

Substance Use Disorder in Afghanistan: The Situation and Needs to Address the Issue

MANSOOR, A. I.

Kabul University of Medical Sciences, Kabul, Afghanistan

Citation | Mansoor, A. I. (2023). Substance use disorder in Afghanistan: The situation and needs to address the issue. *Adiktologie*, 23(4), 303–317. <https://doi.org/10.35198/01-2023-004-0004>

INTRODUCTION: More than four decades of war and tragedy have destroyed most of the public infrastructure in Afghanistan. Currently, drug use is a major public health crisis in the country and drug treatment services have extremely limited coverage. This article is a review of substance use problem and treatment situation prior to the reinstatement of Taliban. The aim of this article is to provide evidence-based recommendations for policy makers to improve substance use treatment services and to integrate some components of this sector into primary health care and to ensure sustainability of services.

METHODS: A systematic search was conducted using key databases Medline, Embase, PsycINFO and Global Health. Manual search was also conducted to find further studies using Google Scholar, WHO, UNODC, relevant NGOs and Afghan government websites.

RESULTS: Substance use treatment programs have significant achievements over the last recent years in Afghanistan. However, many challenges need to be addressed. Current treatment programs are mainly donor dependent, and their sustainability is not ensured.

CONCLUSIONS: Substance use treatment sector has made significant progress in Afghanistan. But almost all programs have been in forms of short-term projects funded by external donors. Community-

based approaches and expanding care to rural areas need to be prioritized as reasonable and cost-effective alternatives for the current resource-intensive programs. Further coordination mechanisms need to be established among different stakeholders to mobilize resources and engage community and local actors.

Keywords | Substance Use Disorders – Addiction Treatment – Afghanistan – Drugs – Heroin

Submitted | 8 August 2023

Accepted | 3 January 2024

Corresponding author | Ahmad Irshad Mansoor, MD, MSc, Kabul University of Medical Sciences, Kabul, Afghanistan

ahirshad@hotmail.com

1 INTRODUCTION

1.1 History and background

Often called the crossroads of central Asia, Afghanistan is a landlocked and mostly mountainous country which shares borders with Pakistan, Iran, Tajikistan, Uzbekistan, Turkmenistan, and China. Due to a significant geopolitical and geostrategic importance, the country has been invaded by many regional and global powers and has suffered numerous conflicts and civil wars over the centuries. Afghanistan connects central Asia to India, and China to the Middle East. Numerous historic trade and migration routes have threaded through the country for a long time. According to The National Statistics and Information Authority (NSIA) of Afghanistan, the estimated population of Afghanistan is 34 million and more than 70 percent are living in rural areas. 5 percent of the population are Kochis with a nomadic lifestyle, mainly uneducated and underprivileged (NSIA, 2021). Afghanistan has 34 provinces as primary administrative divisions. Each province has several districts as secondary level administrative units. Kabul with around 5 million populations is the capital since year 1776 and the largest urban centre in the country. Kandahar, Herat, Nangarhar and Mazar-i-Sharif are other major cities in Afghanistan.

As a complex mosaic of ethnolinguistic collections and mixture of cultures, Afghanistan is home for more than 14 ethnic groups living together. Pashtuns are the largest ethnic group, followed by Tajik, Hazara, Uzbek, Turkaman, Baloch, Aimaq and others. Pashto and Dari are the official languages of the country, while majority of Afghans are bilinguals.

Afghanistan's recent tumultuous history is replete with violent conflicts and tragic wars mainly after the Soviet invasion. Often regarded as a balancing point between the global superpowers, the people have always been victims and vulnerable to rivalries and interferences of neighbouring countries and global powers.

Ordinary Afghans are paying a huge price for the proxy wars in their homeland. They are the main victims subject to brutal war crimes and human rights violations. However, the relative peace and stability in mid-20th century led to some of the biggest steps towards development and modernization with fundamental changes in lives of people, at least in the major cities. However, in 1970s, the Soviet invasion, bloody coups and subsequent civil wars destroyed most of the infrastructures and brought the country to the verge of collapse (Brown, 2013). More than four decades of war and tragedy continuously destroy lives of civilians, access to basic needs, and their hopes for a peaceful future. All attempts towards progress and peace have been unproductive. The prolonged conflicts have devastated all the public infrastructure, security, education, public health, and economy.

As a tragic consequence of conflicts, today, Afghanistan is one of the least developed and poorest countries in the world. More than 8 million Afghans have been forced to flee to Pakistan, Iran and all over the world, making the largest protracted displaced population in the world (Koser, 2009). In 2021, more than 4 million Afghans are internally displaced due to the ongoing conflicts (Amnesty International, 2021).

Currently, majority of the population lives below the national poverty line. For every 1000 children 60 die before age of five; one of the highest child mortality rates in the world. According to the United Nations data, Afghanistan has one of the top maternal mortality rates, child malnutrition, and stunting in the world. Currently, more than two million children are suffering from acute malnutrition (UNICEF, 2018).

Prolonged conflicts deprived majority of the Afghans from education over the decades. According to a recent World Bank report, literacy rate in Afghanistan is only 43 percent (Gender Data Portal, 2021). A high illiteracy level and devastating unemployment and poverty trapping many in the vicious cycle. Lack of education often leads to unhealthy lifestyle and low life expectancy. Poverty leads to poor health, poor productivity and poor nutrition (Trani et al., 2016). Based on a recent report from the US Special Inspector General for Afghanistan Reconstruction (SIGAR), the World Bank has estimated an overall 72% poverty and 38% of unemployment in 2020 in the middle of COVID-19 pandemic (ToloNews, 2021).

Millions Afghan lives lost and millions other disabled during the four decades of conflicts. A report by Asia Foundation in 2020 estimates that around 80 percent of adults in Afghanistan live with some form of disability, including physical, functional, sensory, or other impairments (Shinwari et al., 2020). Access to health care, sanitation and nutrition are key public health concerns as the conflicts exacerbate and more people are being affected.

Access to primary health care and essential medication is a dream to many Afghans. Although, health care services in the recent years have some substantial developments, availability of health services still remain a significant challenge to majority and the country is lacking a functioning health care system. Due to the ongoing warfare, improving health services and investing on care system is not a priority for the government. Security, infrastructure, economic instability, health care workforce and communication and coordination are key challenges to health system in Afghanistan (Acerra et al., 2009). Inequality in service provision between urban and rural settings, gender inequality, and poor measures of the costs are main barriers to accessing health care in Afghanistan (Frost et al., 2016). Current health care services are mostly funded by international community donations and unlikely to sustain without external resources. However, there are no clear commitments by foreign donors for the future.

Afghanistan is one of the leading opium producers in the world (UNODC, 2020). Rising conflicts, failing legal business opportunities, weakening law enforcement (Lind et al., 2014) and lack of proper governance are the factors linked to high opium production. Despite international support, efforts in opium eradication in Afghanistan have not been successful and alternative livelihood programs are not effectively implemented (Felbab-Brown, 2016).

As a result of conflict, potentials for development in Afghanistan like the rich mining and water resources, the highest proportion of young population and the key strategic location are not focused. As these capacities can turn into opportunities for prosperity and development.

Given current humanitarian situation and changing priorities, investing on proper planning and intelligent policy making can lead to effective implementation of services in Afghanistan within current limited resources.

1.2 Conflicts and opium crisis in Afghanistan

When searching about Afghanistan, many will see that conflicts and opium cultivation are deeply interlinked. The country has been renowned for cultivation and supplying opium and heroin. There is a long history of opium cultivation. Afghanistan, together with Iran and Pakistan forms the “Golden Crescent”, an area where opium cultivation and trade of opium existed for centuries (Farooq et al., 2017). Before the communists’ coup and Soviet invasion in 1979, opium cultivation in Afghanistan was in a very low scale and limited to some remote villages and was strictly disapproved by Afghan cultural values. While by the beginning of conflicts, opium cultivation rapidly increased, mainly due to disruption in government control and political order. Following the withdrawal of soviet troops in 1989, warlord commanders further promoted opium cultivation and illegal trade routes to central Asia and Europe expanded (Farooq et al., 2017). Opium production in Afghanistan steadily increased during Taliban rule and the country became the world’s biggest single producer of opium. In 2000, based on an edict by Taliban leader, poppy cultivation seemed to cease (Beyrer, 2002). However, they were ousted from power a year after the ban and effects of these sanctions were very short-term. After the Taliban lost control, the country witnessed a substantial increase in opium cultivation and despite US led invasion in 2001 and substantial engagement of international community in counternarcotic efforts, opium production remained high.

