and is not conditional upon being or becoming drug-free. They target current users, ‘hard-to-reach’ and high-risk groups among drug users and experimental users. This includes outreach services and drop-in centres as well as basic social services.
- **Drop-in centres (DICs):** these are community-based low-threshold services providing outpatient treatment for SUD, including for people who inject drugs. These centres are designed to be close to the communities they serve, ensuring daily contact with patients is possible. DICs provide non-residential treatment, prevention, and harm-reduction services. Patients can access them based on their needs and convenience. In Afghanistan, the services provided by DICs include OAT, distribution of condoms, on-site STI testing, and psychological support for individuals using drugs.

²¹ All definitions used here were obtained from the WHO/UNODC Substance use disorder treatment facility survey (see footnote 17) and adapted to the local context.

5. The Drugs Scenario

In 2022, the Deputy Ministry of the Counter Narcotics Police (DM-CNP) under the Ministry of Interior (MoI) of the DfA assumed an additional role aiming to reduce drug demand by enforcing the implementation of the Decree on the “Prohibition of poppy cultivation and all types of narcotics” issued on 3 April 2022. Since then, the DM-CNP has focused on eradicating opium cultivation and reducing the production of other drugs, such as methamphetamine, while also referring people who use drugs to centres managed by the MoI or DTCs under the MoPH.

For instance, the DM-CNP opened a centre in Kabul called Aghoosh in 2023, with a capacity to accommodate 5,000 people,²² with other similar centres operating around the country. It should be noted that these centres were not included in the current survey, which only covered DTCs affiliated with MoPH and other health facilities providing SUD treatment.

Following the opium poppy ban, which included the prohibition of drug use, the rounding up of people using drugs intensified in Afghanistan. By 2023, according to media sources, the DM-CNP announced that more than 82,000 individuals using drugs from all 34 provinces were taken mostly to centres managed by MoI or to various DTCs. Furthermore, a declining trend in international support for treatment capacities in the country after 2021 posed significant challenges in accommodating new patients and providing adequate treatment services for them.²³

The enforcement of the new drug policies by DfA has led to a significant reduction in visible drug use hotspots in Afghanistan.²⁴ However, these actions may also have driven people using drugs underground to avoid being brought to centres. This could not only further restrict access to individuals with SUD for the provision of support over time but also reduce the willingness of people who use drugs to participate in efforts to assess the drug situation in the country.

²² AfGOV. The Ministry of Interior's message on the occasion of World Anti-Narcotics Day, June 26th. Available at: <https://moi.gov.af/index.php/en/ministry-interiors-message-occasion-world-anti-narcotics-day-june-26th>;

TOLONews. 5,000-Bed Addiction Treatment Center Opens in Kabul. Available at: <https://tolonews.com/fa/afghanistan-181863>

²³ Nikkei Asia. Afghanistan's opium tragedy persists despite Taliban cultivation ban. Available at: <https://asia.nikkei.com/Spotlight/The-Big-Story/Afghanistan-s-opium-tragedy-persists-despite-Taliban-cultivation-ban>

²⁴ Nafeh F, Werb D, Karamouzian M. The ups and downs of harm reduction in Afghanistan. *Lancet Reg Health Southeast Asia*. 2023;13:100186. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10306026>

6. Methods

A structured survey of drug treatment facilities operating in Afghanistan was conducted in December 2022. This survey was based on discussions held with the Directorate of DDR from MoPH, as well as with civil society organizations (CSOs) involved in providing drug treatment services, and it covered all provinces in the country. A total of 109 facilities, managed by CSOs, MoPH, and the private sector, were identified and mapped across 34 provinces (see Table 1). Between 2023 and May 2024, additional centres were opened, and a quick listing was undertaken to update the total number of centres, although no interviews were conducted at these new centres (see Section 6.3 for more details).

Table 1. Number of drug treatment facilities identified during the consultation process with CSOs, the MoPH of the DfA and the private sector (2022).

| Region | Provinces | Number of total centres |
|----------|--------------|-------------------------|
| Central | Kabul | 20 |
| | Logar | 1 |
| | Maydanwardag | 1 |
| | Kapisa | 1 |
| | Panjsher | 1 |
| | Parwan | 1 |
| | Bamyan | 3 |
| | Day Kundi | 1 |
| Southern | Ghazni | 3 |
| | Pakteka | 1 |
| | Paktya | 2 |
| | Khost | 1 |

| | | |
|----------------------|------------|------------|
| Eastern | Nangarhar | 7 |
| | Laghman | 1 |
| | Kunar | 1 |
| | Nuristan | 1 |
| North-eastern | Badakhshan | 9 |
| | Takhar | 1 |
| | Kunduz | 5 |
| | Baghlan | 2 |
| Northern | Balkh | 11 |
| | Samangan | 1 |
| | Saripul | 1 |
| | Jawzjan | 4 |
| | Faryab | 2 |
| Western | Hirat | 9 |
| | Badghis | 1 |
| | Farah | 5 |
| | Ghor | 1 |
| South-western | Kandahar | 4 |
| | Hilmand | 2 |
| | Nimroz | 3 |
| | Uruzgan | 1 |
| | Zabul | 1 |
| Total | | 109 |

Note: Centres managed by MoI of the DfA in Afghanistan were not included in this consultation process.

6.1. Data Collection

Data collection was made possible through the work conducted by 28 field surveyors supervised by five field coordinators deployed across the 34 provinces of Afghanistan. Data was collected through face-to-face interviews with focal points in each facility using Computer Assisted Personal Interviews (CAPI). Survey tools and questionnaires were translated from English to Dari and Pashto, and then transferred to Open Data Kit (ODK) software before initiating the field work. Post-interview verification was conducted by contacting the focal points of each facility as recommended by their parent organization.

Data was collected by surveyors in a group of two or three survey enumerators composed of at least one male and one female surveyor. Where a male surveyor was not allowed access (mostly at facilities designated specifically for female patients), a group of at least two female surveyors was assigned to conduct the mapping exercise. All interviews were conducted during December 2022.

