AFGHANISTAN DRUG REPORT

2012

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FOREWORD (Ministry of Counter Narcotics)

The first Afghanistan Drug Report (2012) which covers all aspects of counter narcotics in Afghanistan is prepared based on modern and scientific techniques in accordance to National Drug Control Strategy, Strategic Plan of Ministry of Counter Narcotics, Law Against Intoxicating Drinks and Drugs and their Control and other policies and programs of the MCN in collaboration with the Research Team of the Country Office of the United Nations Office for Drugs and Crime.

The Report is based on overview of the key trends and conditions related to the production, consumption and regulation of illicit substances in the country. The report presents counter narcotics efforts achieved through the creation of mechanisms, changes in structures and development of programs and new policies in order to respond to the drug problem in Afghanistan which impacts on social, economic, health and political issues.

Considering the transition process and serious challenges related to drugs and organized crimes, effective responses are required by the country with support from the international community. Although most of the world’s opium today comes from Afghanistan (74%), only a small proportion is seized either in country or by regional partners.

Along the borders of Afghanistan with neighboring countries, networks operate to transfer weapons. Money derived from drug trafficking that annually flows to insurgents and warlords is estimated to reach between 200-400 million USD. In addition, the country faces an increasing prevalence of drug users with almost one million drug users but has limited treatment capacity. The illicit drug economy is a key factor in shaping the current and short and long term development of Afghanistan. Counter narcotics challenges further affect stability and regional cooperation among neighboring countries.

The first issue of the Afghanistan Drug Report presents an overview of key factors on poppy cultivation, production, consumption and regulation in the country. The Ministry of Counter Narcotics in publishing of this report intends to strengthen its mandate for counter narcotics policy coordination in the country. A central pillar of sustainable institutional capacity building activities of the Ministry of Counter Narcotics is to facilitate the implementation of the National Drug Contrail Strategy based on evidence of national counter narcotics trends and complemented by international cooperation. In this regard the Afghanistan Drug Report will serve as a fundamental guide for the following issues.

The Afghanistan Drug Report tracks progress of National Drug Control Strategy, shares counter narcotics information among governmental organizations and analyzes the data collected by different mechanisms from a variety of sources. It also provides specific suggestions and recommendations based on current conditions and trends thus enabling the development of evidence based policies. The report is also related with the development of the Afghanistan Drug Reporting System which will serve as a centralized source of counter narcotics data located in the Ministry of Country Narcotics.

Therefore, the Afghanistan Drug Report serves as an important policy and advocacy document for strengthening the counter narcotics efforts of the government of Afghanistan.

The main body of the Afghanistan Drug Report is organized in three main chapters. Chapter 2 reviews the supply of narcotics and the interventions which have been introduced to reduce this supply including eradication and alternative livelihoods, with a closer look at the Hilmand Food Zone Project (FZP). The next chapter considers the human impact of drugs focusing on use, treatment and prevention trends and conditions based on national drug use surveys conducted in 2005 and 2009. Findings from a study on access to drug treatment are also presented. The following chapter looks at trends in narcotics related offences and progress to date in addressing them. It also provides an overview of the multi-step process and procedures of case management in relation to narcotics-related crimes.

I hope that this report will serve as an effective step in capacity building of national institutions in the country in order to address the drivers of poppy cultivation, trafficking and drug use and effective ways for tackling drug dilemma which pose substantial problems in the country.

Zarar Ahmad Osmani
Minister of Counter Narcotics
FOREWORD (United Nations Office for Drugs and Crime)

The launch of the first Afghanistan Drug Report instills pride not only within the Ministry of Counter Narcotics (MCN), the report’s owner, but equally within UNODC, providing technical support to the report. Based on an expressed need by the Ministry to build its own capacity to undertake policy-relevant counter narcotics research, UNODC has been assisting the Ministry to develop its Research Directorate since 2011. The publication of the first Afghanistan Drug Report therefore symbolizes a major milestone in the Ministry’s policy monitoring and coordination functions.

Effective counter narcotics policy oversight requires a strong empirical base founded on robust research and analytical practices. It is with this in mind that the Ministry, the Government lead on counter narcotics policy coordination, has produced this inaugural issue of the Afghanistan Drug Report with technical assistance from UNODC.