Due to an escalation in conflicts and weakening governance, in 2020, opium poppy cultivation increased by 37 percent and the country produced 85 percent of total estimated opium production (UNODC, 2021). Numerous interconnected factors drive poppy cultivation in Afghanistan, many farmers are trapped in a vicious cycle of poverty and conflicts, used by the insurgent and mafia groups to cultivate opium as they get loans in advance for poppy cultivation (Schweich, 2007). Frequent contact with opium lead to dependence and the intersection of poverty and drug use frequently lead to criminal acts like engagement in drug trafficking and supplying drugs to other addicts (Archambault & Barma, 2012).

An unprecedented escalation in conflicts and scheduled withdrawal of US troops in 2021 can turn government priorities and can further weaken counter-narcotic efforts. This may lead to increase in opium trade and the illicit economy due to opium cultivation and trafficking, which in turn promotes conflicts, empowers warlords, and finances terrorism. This not only threatens security and fuels corruption, but also increases risks of substance use disorders.

High level of opium cultivation, easy access, poverty, and unemployment are key socio-economic factors linked to substance use. Many others begin with medicinal and recreational use of opium due to lack of awareness from physiological and

psychological consequences of substance abuse and exposure to stressful live events, trauma, conflicts, which can lead to dependence (Momand et al., 2020).

A survey by the UNODC in 2010 found that approximately 8% of Afghans between 15–64 years are using psychoactive drugs which indicated a double increase from a similar survey in 2005. This study shows that Afghanistan has the highest prevalence rate of opioid use in the world (UNODC, 2009).

In 2015, the Afghanistan National Urban Drug Use Survey found that more than 11% of Afghan population were tested positive for psychoactive drugs, this survey shows that between 2.9–3.6 million people are using drugs and one person in three households tested positive for one or more drugs. Due to a severe stigma associated with drug use in Afghanistan, many people may not report and the actual problem may be much higher (SGI, 2015).

On the other hand, traditional use of opium in rural areas is mainly for medicinal purposes due to lack of access to pain medication and public health services. More than 50 % opium using women are giving opium to their children for pain relief, flu, hunger and behavior control (UNODC, 2009) leading to harmful consequences in individual and family level, and a clear public health crisis in national level.

1.3 Rationale

Opium production has substantially increased over the past years in Afghanistan and opium addiction has grown on the same hyperbolic shape (UNODC, 2009). However, significant funds allocated to eradications and bans on opium cultivation (Mansfield, 2019), drug abuse treatment and prevention services were never proportionately supported. As a leading consumer of its own produced opium, the devastating rate of opium addiction in Afghanistan have cross-cutting consequences on the stability, development, and health. Evidence-based policy and practice in treatment and recovery is essential for developing a coordinated response to substance abuse problem.

Successful treatment and recovery from drug abuse can lead to productive social re-integration and creating employment opportunities for recovering drug addicts, which, in turn, can reduce poverty and crime.

Afghanistan national drug action plan (2015–2019) clarifies that the government is committed to a coordinated and integrated approach in combating illegal drug production, trade, and traffic. One of the three goals of this plan is demand reduction for illicit drugs and increase in drug treatment provision for substance users in Afghanistan. Similarly, a key goal in the revised 2012-2016 national drug demand reduction policy was expanding treatment coverage up to 40 percent (UNODC, 2013), which is certainly not achieved. Even several services have terminated due to lack of resources.

Since consequences of substance abuse as, physical and mental disabilities, engaging in criminal behaviour and conflicts and

economic burden can pose a sizeable challenge to the country. Improving drug treatment services in conflict affected and impoverished communities can restore productivity, psychological support and workforce to the families and communities.

Afghanistan faces a rapid increase in injecting drug use prevalence, particularly in the major cities. Blood-borne diseases like Human Immunodeficiency Virus (HIV), as desperate health outcomes need adequate planning and resources.

High internal demand market for opium is one of the drivers in opium production and illicit trafficking in Afghanistan. Opium production, poverty and drug use makes a vicious cycle in Afghanistan. Demand reduction for opium can be an effective strategy to break this cycle.

Policy makers need evidence-based advice to tackle this challenge. This report provides recommendations for a coordinated response and advises to develop the services in accordance to UNODC and WHO standards of care and international standards for the treatment of drug use disorders and with regard to escalating conflicts, the IASC guidelines on mental health and psychosocial support and Sphere Handbook.

Proposed interventions are based on the context of ongoing conflicts, worsening socio-economic situation, uncertain future, easy access to illegal substance and high prevalence of substance use in Afghanistan. Sustainability and integrating low-threshold services with the primary health care can be a feasible and effective intervention which can reduce stigmatization and discrimination against drug users.

Taking this evidence into consideration, there is a dire need to update the policy framework based on ground realities and current challenges. Implementing successful interventions of other similar contexts can improve outcomes and expand coverage of substance use treatment.

1.4 Overall aim

The aim of this article is to provide evidence-based recommendations for policy makers in Afghanistan to improve substance use treatment services and to integrate some components of this sector into primary health care and to ensure sustainability of services. This article reviews the situation prior to Taliban reinstatement. However, the proposed recommendations can be considered in current context.

Specific objectives of the project

- to describe current situation of substance use treatment services in Afghanistan
- to identify challenges and opportunities for a coordinated response to substance use problems in Afghanistan.
- to propose recommendations for a sustainable approach to substance use problems and integrating specific interventions to the primary health care system.

- to review substance use treatment modalities for LMIC and conflict affected countries and to determine potential adaptation in Afghan context

2 METHODS

A systematic search was conducted to identify published research on substance use treatment in Afghanistan, using key databases Medline, Embase, PsycINFO and Global Health. Manual search was also conducted to find further studies using Google Scholar and other online sources including websites of WHO, UNODC, local and international NGOs working in substance use treatment in Afghanistan and Afghan government relevant ministries' websites were included. Due to a severe lack of studies in Afghan context, grey literature, government reports, international funding agencies, NGOs sources and websites was also searched and included.

The search strategy (*Appendix 1*) developed through a multi-stage process to include all relevant articles. OVID was used to search relevant studies from the selected databases and the findings were exported to Endnote and Rayyan. Search results were de-duplicated using Rayyan and abstracts were screened. Subsequently, full text screening of selected studies was done based on the aims and objectives of this policy report. Data from these studies were narratively synthesized based on the specified themes.

WHO and UNODC guidelines on evidence-based interventions and from similar context LMICs and conflict affected settings were searched manually. Policy documents were searched from government websites and through communication with relevant officials within the Ministry of Public Health and relevant NGOs working in substance use treatment in Afghanistan.

For inclusion criteria the aim was to identify all studies describing implementation of an intervention in substance use treatment and studies evaluating these interventions were considered. Study designs encompassed intervention studies and epidemiological research. The main focus was to identify all publicly available documents with potential in understanding the context, challenges, effectiveness and opportunities in substance use treatment interventions in Afghanistan. All relevant sources in English, and Afghan local languages, Pashto and Dari, were included.

Articles describing the needs and available services and resources for substance use problem in Afghanistan, government policy document and action plans for substance use in Afghanistan were included. Since very few evidence was available in Afghan context, effective interventions from similar LMIC context including grey literature describing UNODC and WHO standards, guidelines and recommended interventions were included.

In exclusion criteria, studies in languages other than English, Pashto and Dari and studies from high-income countries and upper middle-income countries were excluded as they were not relevant to this study purpose.

Key findings were summarized using a work sheet for data extraction. All the findings were classified and analysed based on emerging themes. Analysis of the current situation, challenges, effectiveness, and solutions were the key contents extracted and synthesized, as these domains are identified as vital domains for policy making.

3 RESULTS

Based on the search strategy, 388 articles were identified. In total, 33 articles were found through manual search. Grey literature and reports were accessed through the relevant websites. After a deduplication and exclusion of irrelevant articles, 51 studies were screened for eligibility and 12 were finally reviewed and included. All results of literature including qualitative, quantitative and narrative literature were reviewed. A vast majority of articles were excluded because they were studies conducted on United States and other western war veterans in Afghanistan. Some studies in the search results were covering high income contexts and some others were mainly focused on drug control legislations and trafficking and identified as irrelevant.

The results were categorized based on developing themes mainly to explain background of substance abuse treatment in Afghanistan, challenges and achievements and the way towards a coordinated response. In second section, community-based interventions by WHO and UNODC proposed for Low- and Middle-Income Countries (LMIC) and conflict affected regions were presented and analysed for potential adaptation to Afghan context.