The questionnaire used for the purpose of the current facility mapping was developed based on the global survey questionnaire from the UNODC-WHO Programme on Drug Dependence Treatment and Care.²⁵ The adapted questionnaire for Afghanistan was comprised of five different sections:

- A. treatment facility contact details for survey correspondence
- B. treatment facility contact details for the general public
- C. description of the treatment facility and treatment offered
- D. number of people treated
- E. treatment capacity (buildings, and staff)

A three-day intensive training workshop was organized in Kabul on 4-6 December 2022 for all field surveyors and field coordinators. During the training, surveyors received a comprehensive list of all drug treatment facilities initially screened in Afghanistan, along with the contact information of the focal person for each facility. They were instructed to contact these focal points at least two days prior to the scheduled interviews. Meanwhile, the UNODC country office in Afghanistan, located in Kabul, maintained ongoing engagement with the parent organizations operating these facilities. This facilitated data collection and ensured the provision of accurate and up-to-date information.

²⁵ WHO/UNODC Substance use disorder treatment facility survey (see footnote 17).

6.2. Ethical Considerations

Ethical consideration for this mapping exercise included maintaining the safety and security of field workers and respecting the privacy and safety of respondents. A consent form which was translated into the local language(s) was obtained from interviewees. Anonymity and confidentiality of the information provided by respondents were preserved throughout all phases of the mapping exercise.

6.3. Update on Facilities during 2023-2024

A set of facilities was identified as newly operational following the completion of the UNODC facility mapping in December 2022. These facilities were either not functional during the assessment or were opened shortly thereafter (see Table 2). This included DTCs and facilities providing low-threshold services, such as DICs. The verification and determination of their operation status were based on field visits by UNODC, joint monitoring visits with WHO and other partners, and the status of coverage provided through financial support from UNODC or known partners. All the newly identified facilities were included in this report to summarize the availability of services in the country up to May 2024. However, details on infrastructure, funding mechanism, capacity levels, and treatment options are provided only for those facilities originally identified as operational during the facility mapping completed in December 2022.

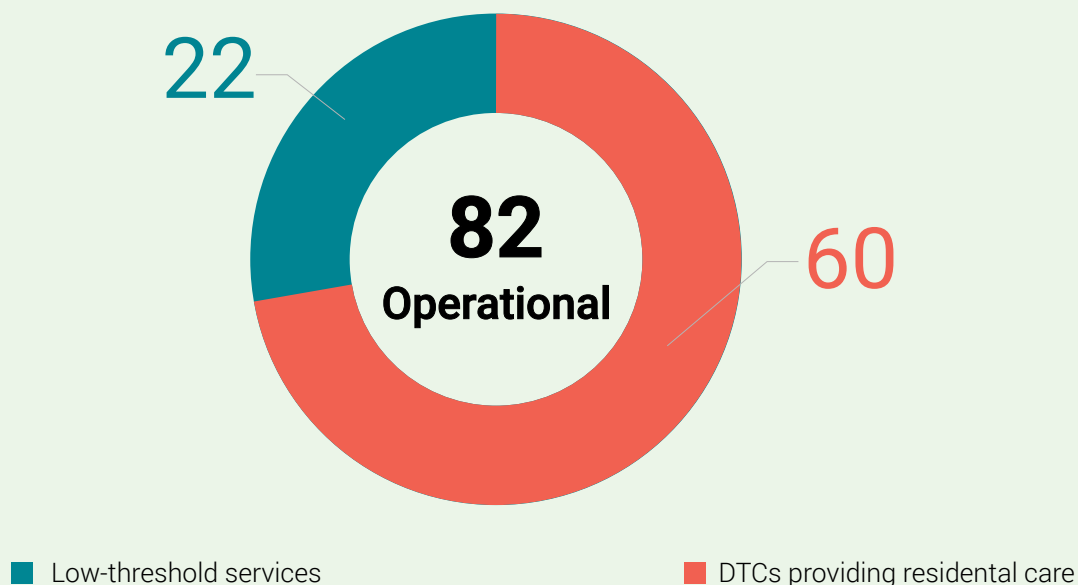
Table 2. DTCs and low-threshold services providing SUD treatment identified in Afghanistan from early 2023 up to May 2024.

| | Province | Type of service | Capacity level | Type of verification |
|----|----------|----------------------------|-----------------|---|
| 1 | Laghman | DIC for both men and women | - | Newly established in March 2023 with support from UNODC |
| 2 | Nuristan | DTC for men | 20 | Supported by UNODC since August 2023 |
| 3 | Nimroz | DTC for men | 80 | Supported by MoPH, with UNODC initiating the provision of basic needs such as food, winterization items, and hygiene kits in March 2023 |
| 4 | Nimroz | DTC for women and children | 20 | Supported by the MoPH, with UNODC initiating the provision of basic needs such as food, winterization items, and hygiene kits in March 2023 |
| 5 | Takhar | DTC for men | 40 | Supported by the MoPH, with UNODC initiating the provision of basic needs such as food, winterization items, and hygiene kits in March 2023 |
| 6 | Pakteka | DTC for men | 30 | Supported by WHO since October 2023 |
| 7 | Hirat | DTC for women | 20 | Newly established in 2023, this facility received short-term support from UNODC between October 2023 and January 2024 |
| 8 | Zabul | DTC for women | 20 | Newly established in 2023, this facility received short-term support provided by UNODC between October 2023 and January 2024 |
| 9 | Nimroz | OAT for men | 500 people/year | Newly established in 2024 with support from UNODC |
| 10 | Hirat | OAT for men | 500 people/year | Newly established in 2024 with support from UNODC |
| 11 | Kabul | OAT for men | 250 people/year | Newly established in 2024 with support from WHO |
| 12 | Hilmand | OAT for men | 250 people/year | Newly established in 2024 with support from WHO |

7. Overview of Results

The survey revealed that a total of 70 facilities were providing treatment services for SUD in Afghanistan as of December 2022, with an additional 12 facilities starting operations between 2023 and May 2024. Although three facilities refused to participate in the 2022 study, their operational status was reported for this mapping. Most of the facilities identified in Afghanistan consisted of DTCs providing residential in-patient care, accounting for 73.2 per cent of the country's facilities actively offering SUD treatment. The remaining facilities were categorized as providing low-threshold services, including outreach services, outpatient services and DICs (see Figure 1).