The report is an absolute pioneer in presenting a comprehensive overview of trends and conditions related to illicit substances in Afghanistan including new and emerging developments. It provides a valuable starting point for national and international stakeholders involved in counter narcotics to guide and review policy and processes but also engage in further research to enhance the evidence base for future policy and advocacy.

As the first issue of what will become a series of annual reports, the report is an example of Afghan institutions taking a lead in the transition process towards 2014 and the transformation post-2014. UNODC does trust that within the principle of international shared responsibilities, as embedded within the UN Conventions on Drug Control, the international community will continue extending and expanding its support towards capacity building of the counter narcotics institutions at large and the Ministry in particular.

It leaves me to express my sincere appreciation to the Governments of Canada, Germany, Japan and the United Kingdom – without their support, the preparation of the report would not have been possible. Most importantly though, I wish to congratulate His Excellency the Minister of Counter Narcotics, Ahmad Zarar Moqbel Osmani, whose vision and oversight was indispensable for the successful publication of the report.

Jean-Luc Lemahieu
Regional Representative for Afghanistan and Neighboring Countries
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<td>Afghan Anti-Crime Police</td>
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<td>Afghan Border Police</td>
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<td>ACP</td>
<td>Afghan Customs Police</td>
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<td>AFN</td>
<td>Afghani (currency)</td>
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<td>Anti-Government Elements</td>
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<td>AGO</td>
<td>The Attorney General Office</td>
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<td>AIDS</td>
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<td>AL</td>
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<td>BPHS</td>
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<td>CNMM</td>
<td>Counter Narcotics Monitoring Mechanism</td>
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<td>CNTA</td>
<td>Counter Narcotics Training Academy</td>
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<td>Acronym</td>
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<td>CNTF</td>
<td>Counter Narcotics Trust Fund</td>
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<td>Central Statistics Office</td>
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<td>Correction System Support Program</td>
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<td>Directorate of Counter Narcotics</td>
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<td>DDR</td>
<td>Drug Demand Reduction</td>
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<td>FZP</td>
<td>Food Zone Program</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GIS</td>
<td>Geographical Information System</td>
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<td>GLE</td>
<td>Governor Led Eradication</td>
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<td>GPI</td>
<td>Good Performance Initiative</td>
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<td>HFZP</td>
<td>Hilmand Food Zone Program</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IBBS</td>
<td>Integrated Behavioral and Biological Surveillance</td>
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<td>ICPC</td>
<td>Interim Criminal Procedure Code</td>
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<td>IDUs</td>
<td>Injecting drug users</td>
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<tr>
<td>INL</td>
<td>Bureau of International Narcotics and Law Enforcement Affairs</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>ISAF</td>
<td>International Security Assistance Force</td>
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<td>JCMB</td>
<td>Joint Coordination Monitoring Board</td>
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<td>JRC</td>
<td>Juvenile Rehabilitation Center</td>
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<td>JSSP</td>
<td>Justice Sector Support Program</td>
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<td>Law Enforcement</td>
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<td>MAIL</td>
<td>Ministry of Agriculture Irrigation and Livestock</td>
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<td>MoD</td>
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<td>MoI</td>
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<td>Ministry of Justice</td>
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<td>MoPH</td>
<td>Ministry of Public Health Afghanistan</td>
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<td>MRRD</td>
<td>Ministry of Rural Rehabilitation and Development</td>
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<td>NACP</td>
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<td>NDCS</td>
<td>National Drug Control Strategy</td>
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<td>NDS</td>
<td>National Directorate of Security</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<td>NPP</td>
<td>National Priority Programs</td>
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<td>ORAS</td>
<td>Opium Rapid Assessment Survey</td>
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<td>OST</td>
<td>Opioid Substances Treatment</td>
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<td>PEF</td>
<td>Poppy Eradication Force</td>
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<td>PI</td>
<td>Public Information</td>
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<td>PRT</td>
<td>Provincial Reconstruction Team</td>
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<td>TOC</td>
<td>Tactical Operation Center</td>
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<td>UNAIDS</td>
<td>United Nations Program on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNDSS</td>
<td>United Nations Department of Safety and Security</td>
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<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crimes</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USD</td>
<td>United States Dollar</td>
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<td>World Drug Report</td>
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<td>WFP</td>
<td>World Food Program</td>
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<td>World Health Organization</td>
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EXECUTIVE SUMMARY