3.1 Background of substance abuse treatment in Afghanistan

Although most of substance abuse treatment programs introduced over the last decade, Afghanistan's first drug treatment centre was established by the Ministry of Public Health in Kabul in 1987 and was providing inpatient treatment services including detoxification and psychosocial services (MCN, 2012). This 20-beds treatment facility was supported by World Health Organization (WHO) and United Nation Office on Drugs and Crime UNODC (UNODC, 2010). In 1990s, the violent fights in Kabul disrupted services by this facility and later on merged with Kabul Mental Health Hospital. However, before that, Ali Abad Teaching Hospital, established in 1932 as the first modern teaching hospital, was the only available source for substance use treatment (MCN, 2012), mainly through a biological approach to treatment and detoxification management.

By the fall of the Taliban in 2001, influx of international aid led to rapid developments in many sectors including health care services. In 2002, only 2 drug treatment centres were available in Kabul (Todd et al., 2012). Although many treatment, prevention and harm reduction projects were implemented in the subsequent years, unprecedented increase in opium production, high number of returning refugees and Internally Displaced Persons (IDPs) and rapid increase in drug use in these years overwhelmingly challenged service provision and the progress made. A survey by UNODC in 2009 indicated that only 10% of

substance users included in the survey, received some sorts of treatment services. While 90% of drug users needed treatment and help (UNODC, 2009).

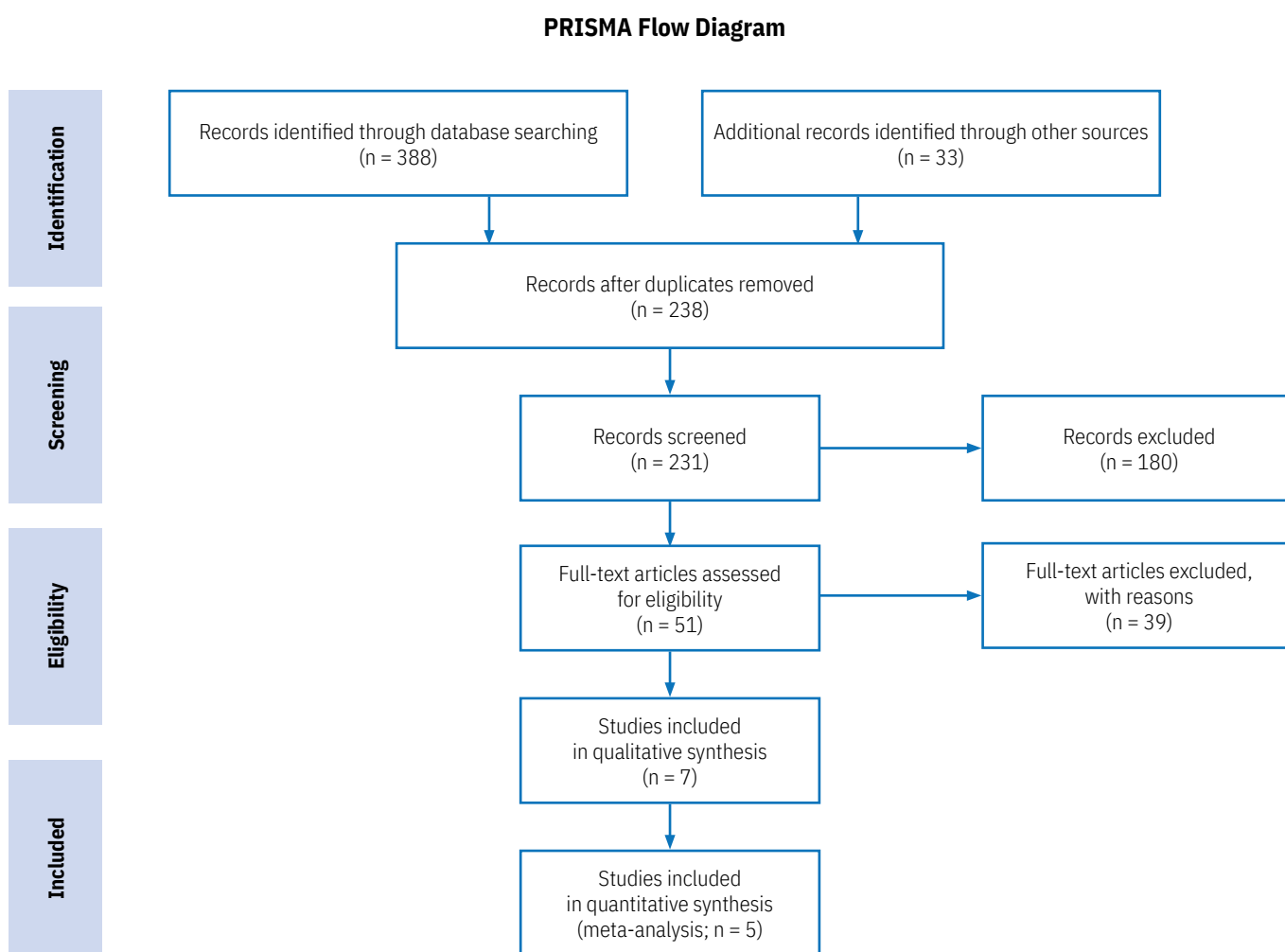
NGOs played a key role in drug treatment and harm reduction initiatives in Afghan refugee camps in Pakistan in 1990s and inside the country after 2001. These organizations set the foundations of current drug treatment programs and developed a network of human resources and professionals in drug treatment programs. Afghan government upgraded Counter Narcotic Directorate (CND) to the Ministry of Counter Narcotics In December 2004, as a response to the alarming increase in illegal opium cultivation and drug use. Policy making, coordination, monitoring and evaluation of all counter narcotic activities were the major responsibilities of MCN (MCN, 2012). As a part of their mandate, they developed programs to enforce Afghanistan's National Drug Control Strategy (NDCS) and Afghan Drugs Law. As well, drug awareness, prevention, treatment, and shelter provision services, initiated in Kabul under this structure for the first time. Ministry of Public Health (MoPH) announced National Drug Demand Reduction program in 2006 and implemented drug treatment services through inpatient centres. They expanded their services from 2 inpatient facilities in 2006 to 84 centres in 32 provinces in 2016. However, after that year, these initiatives are declining and new programs are not introduced, some projects have merged and ended due to lack of resources.

Substance use treatment programs are mainly dependent on external donors. Bureau of International Narcotics Law Enforcement Affaires of US Department of State is the main contributor for the drug treatment programs through the Colombo Plan Drug Advisory Program. Public awareness interventions through mosques were the initial INL supported projects, implemented in 14 projects and expanded to 24 provinces. The key elements of these initiatives included religious/mosque-based outreach, referral to treatment centres, job placement, trainings, 12 step program, peer support groups, sharing messages and food-based after care (UNODC, 2013).

A UNODC Survey in 2005 identified that only 100 inpatient beds were available for either detoxification or drug treatment. A coverage for only 0.25 percent of drug users potentially in need of treatment (UNODC, 2005). Afghan Drug Demand Reduction Policy for 2012–2016, stated a coverage of only up to 2.8 percent drug users, which indicates a huge gap. Absolute majority of treatment programs are located in Kabul and available treatment modalities are abstinence-based counselling and psychoeducation. Benzodiazepines and other psychotropic medications are used for Symptomatic management of acute withdrawal symptoms in detoxification (Todd et al., 2009).

Some inpatient facilities are offering home-based treatment component. Treatment providers visit patients and offer counselling and medical services in their own houses. Home-based approach can significantly expand coverage and provide services to a wider range of drug users. Although the effectiveness and outcomes of home-based modality is hard to determine in Afghan context, but a recent study found similar outcomes in both home-based and inpatient treatment modalities (Shamblen et al., 2022).

Figure 1 | Flow chart of articles



Recently, given the evidence of high substance use rate in villages, the government and donors considered to revise their current approach. A village-based treatment modality was piloted in some rural settings in 2012 and 2018. The aim was to expand coverage and reduce costs, as the inpatient facilities are more resource-intensive and funding resources are limited (How et al., 2014).

The recent figures of MoPH indicate that 101 drug treatment centres are available including 68 inpatient and 34 outpatient facilities. Administration of majority of these centres are transitioned from NGOs to MoPH through a plan led by INL, the main donor, started from 2014. The main goal of this plan is said to ensure sustainability of treatment programs by including them to regular budget of Afghan government (SIGAR, 2018).

Harm reduction projects were supported by some donors including the World Bank and German Society for International Cooperation (GIZ). The later funded “Integrated Drug Prevention, Treatment and Rehabilitation Project” (IDPA) project in Kabul in early 2003 and was extended to some provinces in 2004 (Maguet & Majeed, 2010). These projects were in coordination with the HIV/AIDS programs of MoPH, but harm reduction services are still excluded from conventional drug treatment programs. Some donors funded other approaches

including Methadone Maintenance Therapy (MMT) but not strategically coordinated with drug treatment services. The French NGO, Medecins du Monde, designed a 6 years’ strategy to implement harm reduction initiatives and piloted a national project in Kabul. Although approved by WHO and based on evidence, but harm reduction services including Opioid Substitution Therapy were not accepted due to ambiguities in DDR policy in Afghanistan. Harm reduction is still widely misunderstood in treatment context and not formulated in drug demand reduction policy (Maguet & Majeed, 2010).