Figure 1. Number of facilities for treatment of people with SUD in Afghanistan by operation status (2022-2024).



Note: The initial mapping assessment was conducted in December 2022, and since then, the situation in some centres may have changed. Twelve facilities were identified after the completion of the survey, which were either not operational at the time of the assessment or were inaugurated shortly afterward (see Table 2 for more details). DTCs whose main services are in-patient treatment, but have no financial resources to provide in-patient services, were considered non-operational. Low-threshold services refer to community and/or prison-based services, some of which provide OAT.

7.1. Facilities Overview

Most of the facilities operating and providing residential treatment services are under public administration, while nearly 10 per cent are run by international NGOs. Only 5 per cent fall under the category of privately owned or funded centres and others (see Table 3). All these centres are registered with the MoPH, but have their own distinct approaches, funding mechanisms, or operational structures.

Table 3. Administrative affiliation of operational facilities providing SUD treatment in Afghanistan (2022-2024).

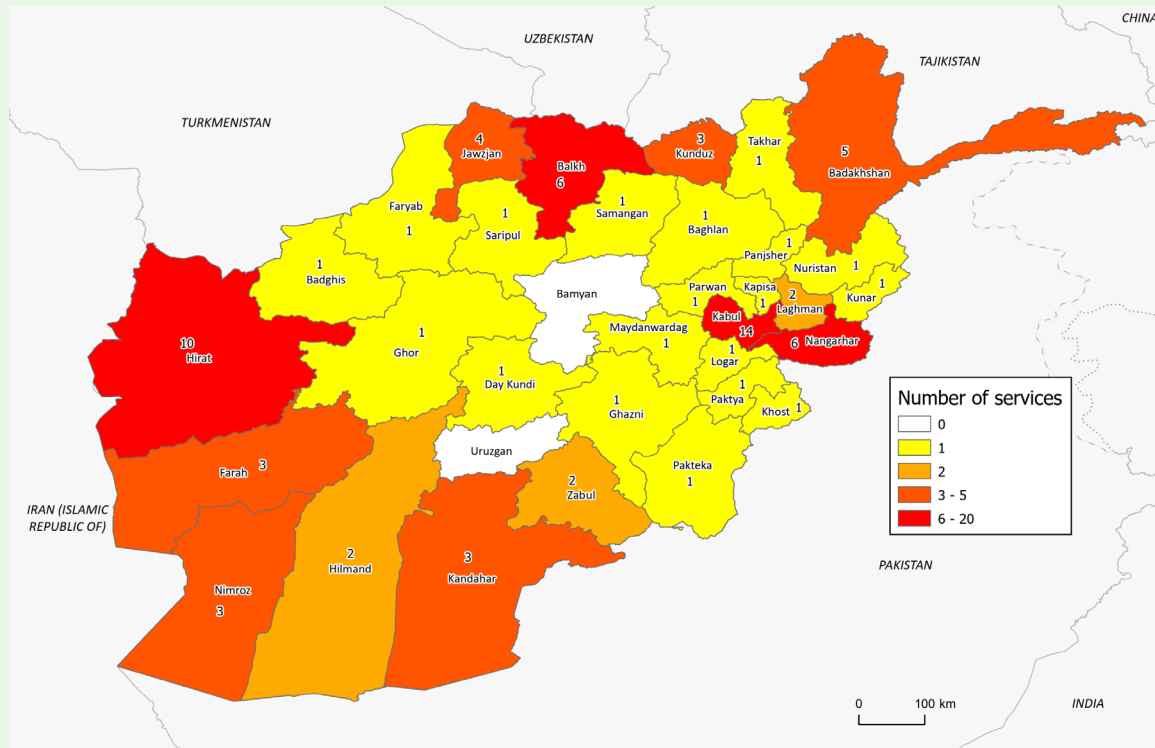
| Affiliation of the treatment facility surveyed | Number of facilities | Percentage (%) of total facilities | Percentage (%) within each service category |
|---|----------------------|------------------------------------|---|
| DTCs providing residential treatment service | 60 | 73.2 | |
| Public | 48 | 58.5 | 80.0 |
| NGOs | 8 | 9.8 | 13.3 |
| Private | 3 | 3.7 | 5.0 |
| Others | 1 | 1.2 | 1.7 |
| Low-threshold service | 22 | 26.8 | |
| NGOs | 22 | 26.8 | 100 |
| Total | 82 | | |

It is worth noting that the specific characteristics of facilities within each administrative affiliation may differ significantly. This variation can include factors such as the size of the facility, available resources, treatment approaches, target populations, geographical coverage, and the range of services provided. For example, most residential treatment services are under public administration, while all low-threshold services such as outreach centres and DICs are operated and funded by international NGOs.

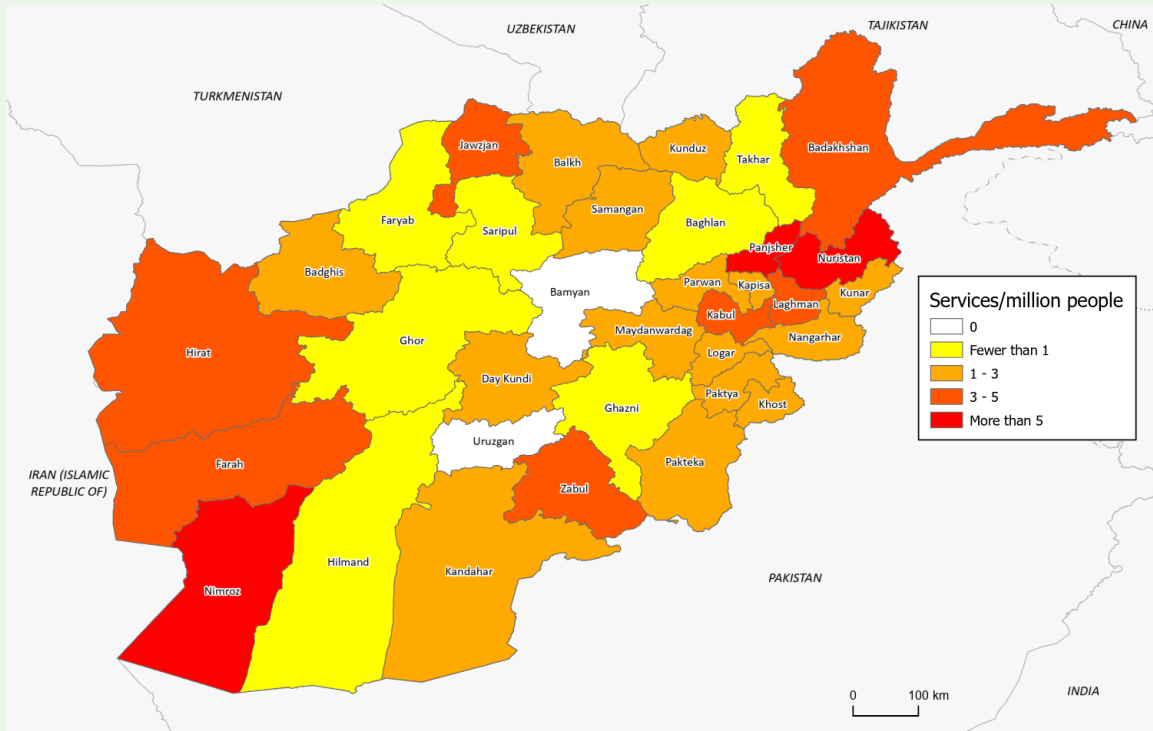
Additionally, although 32 out of the 34 provinces have at least one operational facility, the facilities are not evenly distributed, with many provinces having just one identified facility, especially in the provinces located in the central region of the country (Map 1).