A number of key findings have emerged from the review of trends and conditions of drug supply, use and control in the Afghanistan Drug Report 2012 and these are outlined below. The findings illustrate that achievements have been registered with respect to counter narcotics efforts in Afghanistan including through the creation of necessary institutional mechanisms and structures as well as policy frameworks to respond to the drugs problem. At the same time, the evidence shows that the cultivation, trafficking and use of illicit substances remains one of the most critical challenges facing Afghanistan resulting in significant negative social, economic, health and political impacts on the country. The need to strengthen and scale up counter narcotics policies and interventions is more pressing today than ever before especially in view of the political transition facing Afghanistan in the near future.

DRUG SUPPLY AND SUPPLY REDUCTION

Drug supply

*Poppy cultivation is highly concentrated in two regions but seems to be expanding*

Three quarters of the world’s global illicit opium in 2012 (74%) originated in Afghanistan. The country is also a producer of cannabis. The South and West Regions of Afghanistan account for the majority of opium production in the country - in 2012, 72% of Afghanistan’s opium was cultivated in the South alone with Helmand, Uruzgan, Farah and Kandahar having the highest levels of cultivation. In 2012, there were 17 poppy-free provinces - an improvement from 2006, when there were just six poppy-free provinces, but representing deterioration from 2009 and 2010, when there were 20 poppy-free provinces. There is a similar regional shift in cannabis which has seen cultivation move from the North Region to the South.

*The size of the illicit economy is considerable*

In 2012, the total farm-gate value of the opium produced from poppy cultivation in Afghanistan was US$ 717 million corresponding to four percent of the country's GDP. This represents a significant share for an illicit economy - in Colombia, the 2011 value of the coca crop expressed as a proportion of the licit GDP was just 0.2 per cent. In terms of the export value of opiates as a proportion of the overall Afghan GDP, this was 13.5 per cent in 2011 having declined from 50 percent in 2003. This is not due to a reduction in the scale of the opium economy, but is rather a reflection of the increase of Afghanistan’s GDP from US$ 4.59 billion in 2003 to US$19.18 billion in 2011.

*Illlicit crops are lucrative cash crops*

Illicit crops are attractive for farmers most of whom identify high sales prices as one of the top three reasons for cultivating illicit crops. Households cultivating illicit crops in Afghanistan continue to tend to have higher incomes than households cultivating cereal crops. In 2009 and 2010, net income from cannabis was even higher than the net income from opium poppy cultivation. Wheat tends to be the most popular crop amongst non-illicit crop cultivating households; such households also rely more heavily on wage labour and remittances.
The opium market reacts strongly to supply shocks
Reduced opium production - whether perceived or actual - has a strongly correlated effect on prices, which is that they increase. In turn, an increase in price seems to have a direct correlation to farmers’ decision making process in planting poppy such that production increases at times of high prices.

Prices of illicit crops fluctuate with seasonal changes in supply
Prices for both cannabis and opium fluctuate every year, but also consistently within each year. In both cases, prices are highest just before harvest and at their lowest during the harvest. The differences are more acute with cannabis than with opium - cannabis varies from +10% of yearly average to -6%. Opium varies from maximum +6% of yearly average to -4%. The reason for this is likely due to the storability of hashish vs opium: hashish does not store as well and reduces in quantity over time, so it is traded as quickly as possible after production. Opium seems to be retained more by farmers to sell when prices are more advantageous for them.

Poppy cultivation and insecurity go together
Insecurity promotes lawlessness which in turn promotes opium poppy cultivation and trafficking. It also reduces the ability for the state law enforcement agencies to operate effectively against narcotic threats, as well as reducing the likelihood that alternative livelihood interventions can be successfully implemented.

Potential links between poppy cultivation and development
There appears to be a correlation between development indicators such as education and poppy growth cultivation. Data from 2009 shows that the southern region has the lowest school enrolment rates for boys and girls. In 2012, 90% of non-poppy-growing villages had a boys’ school and almost 75% a girls’ school while these proportions drop to 61% (boys’ school) and 19% (girls’ school) in poppy-growing villages. Potentially this is a developmental link: poppy-growing areas are less secure, which may inhibit the state’s ability to provide the security and development assistance necessary to construct and maintain girls’ schools. However, further research is required to determine the exact nature of the relationship between development indicators and poppy.