Private drug treatment clinics are widely unregulated and treatment modalities, protocols and guidelines are unknown. Some facilities are providing detoxification which cost around USD 205 which is not affordable for the majority of drug using population (Todd et al., 2009).

The Ministry of Public Health (MoPH) leads implementation of drug treatment services, through drug demand reduction directorate. Some activities are run by similar parallel structures, like mental health directorate and national HIV/AIDS program supervising HIV/AIDS programs including Methadone Maintenance Therapy (MMT) within national HIV/AIDS framework. A coordination system does not exist to assemble and mobilize different components of treatment and resources (MoPH, 2021).

Finding of current situation shows that access to drug treatment services is extremely limited, particularly in rural area. The recent Afghanistan Drug Report estimates that 99 percent of drug users don't have access to substance treatment services.

Most of 101 drug treatment centres are financed by donor funds. These programs mainly focus on detoxification and lack treatment planning based on individual needs. Many will close due to funding limitations in 2021.

3.2 Policy and legislations

After the fall of the Taliban in 2001 and formation of a new government, opium cultivation and drug use emerged as key challenges in Afghanistan. As an initial measure, Afghanistan Counter Narcotics and Intoxicants Law and the National Drug Control Strategy (NDCS) were ratified in 2003 and updated in 2006. As a five-years strategic plan to tackle illicit drug problem, the overall goal of this strategy was to “secure a sustainable decrease in cultivation, production, trafficking and consumption of illicit drugs with a view to complete and sustainable elimination”. One of the four priorities was reducing the demand for illicit drugs and treatment of problem drug users. This strategy highlighted the need for rapid scale up and mainstreaming drug demand reduction in healthcare and education sectors. This was in accordance to international drug control regime and UN drug control strategies (Bewley-Taylor, 2014). Government commitments included initiating harm reduction services to injecting drug users, awareness raising and prevention interventions, community-based and residential treatment to drug users. In the light of National Drug Control Strategy, MCN was responsible to develop addiction prevention and treatment guidelines. Counter Narcotics Law revised in 2009 to clarify ambiguities and better respond to the rapid surge in opium and heroin supply (Ministry of Counter-Narcotics, 2006).

In 2005, the Ministry of Counter Narcotics and Ministry of Public Health developed National Harm Reduction Strategy mainly focused on HIV/AIDS prevention (MCN, 2012). Subsequently, National Drug Treatment Guidelines and National Drug Education Guidelines were developed (MacDonald, 2008).

The first national mental health strategy introduced in 2010 emphasized substance use treatment and prevention trainings for primary health care staff. These trainings were incorporated as a component of mental health trainings for the Basic Package of Health Services (BPHS). This strategy was revised for 2019-2023 to be in line with WHO Mental Health Global Action Plan (2013–2020). Specific targets for drug treatment and community mental health included in this strategic approach (MoPH, 2009)

The National Drug Action Plan (2012–2016) focused on a set of three interrelated counternarcotic goals to be achieved by 2016 to effectively reduce demand for drugs and expand treatment coverage. Key instructions in this plan included expanding treatment reach and sustainability of continuum of care for substance use treatment. Furthermore, the government

had pledged to initiate rural treatment and focus on community-based initiatives and to take a leadership role in training of clinical staff in drug demand reduction, to complete transition of “Substance Use Treatment System in Afghanistan” from donor dependence to regular government budget and structure. Establishing addiction studies department at Kabul University and publishing annual progress reports to measure success and shortcomings were promised in this plan.

A new National Drug Demand Reduction Policy was not updated for years 2015–2019. The draft version for 2019–2023 reiterates commitments to upgrade coverage, physical, institutional, and human capacity in the country. Expanding treatment capacity from 10000 to 39000 persons and training and certification of addiction professionals were described as key achievements of the previous years (MacDonald, 2008).

As a final point, government policies recognize substance use and state to improve responding structures, but mechanisms to implement them in the ground are missing. Effectiveness of these policies and plans are not evaluated in the context of Afghanistan.

3.3 Human resources

Ali Abad Teaching Hospital, the first modern medical centre in Afghanistan had initiated specialty trainings in psychiatry from 1940s, but most of the trained doctors left the country during the civil wars. The Kabul Mental Health Hospital initiated specialty trainings in psychiatry in 2006. However, due to a substantial stigma associated with psychiatry, tough working conditions, and low salary, Afghanistan faces a significant dearth of mental health professionals. Working for substance abuse treatment and mental health is highly stigmatized in Afghanistan. In 2004, Afghanistan had only two registered psychiatrists (WHO, 2006). Currently, drug treatment projects have employed around 1000 clinical staff, including medical doctors, psychologists, social workers, counsellors and health workers. But short-term nature of drug treatment project, job insecurity and hard-working conditions, make this a less attractive field with a significant level of staff turnover.

The Colombo Plan training project, funded by the INL have conducted a series of trainings and capacity building projects for clinical staff in drug treatment centres over the last decade. More than 90 % of clinical staff in drug treatment centres were trained on Universal Treatment Curricula (UTC) series. A group of Afghan addiction treatment professionals were qualified as national trainers and eligible for International Addiction Certified Professionals (ICAP) by the Colombo Plan Global Centre for Credentialing and Certification (Global Centre for Credentialing and Certification (GCCC – formerly ICCE), 2021). However, this project has not been in a large-scale to respond to the serious dearth of human resources nationwide. Government has no plans to train professionals in drug treatment field and given the crisis in the country, not a priority in foreseeable future. As of yet, drug addiction is not included in university curriculums and plans to establish addiction counselling and psychology departments within universities are not clear.

3.4 Drug treatment modalities

The National Drug Demand Reduction (DDR) program of MoPH is running 84 drug treatment centres and local NGOs are running 16 centres. Treatment is mainly based on abstinence modality introduced by The Colombo Plan Drug Advisory Program (CPDAP) funded by the INL. This model is comprised of three phases. Pre-treatment phase which focusses on motivation and awareness for a one to three months' period, treatment phase which includes detoxification and withdrawal management and rehabilitation, rehabilitation phase which encompasses counselling, psychoeducation, vocational training, and community re-integration. Phase three mainly includes outpatient support including self-help groups and post-treatment interventions (Courser et al., 2013).

Home-based treatment component is provided by 44 of these residential drug treatment centres. Although, this modality can provide treatment to those who cannot attend inpatient treatment due to social stigma, employment status, and economic barriers, but quality control and monitoring of these services is more complicated. No treatment guidelines and protocols for home-based are not developed in Afghanistan (SIGAR, 2018).

More than 30 outpatient treatment facilities are functional in Afghanistan. Treatment is provided through non-residential services in daily basis. If regulated, this works best for moderate drug use cases and for those unable to attend inpatient treatment.

3.5 Injecting Drug Use (IDU) and Harm Reduction

Using multiple drugs like opium with cannabis and abusing prescription medicine like tranquilizers, benzodiazepines and analgesics became an increasing trend in the country (UNODC, 2009). Routes of drug administration become more hazardous in Afghanistan witnessing a rapid rise in injecting drug use in recent years. Easy access, low costs and widespread availability of refined heroin (crystal) and amphetamines, curiosity and peer influence are the main driving factors in injecting drug use (Todd et al., 2009). Returning refugees from Pakistan and Iran are considered to have a key role in flowing Injecting drug use in Afghanistan (Farooq et al., 2017).

Despite an alarming surge in injecting drug use, harm reduction services in Afghanistan are extremely inadequate. Although, the first National Drug Control Strategy has emphasized to offer harm reduction measure to IDUs and to coordinate with other initiatives to prevent spread of HIV/AIDS and other blood borne diseases (MCN, 2012). While harm reduction services extended in the subsequent years, but never responsive to the high demand.

Harm reduction interventions are not integrated to substance use treatment programs. Although, methadone-based opioid substitution therapy was piloted and current DDR policy endorses harm reduction in principle, but no clear guidelines are available for implementation (Frost et al., 2016).

National drug treatment and harm reduction protocols and guidelines are still in development stage and a unified strategy

is not available on harm reduction interventions. Evaluations to measure feasibility and effectiveness of current protocols and made revisions accordingly is a serious unmet need.

Over the last two decades, World Bank, Global Fund and other donors allocated more funds to harm reduction. While abstinence-based treatment programs were funded by INL through the Colombo Plan. These programs were run in two different directions. As harm reduction is commonly misunderstood in treatment context, abstinence-based programs have not included harm reduction services in continuum of care (Pain, 2021).