Map 1. Number of facilities (a) and the rate of facilities per million people (b) providing SUD treatment by status of operation and location by province in Afghanistan (2022-2024).

a)



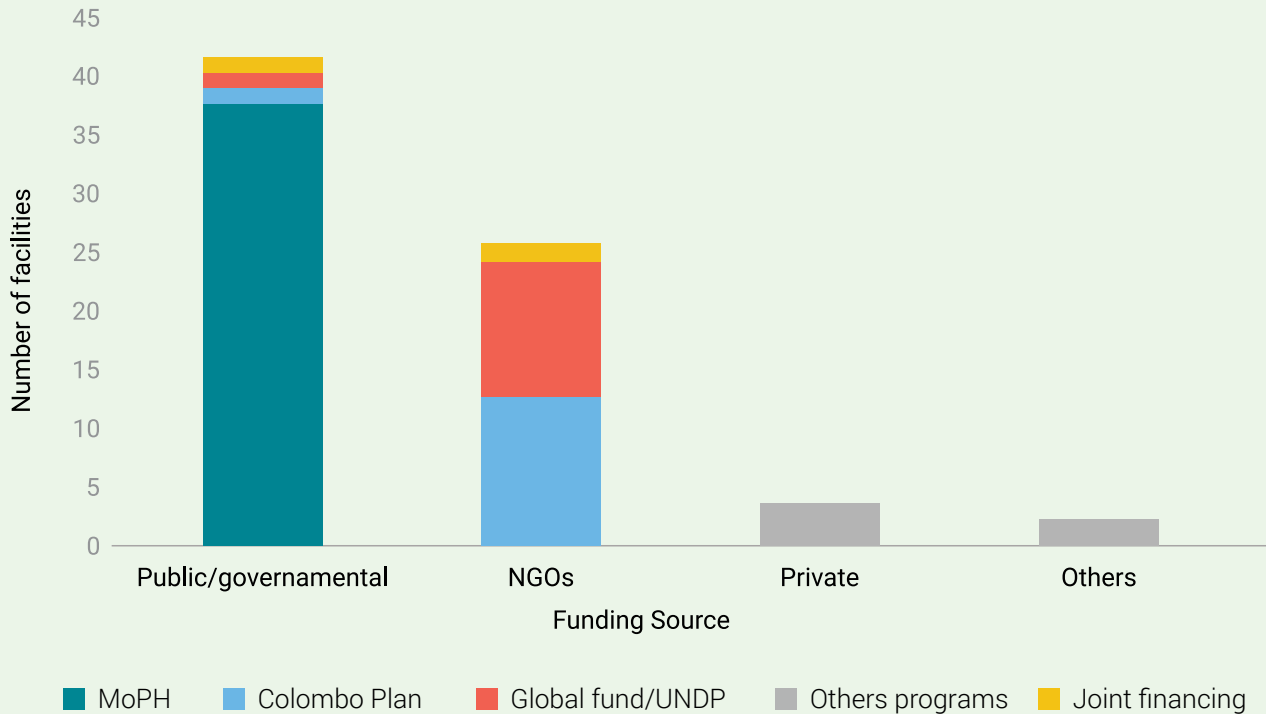
b)



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. Provincial population figures are approximate and based on the Microsoft Building Footprints dataset combined with population data from REACH.

Regarding the source of funding, the MoPH is primarily responsible for providing resources for DTCs under public administration, while funding for NGO-based facilities stems from international agencies (see Figure 2).

Figure 2. Source of funding for facilities providing treatment for SUD in Afghanistan (2022).

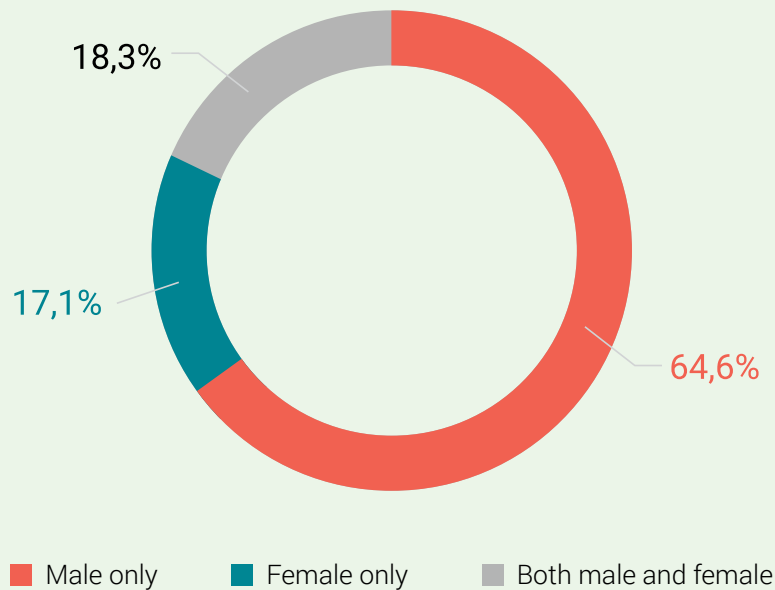


Note: Joint financing is when two or more programmes support the operational facilities identified. Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