Drug supply reduction
Public awareness is a potentially effective policy response
Public awareness campaigns appear to have a significant effect in influencing decisions to cultivate opium poppy, but there need for more information about their effectiveness. MCN/UNODC surveys show that villages that were exposed to an awareness campaign seem to be less likely to cultivate poppy in the following season. Evidence from the Hilmand Food Zone also indicates that messaging has been an effective supply reduction technique. Specific research would be necessary to fully understand the effectiveness of CN messaging; such research would be dependent on improved monitoring of the messaging performance.

Maximizing the impact of eradication campaigns
Eradication levels have varied over the years but in 2012, eradication increased markedly by 154% compared to the previous year, with 9,672 hectares eradicated. The ban by government was among the top two reasons cited by respondents in the 2011 and 2012 and annual opium surveys for not cultivating poppy. Since eradication is closely associated with government bans on poppy,
it can be assumed that government bans and by implication enforcement through eradication do influence farmer’s decisions not to cultivate poppy. However, eradication can be responsible for insecurity and loss of government support. Furthermore, eradication needs to be coupled with development assistance in order to maximize its impact and better influence farmer decisions to cultivate licit crops instead of poppy. Thus, interventions designed to provide broader alternative development opportunities are a necessary complement to eradication strategies.

Building alternative livelihoods
There have been substantial investments and interventions aimed at improving rural livelihoods. For instance, the MRRD has been a major player in this regard, spending over US$ 1 billion on development projects since 2002. In terms of alternative crops, vegetables earn considerably more gross income than do cereals, with wheat, maize and cotton being the least valuable crops in terms of gross income earned per hectare. Saffron does have a very high gross income potential - the total yield of saffron products from a single hectare can be worth almost four times as much as the gross income from a hectare of opium poppy. Also, access to off-farm income can be a decisive factor in growing poppy: some areas, such as Nangarhar, have better access to off-farm income than others, such as Hilmand.

Impact of the food zone programme on poppy cultivation in Hilmand
Following the introduction of the Food Zone Program in the autumn of 2008, Hilmand poppy cultivation levels dropped by 33% to 69,833 ha in 2009. When expressed as the share of total cultivation in Afghanistan, Hilmand contributed as much as 66% to total cultivation levels in 2008, but only 48% in 2011 and 49% in 2012. Inside the Food Zone, farmers rely less on poppy and more on wheat for their income than farmers outside the Food Zone.

DRUG USE, PREVENTION AND TREATMENT

Drug use

Significant increase in opiate consumption
Afghanistan has close to one million adult drug users with a particularly high annual opiate prevalence amongst the adult population of 2.7%, similar to countries like Russia and Iran. Significant increases in the use of opium and heroin have been observed in the country in recent years and cannabis has emerged as the most widely used substance with over half a million users countrywide. Between 2005 and 2009, the numbers of regular opium and heroin users increased by 53% and 140% respectively.

Urban areas emerging as hot spots
While drug use in rural areas is still prevalent, urban areas are fast becoming home to significant numbers of drug users with concentrated drug using ‘hot spots’ in cities like Kabul, Herat, Mazar, Farah, Nimroz, Kandahar and Nangarhar. The Central region, where the capital is located, has the highest number of drug users in the country.

Injecting drug use on the rise
There are 19,000 injecting drug users (IDUs) in country with Herat, Farah and Nimroz emerging as hot spots and Kabul city being home to the largest number of IDUs. High rates of risky behaviour have been observed amongst IDUs including sharing of needles and syringes, low condom use and exchange of sex for money and drugs.
HIV/AIDS at risk of becoming a concentrated epidemic
HIV may evolve into a concentrated epidemic, with returnee, prison and injecting drug user groups being especially vulnerable to infection due to risky behaviour. One study within prisons found that only 42% had heard about the disease and most did not connect condom use with protection from HIV/AIDS.

Financial burdens of drug use are high
Drug users are financially burdened by their addiction with total spending on drug use averaging 14.5 billion Afghanis (US$ 300 million) annually in the country. Drug users in the southern parts of the country spend less on opium and heroin possibly due to widespread cultivation and production.