Private addiction treatment clinics are functioning in some cities, but their services are not regulated and the government laws and policy for them are unspecified. Some of these private centres commonly use pharmaceutical narcotics as a substitute for opiates with a high potential for abuse due to lack of regulations and control. Private centres mainly lack drug treatment guidelines and no quality assessment and monitoring by the government is in place.

To conclude, addiction as a disease is widely misperceived in Afghanistan. As most of the efforts are limited to detoxification and withdrawal management with no long-term comprehensive treatment and rehabilitation approach.

3.6 Rural drug use

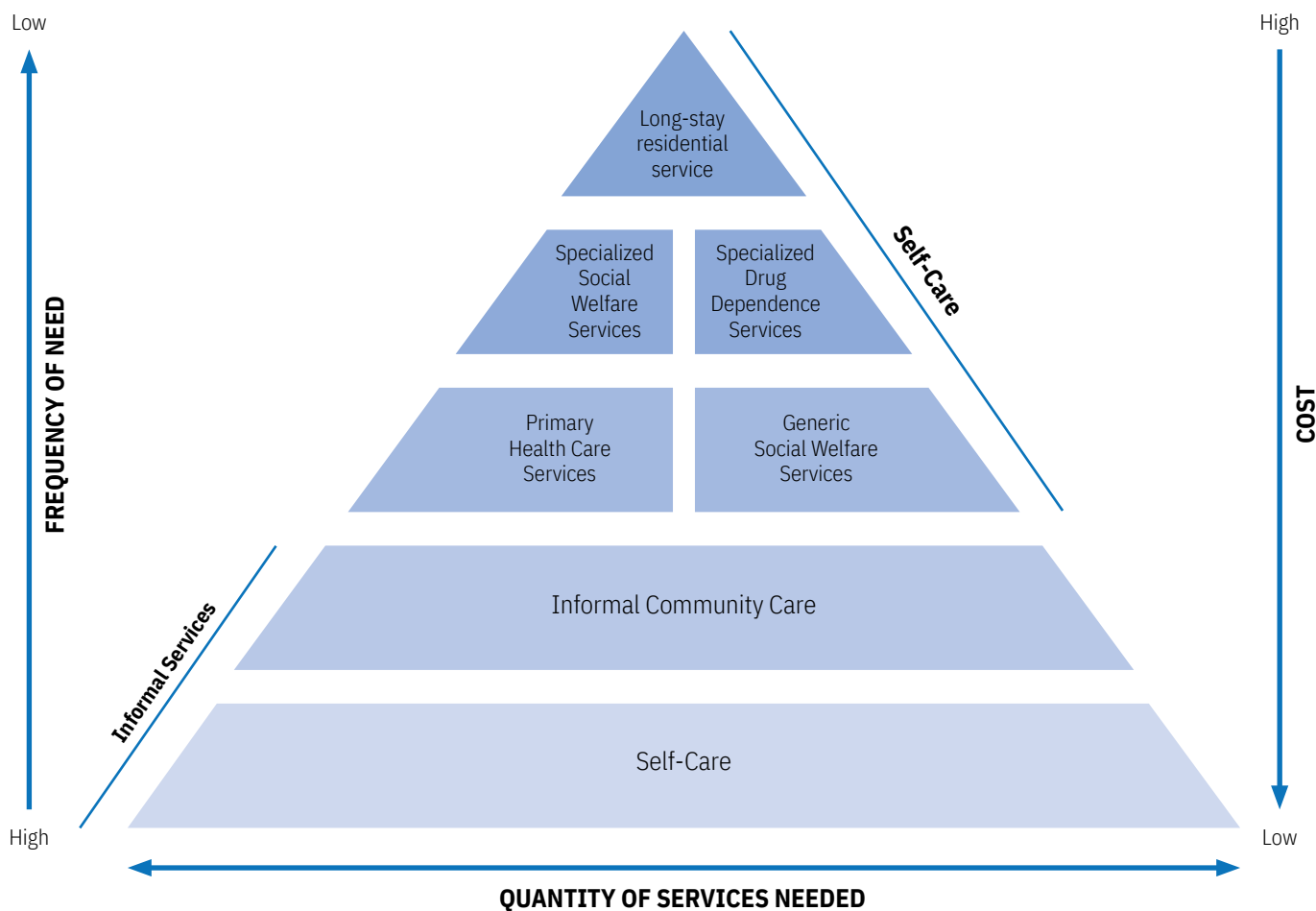
Afghanistan National Rural Drug Use Survey by the Bureau for International Narcotics and Law Enforcement Affairs of the U.S. Department of State estimated a threefold more opium use in rural areas compared to cities (SGI, 2015). Key contributing factors in rural drug addiction include, using opium for medicinal purposes, lack of awareness on consequences of substance use and frequent contact with opiates during cultivation and trafficking. Drug use among women in Afghan villages is more complicated than men, affecting all family members including children. A high number of carpet weaving women use opium to calm the pain and tiredness due to long working hours. They also give opium to calm their children (Momand et al., 2020).

A community-based treatment modality piloted in some Afghan villages as an effective intervention through low-cost services for resource-poor and hard to access settings.

The rationale for this project was to help more people receive services in their own communities. At the same time, MoPH and MCN has developed a strategy to address substance use in community level where drug users work and live. But there is no evidence of actual steps by the government in this regard.

In 1980s many community-based treatment interventions conducted in different parts of the world. A model with successful results in India was initiated in 1987 by T. T. Ranganathan Clinical Research Foundation, known as TTK Hospital as outreach and community-based camps in rural areas of Tamil Nadu, India (Ranganathan, 2008). Inspired from these achievements, the Colombo Plan, funded by INL, adapted the camp-based approach to Afghanistan.

Figure 2 | WHO pyramid for substance use disorder treatment and care



A study of this pilot found out that, building on Indian experience, the village-based treatment model is feasible and pragmatic in the Afghan context with positive initial results (How et al., 2014).

The piloted village-based services in Afghanistan have been short-term and project-based. There is no plan to expand community-based interventions and to effectively integrate them to BPHS and conventional primary health care (How et al., 2014). This can be a less stigmatizing and cost-effective approach and can also help in early-stage detection and treatment of substance use disorders.

3.7 Conflicts in Afghanistan and substance use treatment

Implementing substance use treatment is a complicated intervention almost everywhere. In conflict affected contexts certain challenges need to be addressed in substance use treatment programs. Inadequate facilities, stigma, lack of human resources and lack of political will are common barriers in most resource poor settings (Odejide, 2006). Humanitarian agencies for conflict-affected population mainly focused on basic needs and emergency care.

For a coordinated and effective response to substance use treatment, ongoing conflicts, poor resources, lack of political will

and changing priorities are the main challenges. On the other hand, more than 3 million drug users and less than 1 percent of treatment coverage is a clear failure of ongoing programs. Quality of existing treatment programs is another key concern, as a 90 percent of relapse rate is estimated in addiction treatment in Afghanistan (MCN, 2012).

Many aspects of drug treatment policies and programs are not designed to fit with conflicts and humanitarian context in Afghanistan. The effects of war and psychological suffering are not studied as certain drivers to drug use and relapse after treatment. Losing a meaningful and productive life due to drug use may also affect the capacity of the entire society to recover and restore peace.

Service coverage is a major concern in Afghanistan. A proportionate distribution of resources between low-threshold community-based services and intensive hospital-based care for addiction treatment are not considered. More cost-effective services particularly for mild and moderate drug use cases, which makes the majority of those seeking treatment, can have more practical outcomes.

Funding is a key challenge as the government has no regular budget to substance use treatment programs and substance use is not a priority for the ministry of public health. Particularly

in a time point when the conflicts are escalating, and the country is suffering from a widespread humanitarian crisis.

The government and civil society have failed to attract further funds through advocacy and coordination. The national budget for drug treatment services is seriously insufficient. Currently, INL is the main donor which has already cut 80 percent of funds and the remaining projects are going to be transitioned to the government structure. Drug treatment programs are almost fully donor dependent. Therefore, most of the programs may close due to lack of governmental budget.

3.8 Challenges

Limited coverage: Access to substance use treatment is a serious concern. In 2014, the government announced that 99 percent of drug users are not receiving treatment in Afghanistan.

High relapse rate: current treatment programs are mainly inpatient, and abstinence based. MCN reported more than 90 % relapse in treated drug users. A study of relapse causes by MCN indicated that lack of employment opportunities, easy access to drugs, peer pressure and presence of drug users in the family are the main causes of relapse and treatment failure. Half or these cases were identified in the first three months after treatment which shows lack of rehabilitation and follow up interventions after active treatment phase. Compulsory treatment

is a common practice and another key factor in a high relapse rate and non-adherence to treatment (Relapse Causes, 2015).