7.2. Services Availability

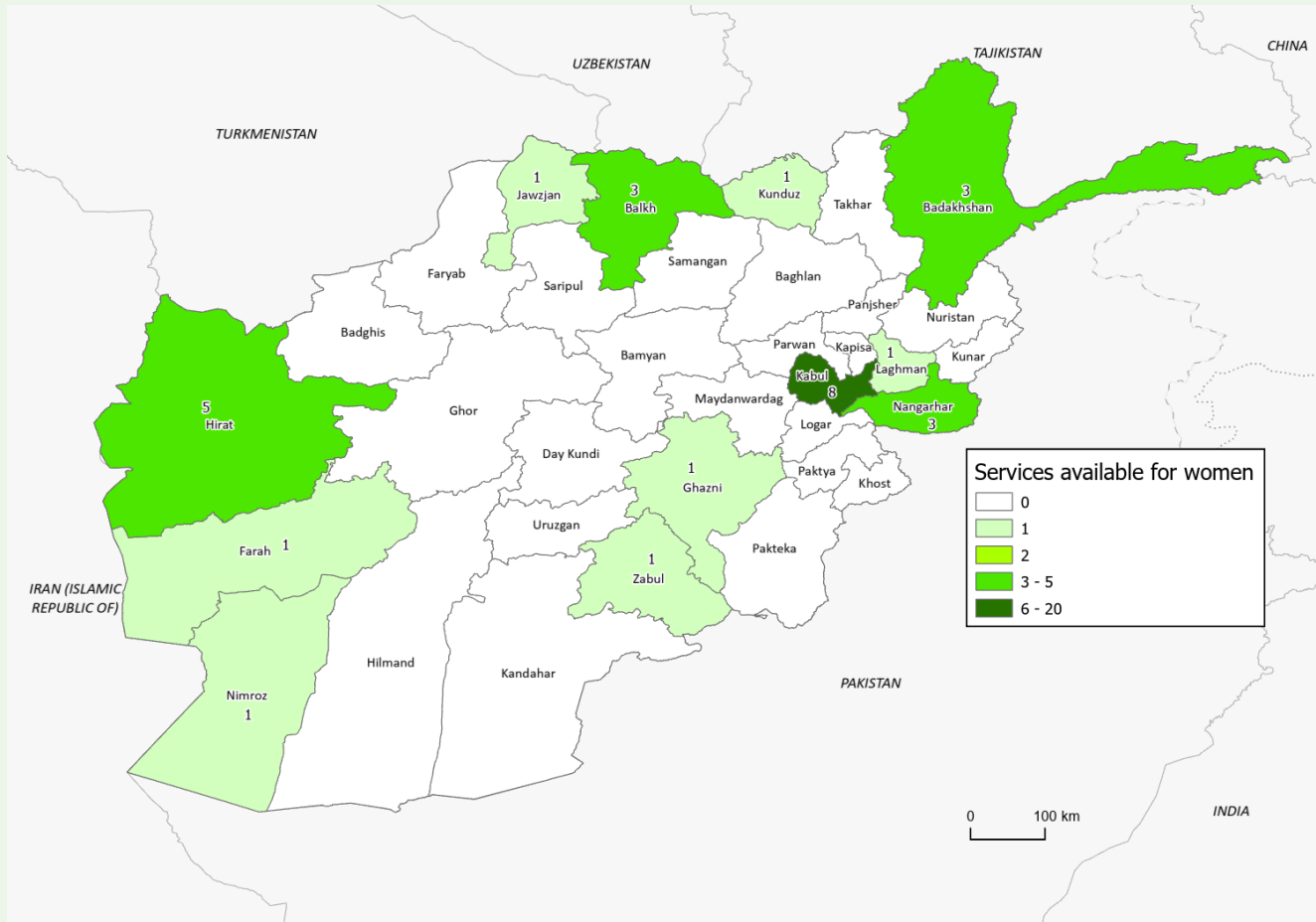
In terms of services offered to individuals receiving SUD treatment, most facilities provided treatment for male patients only, with few providing services for both women and men (see Figure 3).

Figure 3. Service availability by sex in facilities for the treatment of SUD in Afghanistan (2022-2024).