Returnees and prison populations particularly vulnerable
Existing evidence suggests regular drug use in prisons. Significant levels of injecting drug use were also found in different studies together with practices which increase HIV transmission. At the same time drug treatment and harm reduction services within prisons are insignificant. Drug use rates amongst returning refugees were high, especially amongst those from Pakistan and Iran.

Drug use within families is a significant challenge
The use of opium within families is significant including amongst children, adolescents and women. A study in 2009 found that about 50 per cent of drug users interviewed gave drugs to their children. Children are given opium to numb hunger and drugs are generally used to deal with stress, health problems and other challenges in life within families.

Prevention and treatment
Continued expansion of prevention programmes needed
Information about drug prevention, drug use and its negative effects are communicated within the country through a range of channels. MCN leads the coordination on drug prevention interventions with other relevant ministries. The main drug prevention activities include awareness programs in Drug Treatment Centers, school-based awareness programs, mosque-based awareness programs, youth congresses and vocational training. During 2012 an estimated 1,848,532 individuals benefited from such awareness interventions.

Treatment capacity has increased but remains insufficient
In 2012, an estimated 102 treatment centers were providing a range of services, up from 43 centers in 2009. However, treatment capacity remains low at an estimated 20,800. This covers only 5.9% of the opium and heroin users in the country. The central region has the highest number of treatment centers and variety of services compared to other regions, followed by the western and northern regions. The 2012 Drug Demand Reduction policy of MCN sets a target to increase drug prevention and treatment capacity by 30% for heroin and opium users between 2012 and 2016.

Social support and cost of services influence access to treatment
Results from a pilot study suggest that social support in the form of encouragement and advice from family and friends is important in users seeking access to treatment. The cost of accessing treatment is another significant factor in users seeking treatment. In particular, free services are crucial in motivating users to seek access to those services. Also, the majority of users have not had any contact with outreach teams; and where outreach teams have had contact with users,
their most effective contact has been in an advisory role, and not so much in a practical role (such as escorting patients to available centres or making appointments on their behalf).

**LAW ENFORCEMENT AND CRIMINAL JUSTICE**

**Law enforcement**

*Law enforcement agencies are meeting seizure targets*
Since September 2012, reporting indicates that law enforcement agencies have been successfully meeting targets, as assigned by the MCN, for several months. This is especially true in the case of high-value and low-value drug traffickers. Most of the arrests have been carried out by Counter Narcotics Police of Afghanistan followed by National Directorate of Security with the rest of the agencies reporting comparatively fewer seizures.

*The number of seizure cases is on the rise*
Significant increases have been observed in the number of seizure cases for most illicit substances. Between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), the following increases in seizures were observed: heroin (250.4%), opium (212.6%), hashish (328%), morphine (88.9%) and alcohol (1900%).

*Extent of heroin production unclear*
Although heroin seizures account for the highest number of cases, half of them were smaller than 0.04kg. These small quantity heroin seizures appear to suggest street-level seizures. At the same time morphine seizures are on the rise suggesting that the initial steps of the heroin production could take place in Afghanistan, with the process finishing elsewhere. The small number of labs dismantled as well as the relatively low amounts of acetic anhydride seized also seems to support this theory. However, ultimately it is unclear how much heroin is produced in the country. This highlights the need for greater regional support and cooperation involving countries where labs may exist.

*Methamphetamine possibly an emerging substance*
Since the first seizure in 2008, the number of methamphetamine seizure samples tested by the CNPA forensic lab has been increasing, rising by 300% from 2011 to 2012. In 2012, the CNPA Forensics Laboratory reported having received seizures from Herat, Farah, Faryab, Kandahar, Balkh and Kabul provinces—the largest of which was from Faryab province which contained 530 grams of methamphetamine and the second largest seizure was in Kandahar province comprising 240 grams of the drug.

*Hashish seizures increased substantially*
Between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), there was a 328% increase in the number of hashish seizures. During this same period, a 785% increase was seen in the amount of hashish seized, highlighting an important problem for authorities to address.

*Drug and precursor seizures predominantly in the West and South*
Geographically speaking, heroin is being seized mainly in the western and southern provinces of Hirat, Nimroz and Hilmand. Morphine seizures are also occurring mainly in the southern provinces of Kandahar and Hilmand. Additionally, the largest amounts of precursors seized and the largest percentage of labs destroyed (68%) were also in the southern provinces. Precursors are not
produced in Afghanistan but rather originate from outside the country further highlighting the need for greater regional and international cooperation.