Stigma: drug use is a highly stigmatized behaviour and discrimination towards drug users is a common practice in Afghanistan. A serious punitive approach towards drug users in some places force them to avoid seeking services (Todd et al., 2007). Drug use in families affects their reputation and they try to be hidden from the society. This can lead to further progression of substance use disorders among family members.

Treatment modalities are mainly introduced through a top-down approach. Feasibility studies and evaluation of effectiveness are not the basis for scaling up in treatment approaches. In addition to stigma, attending an inpatient centre for 45–90 days can be challenging to those drug users who are mainly surviving on daily labour and irregular income (Relapse Causes 2015).

According to Afghanistan National Drug Use Survey, drug use rate in rural population is estimated three times higher than urban (13% vs 5%) and 39% rural household tested positive for one or more substances. However, treatment programs in rural areas are almost unavailable all over the country. Nearly all treatment centres are limited to city centres and mainly inpatient services. While according to WHO, only 20 percent drug users need inpatient treatment and majority can get maximum advantage of low-threshold interventions.

On the other hand, Afghanistan faces serious limitations of financial resources and substance use treatment is not perceived as a significant issue. Resource-intensive interventions like in-

patient facilities and hospital-based treatment services are difficult to sustain, given the uncertainty in budget and deteriorating conflicts. Drug users cannot access services due to stigma, poverty, lack of awareness, poor family support and illiteracy.

Community-based interventions are not recognized in government plans and projects. While high drug use rates and frequent contact with opium in rural areas, requires immediate response. Cost-effective approaches to resource-poor rural areas can be favourable for economically deprived drug users and those struggling with daily livelihoods.

Search findings show that drug treatment programs and policy makers have never coordinated their activities with community elders, religious leaders, Imams and Maliks to seek their contribution. The strategy developed for community-based treatment is not considered in practice (Relapse Causes, 2015).

4 DISCUSSION

The result of this literature review demonstrates an alarming prevalence of substance use in the country. Increase in opium use is in line with growth in production and substance use in Afghanistan is double the global rate. Significant funds have been allocated to drug control initiatives over the past two decades by the international donors. While most of the focus was on eradication and reducing cultivation. However, very insignificant amount of funds has been allocated to treatment and prevention.

Drug treatment programs have some significant achievements in the past twenty years. Drug treatment centres expanded from only 2 to more than 100 facilities and almost all provincial capitals have a treatment program. Since 2008, INL the major donor, has obligated more than USD 150 million through the Colombo Plan in drug treatment initiatives (SIGAR, 2018). Hundreds of clinical staff are trained in drug treatment and counselling principles and a network of drug demand reduction professionals is established. However, most of the interventions have been in short-term project formats without a strategic approach to sustainability. An applicable strategy, based on Afghan context is needed for coordinated response to the terrible surge in drug use.

Afghanistan is in the middle of a long-term conflict with humanitarian crisis in most parts of the county in 2021. Recommendations for addressing drug use from Inter-Agency Standing committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), the Sphere Handbook (Santana, 2018) and World Health Organization mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (Thurstans et al., 2011) can provide essential guidelines on minimum requirements for response to harmful substance use in humanitarian settings. These principles are absent in current policy and treatment programs in Afghanistan.

The top-down approach in planning and implementation of drug treatment services has resulted in weak incorporation

of context and ground realities. These have affected outcomes and sustainability potentials of treatment programs. Most of the implemented projects are resource-intensive and based only on detoxification and 45–90 days of inpatient treatment.

Dearth of research in substance use sector, particularly treatment and effectiveness of the interventions is a key challenge. There is a critical need for research in substance use patterns, drivers and programs and to generate knowledge on effectiveness of interventions and building scientific evidence on outcomes. Treatment needs to go beyond detoxification and pharmacological management. Psychological, psychosocial, and economic interventions should also be incorporated and studied for effectiveness. Findings of evaluations should be reflected in treatment guidelines and protocols. At the moment, treatment programs are not harmonized with the context and local needs.

Training programs for capacity building of substance use treatment professionals have been effective and have strengthened treatment outcomes (Courser et al., 2013). However, these trainings were in a small scale and for short term, expanding trainings and developing a national framework for certification and education can improve treatment quality and human resources.

The government has developed several policy documents including national drug demand reduction policy which includes commitments on expanding treatment programs, improving coordination with stakeholders, including substance use treatment in medicine and psychology faculties curricula and establishing drug treatment and prevention departments in universities. Tackling stigma and discrimination, raising awareness, implementing community-based initiatives, efforts to reduce discrimination and criminalization against those seeking drug use treatment. The policy also declares commitments to integrating some drug treatment services to primary health care and Basic Package of Public Health (BPHS) and diversify treatment options including the use of opium tincture as an alternative OST programs (Noroozi et al., 2021). But mechanisms to operationalize these policies are unavailable and most of these commitments are not practically carried out.

Coordination of services and harmonizing different components of treatment can prevent waste of resources and can expand treatment coverage. For instance, harm reduction services may be incorporated to treatment continuum and specifying OSD and MMT programs through policy and legislation (Noroozi et al., 2021).

Community ownership can be strengthened through engaging community leaders in planning and implementation. Task sharing can be a useful response to the serious lack of funds and professionals.

National drug demand reduction policy for 2012–2016 and 2019–2023 recognize the need for treatment expansion. It was promised to expand coverage up to 40 percent by the end of 2016, while in practice only 1 percent of drug users have received care. even in the subsequent years, some centres are closed, and treatment beds declined. Although, community-based care was recommended in the policy, but the main focus remained on inpatient treatment.

Afghanistan is experiencing a humanitarian crisis and treatment services need to follow the WHO pyramid of care, while this essential foundation is missing in current service structure.

Mechanisms to secure budget and resolve fund deficits are not identified in the policy and government action plan. Sustainability and system building need plans and mechanisms to specify budget. Otherwise, current programs will be terminated after donor fund cuts. As of yet, the government have not developed implementation plans and strategic approach.

2012–2016 DDR policy is not assessed for achievements, effectiveness, and shortcomings to lay a foundation for 2019–2023 policy. Lessons learned from previous strategy and practice are not systematically integrated to the revised policy.

Large scale research to evaluate treatment outcomes are not conducted so far. However, INL funded a study between 2009–2012 to build evidence on effectiveness of this treatment model. The finding stated that completing this treatment duration results in decreased drug and alcohol use and criminal behaviour (Courser et al., 2013).

With regards to long term conflicts and humanitarian context, NGOs have a key role in reaching to communities and service delivery. NGOs have played a key role in humanitarian service and drug treatment in Afghanistan. NGOs and government can mobilize further resources to work in coordination. However, a multi-sectorial engagement of different governmental agencies was promised in the action plan, but evidence of practical engagement is not available.

Three dimensions of supply reduction, demand reduction and law enforcement in Afghanistan have not been addressed through a unified lens. Community-based programs can incorporate supply and demand reduction in a practical way. Majority of drug use problems in rural areas need mild to moderate intensity of services. Low-threshold prevention and public awareness programs can be cost-effective approaches and can cover a wide range of drug users (Ali et al., 2015).

Community Health Workers (CHWs): Afghanistan have a network of 20 thousand CHWs, a key success over the last two decades in public health sector. CHWs are a key potential resource in service delivery for drug addicts, to gap the bridge with primary health care and referral. Focus on community-based treatment approaches is a practical solution to the current gap of services and increasing number of drug users in the country. This has not been planned and the policy does not have clear tools to utilize these resources.

Demand side barriers are not recognized as a key challenge in substance use treatment in Afghanistan. A systematic vision to combat social stigma, criminalization and cultural sensitivities is not documented in the policy.

Finally, Afghanistan immediately needs enough funding and expansion of drug treatment capacity and prioritization of substance use problems as a national public health crisis.

Focus on Community-based Treatment

Community based treatment is a part of a combined strategic approach that covers supply reduction, demand reduction and law enforcement as a whole response. In a context like Afghanistan, where opium cultivation is high, law enforcement is fragile and resources are limited, community-based approaches can provide services to a wider range of drug users. Supply reduction through improving economic and social wellbeing of communities, particularly where opium cultivation is high, can be targeted in community-based treatment. This approach provides a channel to reach families with resources and information as most of these people may not be able to use other services. Mobilizing community resources and coordination of local contribution is a key aspect of community-based treatment. Local knowledge, volunteers and lay health workers without specialized trainings and community leaders are mainly involved. These programs can link substance use treatment to primary care centres near the communities and refer to specialized care if needed (Ali et al., 2015).

UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia can be utilized as a good reference to develop context specific plans in Afghanistan. The main goal of community-based treatment model is to have a holistic approach to treatment and care of drug users with the intensity and extent of care is varied according to the nature and needs of individuals (How et al., 2014).

Afghanistan has a rich network of local NGOs engaged with communities and rural areas for the last few decades. At the moment, the government presence is limited to main cities and most of the country is affected by ongoing conflicts, the NGOs can play a key role to reach out, scale up treatment, provide support, facilitate rehabilitation and reintegration to drug using population in the rural areas.

Components and role of community-based approach include community outreach which focus on awareness raising, public education and health promotion by community workers. Contacting drug users, initial screening and assessment and basic needs assessment and mobilizing key support sources in the community.

Community health centres are close to the living area of drug users. Community health workers, religious leaders or police can refer drug users to health centres, and they can receive brief counselling and basic primary health services. Poly drug use, severe drug addiction and comorbid psychiatric and medical conditions are referred to hospitals and further evaluation. This stage of services can cover a wide range of drug users with moderate severity and prevent them from further progression and dependence.

Hospitals and specialized substance use treatment clinics: a specific category of drug users may need residential treatment or acute medical or surgical interventions. Hospitals are mainly in city centres and a referral system with community-based care can be established.

NGOs have a key role in community-based care model. According to this model, NGOs are responsible to ensure continuum of care

and support clients and families and are the focal points in client management and coordination.

Afghanistan has more than 20 thousand CHWs across the country, community based treatment in coordination with primary health care and the Basic Package of Health Services (BPHS) can cover a wide range of drug using population and extend services to remote areas (Najafizada et al., 2014).

4.1 Limitations

Literature gap is a serious challenge in all aspects of public health in Afghanistan. Drug treatment programs are particularly ignored and are not addressed through a research perspective. Available papers on drug treatment intervention are very scarce and mainly conducted by program donor and implementing agencies. Studies to evaluate effectiveness of key drug treatment modalities in Afghanistan are not available. Studies to address demand side barriers are not available.

This study was mainly dependent on data available online. While most of stakeholders in drug treatment in Afghanistan are not sharing their reports and documents through their websites. Due to recent escalations in conflict, many key governmental and nongovernmental officials were not available to cooperate in provision of grey literature and data through different means of communication. Most of the accessible research are funded by donor organizations which might be affected by a top-down approach and influenced by donor perspectives.

5 CONCLUSIONS AND RECOMMENDATIONS

Substance use treatment sector has made significant progress in Afghanistan since 2001. Treatment capacity has grown, and hundreds of clinical staff work in drug treatment centres. Several donor agencies funded treatment programs and trained professionals in drug demand reduction. Many policies and documentation efforts have taken place by the government and donor agencies. However, not implemented in the ground and evidence of practical changes were not available.

Treatment approach is mainly based on biological concepts and mostly limited to detoxification and withdrawal management. Sustainability and ownership domains in ongoing and accomplished projects have not been recognized by donors and government. Majority of services are inpatient and need intensive resources. While community-based care is widely disregarded and humanitarian context, ongoing conflicts and cost-effectiveness is considered in design and implementation.

The following steps could improve treatment and prevention services in Afghanistan, with enabling more people to access services:

Community based approaches: as majority of the population live in rural areas and the prevalence of substance use in rural areas is significantly higher than urban centres. WHO pyramid

of care and UNODC guidelines for community-based care and rural treatment modalities can provide reference in piloting and scaling up these initiatives. The village-based treatment program which is already piloted in Afghanistan and adapted from Indian T. T. K. model can be further studied and modified to Afghan context for extension and maintenance.

De-stigmatization: Change in public knowledge, attitude and substance use dependence related awareness should be an inter-sectorial strategy of the government. Ministry of education, higher education, work and social affairs and ministry of religious affair through

partnership with other stakeholder civil society organizations and media community may develop a national strategy to improve prevention measures and tackle stigma, discrimination. Provision of basic substance use treatment services through primary health care system can be an important step to reduce demand side barriers and gain family and community support.

Policy revision: Funding treatment program is a key challenge and cost-effectiveness should be considered a key domain in treatment programs. Given the almost total dependence on do-

nor agencies, advocacy for securing international support should be prioritized. As well, integrating some of the interventions to regular governmental budget and primary health care need to be formulated through government policies and legislations.

NGOs and civil society engagement: Afghanistan has a well-known network of local NGOs which have great experience of working with communities and conflict settings. Engaging civil society in policy and implementation initiatives can have great outcomes. They can also effectively engage in monitoring, evaluation and quality assurance of substance use treatment services.

Human resources: sustainability and expanding treatment network is directly related to availability and training of human resources. Counselling, addiction psychology and related subjects need to be added to the university curricula, particularly to medicine and psychology faculties. As well, short-term training programs can be effective to respond to the current gap. Substance use treatment and prevention is not available in current higher education system.

REFERENCES

- Acerra, J. R., Iskryan, K., Qureshi, Z. A., & Sharma, R. K. (2009). Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services. *International Journal of Emergency Medicine*, 2(2), 77–82. <https://doi.org/10.1007/s12245-009-0106-y>
- Ali, R., Gowing, L., & Farrell, M. (2014). *Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia*. (2015). https://www.unodc.org/documents/drug-treatment/UNODC_cbtg_guidance_EN.pdf
- Amnesty International. (2021). *Afghanistan: Country's four million internally displaced need urgent support amid pandemic*. <https://www.amnesty.org/en/latest/press-release/2021/03/afghanistan-countrys-four-million-internally-displaced-need-urgent-support-amid-pandemic/>
- Archambault, A. K. (2012). *Drug treatment centers in Afghanistan: Creating a participatory approach to tackling the drug trade* [Master's thesis, Naval Postgraduate School]. <https://apps.dtic.mil/sti/citations/ADA573578>
- Bewley-Taylor D. R. (2014). Legitimacy and modernity via policy transfer: the utility of the 2003 Afghan National Drug Control Strategy. *International Journal on Drug Policy*, 25(5), 1009–1018. <https://doi.org/10.1016/j.drugpo.2014.04.002>
- Beyrer, C. (2002). Human immunodeficiency virus (HIV) infection rates and heroin trafficking: Fearful symmetries. *Bulletin on Narcotics*, 14(1–2), 103–116. https://www.unodc.org/pdf/bulletin/bulletin_2002_01_01_1.pdf#page=107
- Brown, J. D. (2013). Oil fueled? The Soviet invasion of Afghanistan. *Post-Soviet Affairs*, 29(1), 56–94. <https://doi.org/10.1080/1060586X.2013.778543>
- Courser, M., Johnson, K., Abadi, M. H., Shamblen, S. R., Young, L., Thompson, K., & Browne, T. (2013). Building an evidence base for drug abuse treatment in Afghanistan: Lessons learned and implications for future research. *International Journal of Prevention and Treatment of Substance Use Disorders*, 1(1), 12–27. <https://doi.org/10.4038/IJPTSUD.V1I1.5908>
- Farooq, S. A., Rasooly, M. H., Abidi, S. H., Modjarrad, K., & Ali, S. (2017). Opium trade and the spread of HIV in the Golden Crescent. *Harm Reduction Journal*, 14(1), 47. <https://doi.org/10.1186/s12954-017-0170-1>
- Felbab-Brown, V. (2016). *No easy exit: Drugs and counternarcotics policies in Afghanistan*. Foreign Policy at Brookings. <https://www.brookings.edu/wp-content/uploads/2016/07/FelbabBrown-Afghanistan-final.pdf>
- Frost, A., Wilkinson, M., Boyle, P., Patel, P., & Sullivan, R. (2016). An assessment of the barriers to accessing the Basic Package of Health Services (BPHS) in Afghanistan: Was the BPHS a success?. *Globalization and Health*, 12(1), 71. <https://doi.org/10.1186/s12992-016-0212-6>
- Gender Data Portal. (2021). *In L. r. (%)*. The World Bank.
- Global Centre for Credentialing and Certification. (2021). *About GCCC*. <https://www.globalccc.org/about-gccc/>
- How, T., Morales, B., Thirumagal, V., & Ayub, M. (2014). Development of a village based treatment model for Afghanistan. *International Journal of Prevention and Treatment of Substance Use Disorders*, 1(2), 28–38. <https://pdfs.semanticscholar.org/3f1b/b59114115fcefad61d9b81d8349460e1f9e5.pdf>
- Inter-Agency Standing Committee. (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. <https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007>
- Koser, K. (2009). *The migration-displacement nexus in Afghanistan*. Brookings. <https://www.brookings.edu/articles/the-migration-displacement-nexus-in-afghanistan/>
- Lind, J. T., Moene, K. O., & Willumsen, F. (2014). Opium for the masses? Conflict-induced narcotics production in Afghanistan. *Review of Economics and Statistics*, 96(5), 949–966. <https://direct.mit.edu/rest/article-abstract/96/5/949/58194>
- MacDonald, D. (2008). *Afghanistan's hidden drug problem: the misuse of psychotropics*. *Afghanistan Research and Evaluation Unit*. https://www.ecoi.net/en/file/local/1186226/1002_1225123610_afghanistan-drug-abuse.pdf
- Maguet, O., & Majeed, M. (2010). Implementing harm reduction for heroin users in Afghanistan, the worldwide opium supplier. *Int J Drug Policy*, 21(2), 119–121. <https://doi.org/10.1016/j.drugpo.2010.01.006>
- Mansfield, D. (2019). *The Helmand food zone: The illusion of success*. Afghanistan Research and Evaluation Unit. <https://areu.org.af/publications/?author=david-mansfield&lang=en>
- Ministry of Counter Narcotics. (2006). *National Drug Control Strategy. An updated five-year strategy for tackling the illicit drug problem*. https://assets.publishing.service.gov.uk/media/5a78ac36e5274a277e68e8fe/fco_nationaldrugcontrolstrategy.pdf
- Ministry of Counter Narcotics. (2012). *Afghanistan National Drug Demand Reduction Policy Kabul*. Ministry of Counter Narcotics of Afghanistan, Ministry of Public Health of Afghanistan.
- Ministry of Counter Narcotics. (2015). *Relapse causes*. Ministry of Counter Narcotics of Afghanistan.
- Ministry of Public Health. (2009). *National mental health strategy 2009–2014*. Ministry of Public Health of Afghanistan. https://moph.gov.af/sites/default/files/2019-09/01_National_MH_Strategy-Eng..pdf
- Ministry of Public Health. (2021). *National Drug Treatment Program, drug demand reduction projects*. Ministry of Public Health of Afghanistan. www.moph.gov.af
- Momand, A. S., Mattfeld, E., Gerra, G., Morales, B., Browne, T., Haq, M. U., O'Grady, K. E., & Jones, H. E. (2020). Implementation and Evaluation of a Psychoactive Substance Use Intervention for Children in Afghanistan: Differences Between Girls and Boys at Treatment Entry and in Response to Treatment. *Global Journal of Pediatrics & Neonatal Care*, 2(1), 527. <https://doi.org/10.33552/gjpn.2020.02.000527>
- Najafzada, S. A., Labonté, R., & Bourgeault, I. L. (2014). Community health workers of Afghanistan: a qualitative study of a national program. *Conflict and Health*, 8, 26. <https://doi.org/10.1186/1752-1505-8-26>
- National Statistics and Information Authority. (2021). *NSIA estimates Afghanistan's population at 33.6 million*. <https://tolonews.com/afghanistan-172702>
- Noroozi, A., Kebriaeezadeh, A., Mirrahimi, B., Armoon, B., Ahounbar, E., Narenjiha, H., Salehi, M., & Karamouzian, M. (2021). Opium tincture-assisted treatment for opioid use disorder: A systematic review. *Journal of Substance Abuse Treatment*, 129, Article 108519. <https://doi.org/10.1016/j.jsat.2021.108519>
- Odejide, A. (2006). Status of drug use/abuse in Africa: A review. *International Journal of Mental Health and Addiction*, 4, 87–102. <https://doi.org/10.1007/s11469-006-9015-y>
- Pain, A, Kerami, K., & Nemat, O. (2021). *Drugs and development in Afghanistan-National policy and actor analysis*. Drugs & (Dis) order. file:///C:/Users/user/3D%20Objects/Afghanistan-stakeholder-analysis-2021_Final.pdf
- Ranganathan, S. (2008). *Community based treatment*. UNODC. <https://www.unodc.org/documents/india/ddch9.pdf>