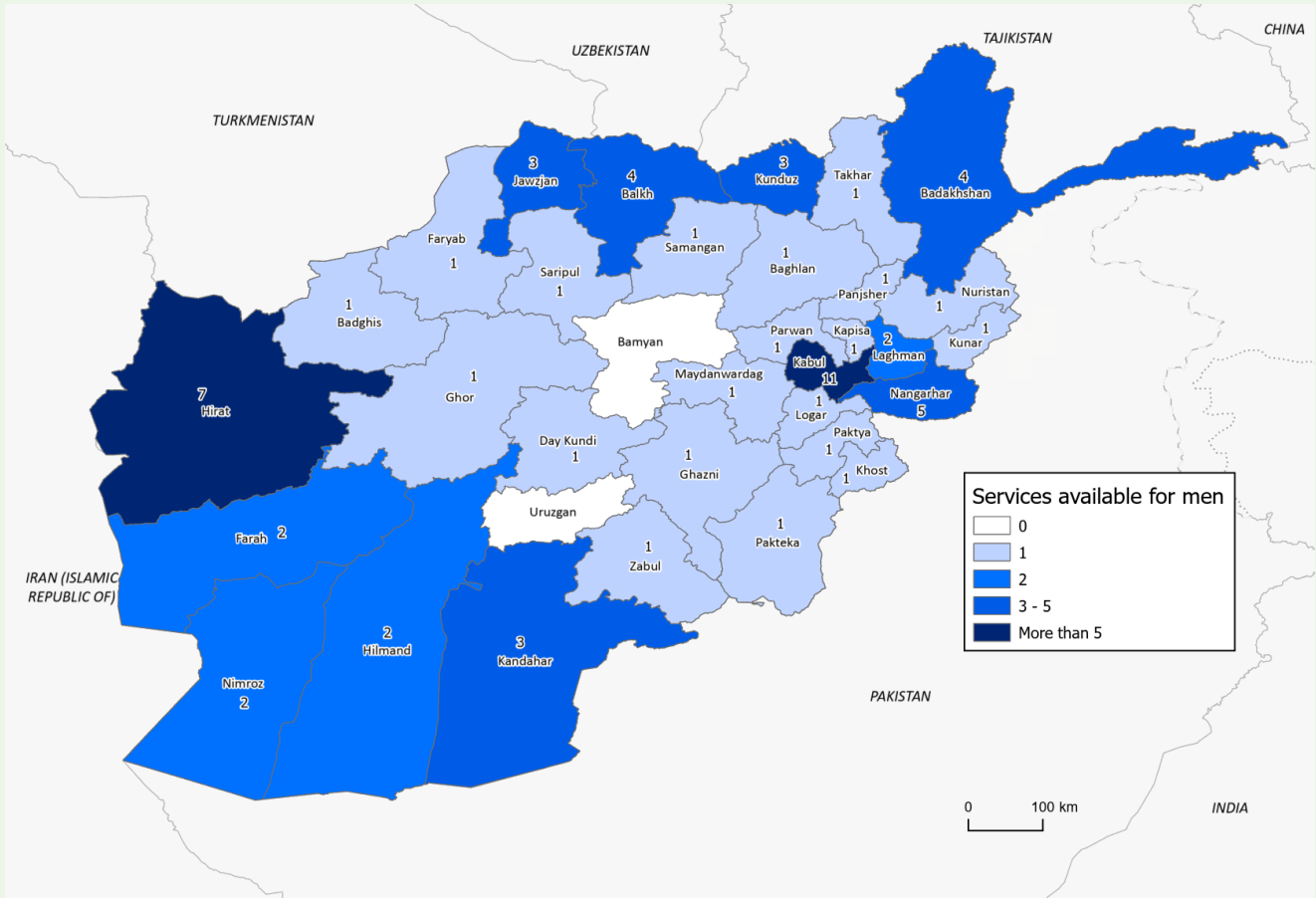


Moreover, among the 32 provinces where at least one facility was identified, slightly over one-third of the provinces had services available for women (see Map 2).

Map 2. Service availability by sex in facilities for the treatment of SUD according to location, by province in Afghanistan (2022-2024).



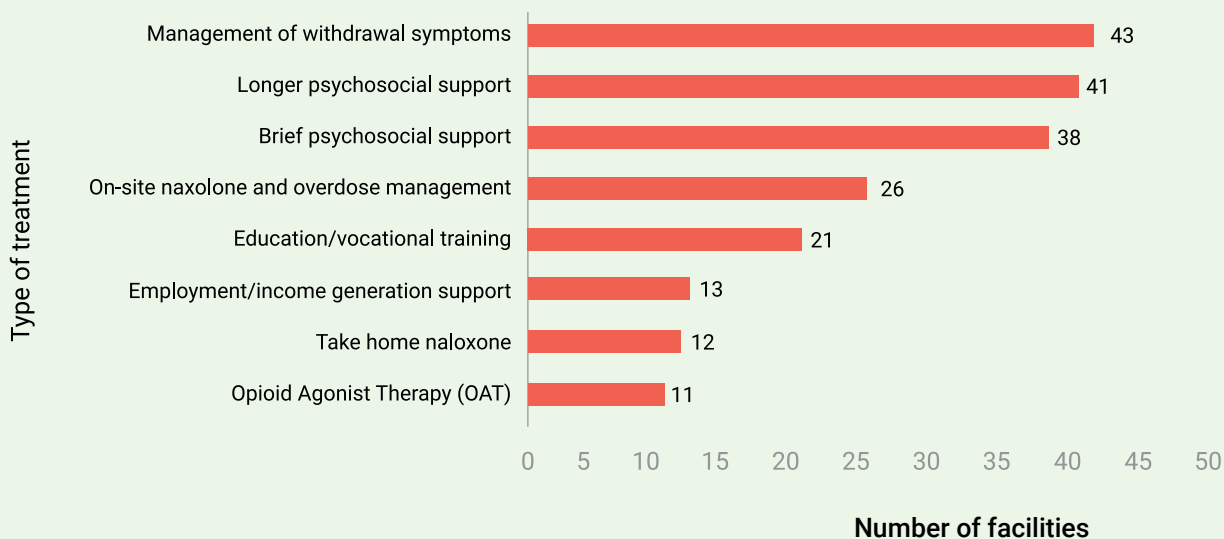
Afghanistan Drug Insights Volume 3:
**Mapping of Facilities for Treatment of Substance Use Disorders: Addressing Service
 Provision Challenges in a Humanitarian Crisis**



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Among the 70 facilities that provided details about the type of treatment and services offered, the majority reported management of withdrawal symptoms (mainly through symptomatic management only) and psychosocial support as treatment tools. Less than half of the facilities reported having educational/vocational training available or on-site availability of naloxone, an emergency medication for the reversal of opioid overdoses. Furthermore, fewer than a third of the facilities offered income generation support programmes (see Figure 4).

