Drug policies and responses in Afghanistan

Lancet Psychiatry 2023
Published Online
December 12, 2023
https://doi.org/10.1016/
S2215-0366(23)00390-5

Afghanistan has experienced more than four decades of war, natural disasters, and population displacement. About 85% of Afghans have either personally experienced or witnessed a traumatic event, 50% of the population are experiencing psychological distress, and 20% are impaired in their daily role because of mental health conditions.[1] Afghanistan has the highest level of illicit drug use among Eastern Mediterranean countries, with opioids as the most used drug.[2] The Afghanistan national drug survey in 2015 showed that 11·1% of the general population (12·8% of adults and 9·2% of children) tested positive for at least one type of drug or class of drugs. The rate of positive drug tests was higher among men (16·1% *vs* 9·5% in women) and those in rural populations (13·0% *vs* 5·3% in the urban population).[3]

The political change in Afghanistan in August, 2021, has been associated with a range of developments in the country's drug policies and has deepened pre-existing fragilities in the health-care services for people with drug use disorders. The de-facto authorities announced a ban on opium poppy cultivation in Afghanistan in April, 2022; however, a UN report[4] in November, 2022, showed that the Taliban granted a grace period and the yield was largely unaffected. The extent to which the de-facto government will enforce the ban in the long term is yet to be seen. The opium price has spiked following the takeover in August, 2021, and the 2022 ban on opium poppy cultivation has further increased the national opiate prices.[4] Afghanistan has long been identified as the main producer of opiates globally. However, a new epidemic of methamphetamine production, seizure, and use has emerged during the past decade. Staff working in drug treatment centres interviewed in 2016 reported that 1 g of methamphetamine was more expensive (450–2500₰) than 1 g of heroin (20–100₰) in the illicit drug market.[5] Interviews conducted by one of the authors (AN) with patients in drug treatment centres in June, 2023, in Kabul and Jalalabad found that the situation has been reversed and now 1 g of methamphetamine is cheaper (100₰) than 1 g of heroin (400–500₰). Although myriad factors affect drug use epidemiology in Afghanistan, economic contraction and unemployment can increase drug use. Additionally, high opium and heroin prices might result in a surge in the use of methamphetamine and its associated health and social consequences across the country. Anecdotal reports from drug treatment centres in different regions of the country support that there has been a change in drug use (unpublished).

Drug treatment services in Afghanistan are based on inpatient drug treatment centres located in provincial capitals. These programmes do not provide active community-based outpatient aftercare and follow-up, and an evaluation[6] has shown that the 12-month relapse rate to illicit drug use was as high as 70%. According to the Afghanistan Drug Report 2015,[7] there were only 123 drug treatment centres in the country in 2015, which is sufficient to treat 10·7% of patients needing treatment. Harm reduction programmes started in 2008 and were scaled up slowly. By 2020, there were 25 needle and syringe programmes and eight opioid substitution treatment sites in the country.[8] According to email communication with Dr Abdul Qudos Saadat (Afghanistan Ministry of Public Health, personal communication) on Aug 16, 2023, following the Taliban takeover of the government and due to the reduction in international and public funds, only 10% of the drug treatment centres remained functional with international support, 44% were closed, and the remainder were running with a limited budget. Furthermore, as of Aug 15, 2023, the number of needle and syringe programmes had fallen to eight and the number of opioid substitution treatment sites had fallen to six.

Medically assisted withdrawal management is only the first stage of addiction treatment and, by itself, does little to change long-term drug use.[10] Despite the low effectiveness of withdrawal management alone, drug treatment programmes in Afghanistan used to conceptualise addiction as an acute intoxication that could be cured by isolation in inpatient centres and 2 weeks of symptomatic management of withdrawal syndrome, followed by 4 weeks of residential stay. Disregard for the chronic nature of addiction in Afghanistan has intensified in the past few years and has resulted in people with addiction being rounded up by force and moved to compulsory camps with the hope of eradicating addiction from the country.[9]

International evidence supports a tiered model of care to provide an adequate response to the needs of

individuals with different levels of severity of addiction, in which those with less severe addiction, who are more numerous, can be treated with less intensive, low-cost interventions made available through community-based settings (including primary health care and specialised outpatient treatment and harm reduction programmes), whereas people with more severe addiction can receive more intensive care within residential or inpatient settings.[10] However, community-based services required for the long-term management of addiction as a chronic and relapsing disease have not been developed in Afghanistan.

There is an urgent need for a paradigm shift in drug policies from institution-based measures to the provision of voluntary, community-based services integrated into or linked with the public health system. National and international resources should be restructured to create a tiered model of care with a special emphasis on the provision of long-term, low-cost, evidence-based, and human rights-based services through a network of community programmes.

We declare no competing interests.

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