- Santana, C. L. A. d. (2018). mhGAP Intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Version 2.0. In SGI Global (Ed.), *Afghanistan National Drug Use Survey 2015*. <https://www.issup.net/knowledge-share/resources/2016-10/afghanistan-national-drug-use-survey-2015>
- Shamblen, S., Courser, M., Young, L., Schweinhart, A., Shepherd, C., Morales, B., & Redpath, B. (2022). The efficacy of drug treatment in Afghanistan: Overall results and implications from a new evaluation. *International Journal of Mental Health and Addiction, 20*. <https://doi.org/10.1007/s11469-020-00382-1>
- Shinwari, N., Akseer, T., & Mahdis, T. (2020). *Asia Foundation releases model disability survey of Afghanistan*. Afghan Center for Socio-Economic and Opinion Research. <https://acsor-surveys.com/research/asia-foundation-releases-model-disability-survey-of-afghanistan/>
- Schweich, T. A. (2007). *U.S. counternarcotics strategy for Afghanistan*. <https://2001-2009.state.gov/documents/organization/90671.pdf>
- Special Inspector General for Afghanistan. (2018). *Quarterly report to the United States Congress*. Defence Technical Information Center. <https://apps.dtic.mil/sti/pdfs/AD1139431.pdf>
- Thurstans, S., Turnbull, P., Velly, D., & Middleton, W. (2011). *Humanitarian charter and minimum standards in humanitarian response*. The Sphere Project. <https://www.unhcr.org/fr-fr/sites/fr-fr/files/legacy-pdf/50b491b09.pdf>
- Todd, C. S., Abed, A. M., Scott, P. T., Safi, N., Earhart, K. C., & Strathdee, S. A. (2009). A cross-sectional assessment of utilization of addiction treatment among injection drug users in Kabul, Afghanistan. *Substance Use & Misuse, 44*(3), 416–430. <https://doi.org/10.1080/10826080802347669>
- Todd, C. S., Nassiramanesh, B., Stanekzai, M. R., & Kamarulzaman, A. (2007). Emerging HIV epidemics in Muslim countries: Assessment of different cultural responses to harm reduction and implications for HIV control. *Current HIV/AIDS Reports, 4*(4), 151–157. <https://doi.org/10.1007/s11904-007-0022-9>
- Todd, C. S., Stibich, M. A., Stanekzai, M. R., Rasuli, M. Z., Bayan, S., Wardak, S. R., & Strathdee, S. A. (2009). A qualitative assessment of injection drug use and harm reduction programmes in Kabul, Afghanistan: 2006–2007. *International Journal on Drug Policy, 20*(2), 111–120. <https://doi.org/10.1016/j.drugpo.2007.11.022>
- ToloNews. (2021). *SIGAR: 17% poverty rise in Afghanistan amid COVID-19*. <https://tolonews.com/business-169704>
- Trani, J.-F., Kuhlberg, J., Cannings, T., & Chakkal, D. (2016). Multidimensional poverty in Afghanistan: Who are the poorest of the poor? *Oxford Development Studies, 44*(2), 220–245. <https://doi.org/10.1080/13600818.2016.1160042>
- United Nations International Children's Emergency Fund. (2018). *Afghanistan's silent emergency. Families and the fight against malnutrition*. <https://www.unicef.org/afghanistan/stories/afghanistans-silent-emergency>
- United Nations Office on Drugs and Crime. (2005). *Afghanistan Drug Use Survey 2005*. <https://www.unodc.org/pdf/afg/2005AfghanistanDrugUseSurvey.pdf>
- United Nations Office on Drugs and Crime. (2009). *Drug use in Afghanistan: 2009 survey*. https://www.unodc.org/documents/data-and-analysis/statistics/Drugs/Drug%20use/Drug_use_in_Afghanistan_2009_survey.pdf
- United Nations Office on Drugs and Crime. (2010). *World Drug Report 2010*. https://www.unodc.org/documents/wdr/WDR_2010/World_Drug_Report_2010_lo-res.pdf
- United Nations Office on Drugs and Crime. (2013). *Independent project cluster evaluation of the Drug Demand Reduction Projects in Afghanistan*. https://www.unodc.org/documents/evaluation/Independent_Project_Evaluations/2013/AFG_H09_H87_G68_Cluster_Evaluation_Final_Report_22JUL2013.pdf
- United Nations Office on Drugs and Crime. (2020). *Afghanistan Opium Survey 2020 – Executive summary*. https://www.unodc.org/documents/crop-monitoring/Afghanistan/20210503_Executive_summary_Opium_Survey_2020_SMALL.pdf
- United Nations Office on Drugs and Crime. (2021). *World Drug Report 2021*. <https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html>
- World Health Organization. (2006). *WHO-AIMS report on mental health in Afghanistan*. https://cdn.who.int/media/docs/default-source/mental-health/who-aims-country-reports/afghanistan_who_aims_report.pdf?sfvrsn=2a61bfb3_3&download=true