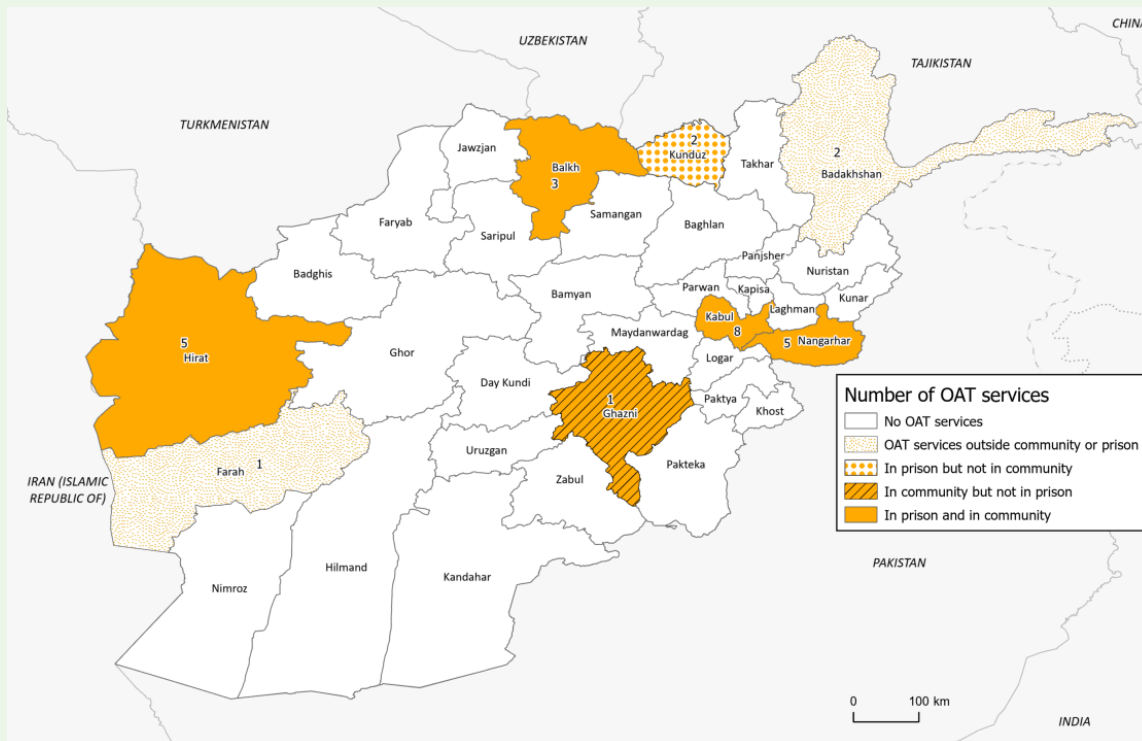
Figure 4. Type of treatment services provided by facilities for the treatment of SUD in Afghanistan (2022).



Note: Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

Regarding OAT provision, eight provinces were providing this type of treatment through NGO-based facilities, with five of them working in prison settings (see Map 3).

Map 3. OAT provided by facilities for the treatment of SUD by location, Afghanistan (2022).



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

7.3. Capacity Levels

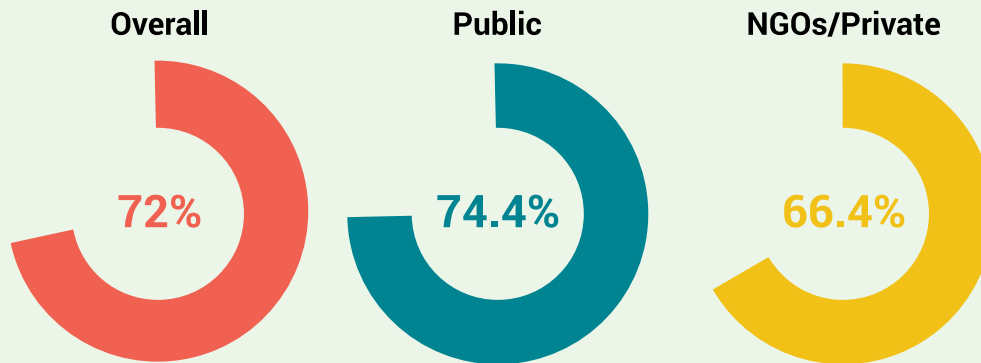
A total of 2,817 personnel were reported working across all facilities identified in Afghanistan in 2022. Of these, 361 were medical staff (details about the composition of different personnel types are presented in Table 4). The bed occupancy rate among facilities offering in-patient SUD treatment in Afghanistan varied little among the different types of facilities with available data, with an overall rate of 72%. Facilities under public administration had a higher bed occupancy rate than those funded by NGOs and private organizations (see Figure 5).

Table 4. Type of personnel working in facilities providing SUD treatment in Afghanistan (2022).

| Type of personnel | Total number reported |
|---|-----------------------|
| Medical staff | 361 |
| - medical doctors specialized in addiction medicine or addiction psychiatry | 93 |
| - general psychiatrists | 44 |
| - medical doctors not specialized in psychiatry or addiction medicine | 224 |
| Nursing staff, of which: | 410 |
| - addiction/psychiatric nurses | 144 |
| - general nurses | 266 |
| Nursing assistants | 15 |
| Pharmacists | 34 |
| Psychologists | 172 |
| Social workers | 413 |
| Other professionals (degree level) | 178 |
| Other treatment personnel, of which: | 809 |
| - outreach workers | 172 |
| - community health workers | 37 |
| - volunteers | 85 |
| - others | 515 |
| People not providing treatment, of which: | 425 |
| - staff (administrative) | 403 |
| - volunteers/interns | 22 |
| Total personnel | 2,817 |

Note: Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

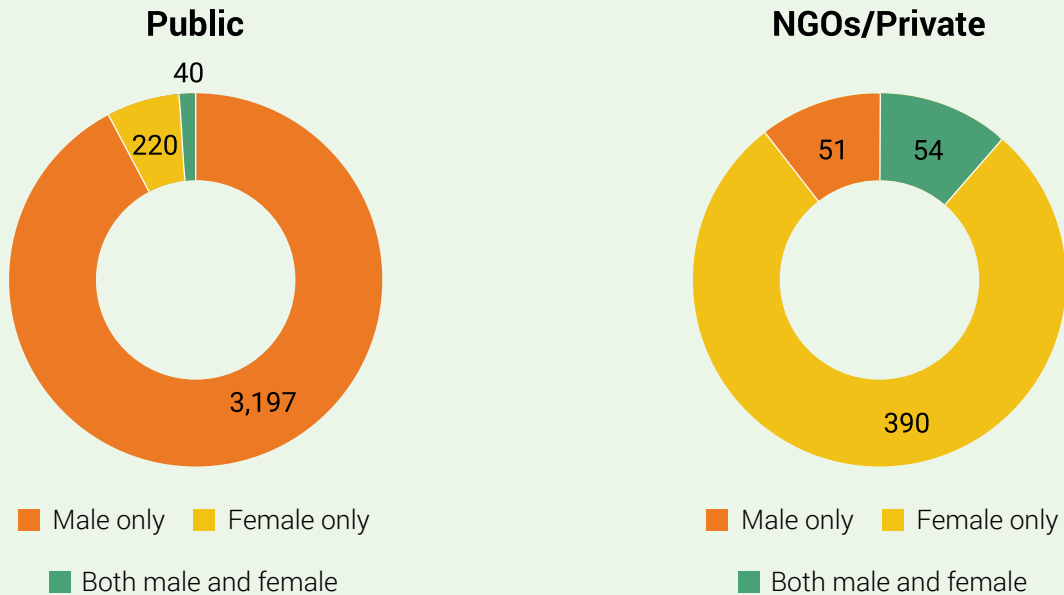
Figure 5. Bed occupancy rate (%) by type of affiliation for facilities providing SUD treatment in Afghanistan (2022).



Note: Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

The total capacity, measured as the number of beds available in facilities providing in-patient treatment, reached 3,952 by December 2022, with an overall average of 48 beds per facility. Most of the capacity available was reported by facilities under public administration (3,457), while the remaining capacity was provided by NGOs/private sources (495). Capacity levels for female-only attendance were higher among privately and NGO-funded facilities compared to those under public administration (see Figure 6).

Figure 6. Capacity levels as measured by the number of beds available reported among facilities providing in-patient treatment for SUD in Afghanistan according to the type of affiliation and availability by sex (2022).

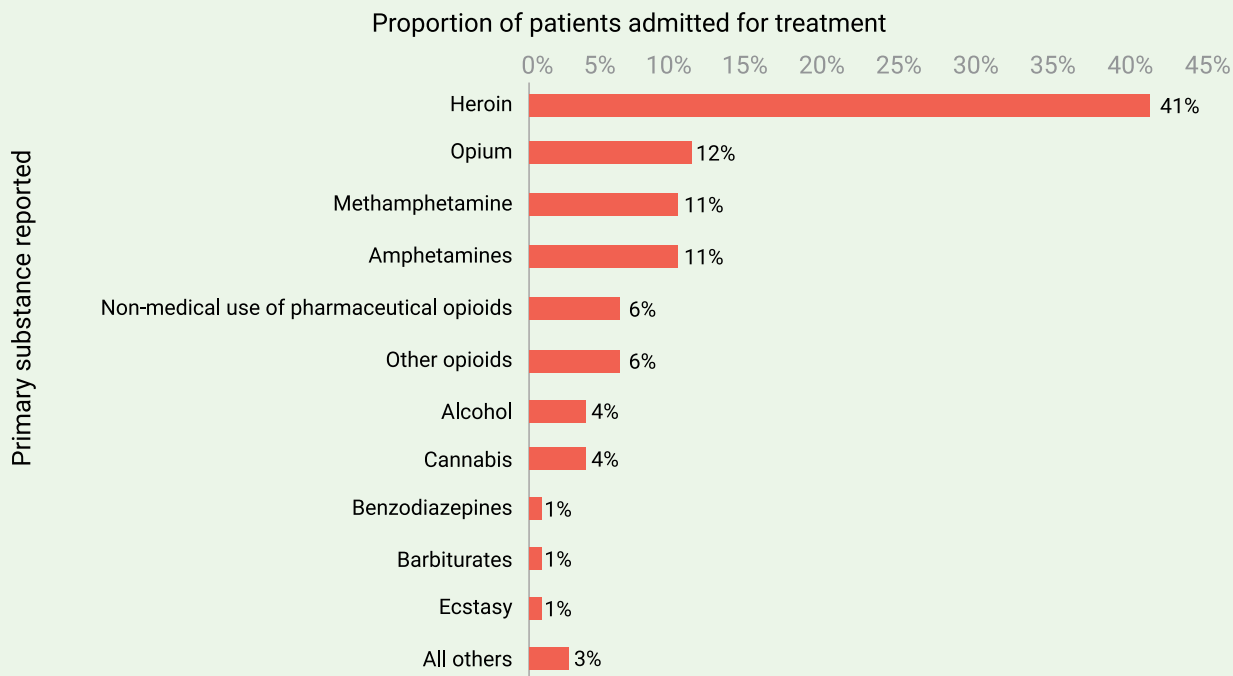


Note: Data was provided only by the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

7.4. Number of patients treated by substance type

Opiates (heroin and opium) were the most prevalent primary substances reported as the cause for SUD treatment in the identified facilities, followed by stimulants (methamphetamine and amphetamine). Pharmaceutical opioids, alcohol and cannabis also comprised a substantial portion of the volume of primary treatment demand reported (see Figure 7).

Figure 7. Proportion of patients receiving SUD treatment during the past 12 months by type of primary substance as reported by facilities in Afghanistan in 2022 (N=38,690).



Note: The number of patients reported for each substance refers to the primary cause for SUD treatment as estimated by the annual demand described by focal points in facilities. A total of 38,690 annual clients were reported among the 70 facilities initially surveyed during the facility mapping conducted in December 2022.

7.5. Qualitative assessment of SUD treatment services

According to qualitative assessments based on interviews with focal points from facilities obtained during field work in December 2022, many facilities providing SUD treatment in Afghanistan are grappling with significant staffing issues exacerbated by prolonged delays in salary payments. This financial strain and inadequate remuneration have forced many skilled personnel to resign. Furthermore, facilities are also facing acute difficulties in recruiting competent staff members, and there is a pressing need to enhance the capacity of the existing workforce.

DTCs are also lacking essential medical professionals who can provide crucial diagnoses and treatments for both drug use and associated diseases. Community-based treatment, often considered an effective and efficient approach, is underdeveloped, and remains insufficiently prioritized. Recovery support services tailored to educational assistance, employment support, and temporary livelihood opportunities for individuals undergoing recovery or already recovered also need to be improved.

Additionally, these centres face shortages of fundamental necessities such as nutritious food, clothing, hygiene kits, and medicines. Furthermore, they struggle with insufficient access to clean drinking water, electricity, beds, bed sheets, blankets, washing machines, among other essential items.

Transportation poses another significant challenge, as staff members are often not paid travel expenses, and there are limited transportation services available to reach people using drugs in need of treatment. DTCs also require essential technological equipment to effectively provide follow up support and ensure reintegration of patients.