Criminal justice

Number of Criminal Justice Task Force (CJTF) cases on the rise
The total number of incoming cases at the CJTF has been increasing continuously from 395 in 1388 (March 2009-March 2010) to 588 in 1391 (March 2012-March 2013) representing a significant rise of 48.8%. Overall increases during this period were observed across all regions of the country. The Southern region accounts for the highest proportion of the incoming cases followed by the Western and Central regions.

Number of suspects at Primary and Appellate courts increased
The number of suspects at the Primary Court level increased from 1388 (March 2009-March 2010) to 1391 (March 2012-March 2013) while the number of acquittals decreased during the same period.

Changes to illicit substance thresholds would require careful consideration
There is an on-going policy discussion surrounding the thresholds of narcotics and intoxicants in Afghanistan. Cases below the threshold (as classified by substance) are dealt with at the provincial level, cases above the threshold are referred to the CJTF in Kabul. Only a significant change of the thresholds by more than 50% would lead to a substantial increase in cases for the CJTF. Minor changes of the threshold would not lead to a re-classification of a large proportion of narcotics-related cases.

Number of prisoners incarcerated for narcotics-related crimes on the rise
There was a slight increase in the number of prisoners incarcerated for narcotics-related crimes between 1388 (March 2009-March 2010) and 1389 (March 2010-March 2011), but a much larger increase in prisoners incarcerated for narcotics-related crimes between 1390 (March 2011-March 2012) and 1391 (March 2012-March 2013) when compared to 1388 (March 2009-March 2010) and 1389 (March 2010-March 2011).

Most prisoners convicted for narcotics crimes from western region
Between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), the number of prisoners convicted for narcotics crimes are highest in the Western region followed by the Southern region, Northern region, Eastern region, North-eastern region with the fewest number found in the Central region. Over the period of 4 years, the most significant increase in the number of cases by year and the total number of cases countrywide happened in the Western region.

Increased number of juveniles incarcerated for narcotics-related crimes
From 1387 (March 2008-March 2009) to 1391 (March 2012-March 2013), there was a gradual increase in the total number of juveniles incarcerated each year. The total number of juveniles in 1391 (March 2012-March 2013) is over double the total number of juveniles in 1387 (March 2008-March 2009). However, juveniles incarcerated for narcotics-related crimes still represents a fairly small percentage of those incarcerated for overall crimes. The Western region appears to have the largest problem with juveniles detained for narcotic-related offences.
Expanding coverage of Case Management System

Significant progress is observed with respect to case management or the multi-step process and procedures for handling narcotics-related crimes as defined in the Afghan Counter Narcotics and Intoxicants Law and the Interim Criminal Code for Courts. However, the current system does not cover all stages of case management in all provinces as it has been only implemented in three provinces (Kabul, Herat and Balkh). In the remaining 31 provinces, the system is only implemented at detention and prison facilities.
CHAPTER 1: INTRODUCTION

Afghanistan faces serious challenges related to drugs that require effective responses by the country with support from the international community. Although most of the world’s opium today comes from Afghanistan (74%)\(^1\), only a small proportion is seized either in country or by regional partners. Along the borders of Afghanistan, illicit drug trafficking is proliferating together with the movement of insurgents, money, people and weapons and precursor chemicals imported into the country.

The drug trade funds accrued annually by insurgents and warlords have been estimated to net between 200 and 400 million USD\(^2\). Additionally, the country has to deal with close to one million adult drug users with limited capacity for treatment\(^3\). The illicit economy is thus a key factor shaping Afghanistan’s current and longer term national development and by implication also related programmes and investment. The counter narcotics challenge also significantly shapes regional dynamics and stability which requires more collaboration by concerned neighboring countries.

This first issue of the *Afghanistan Drug Report* presents an overview of the key trends and conditions related to the production, consumption and regulation of illicit substances in the country. Through the preparation of this report, the MCN will advance its overall mandate to coordinate counter narcotics policies in Afghanistan. A central pillar of the MCN approach focuses on sustained capacity and institution building to facilitate the development and delivery of the National Drug Control Strategy (NDCS) and evidence-informed policy on counter narcotics issues nationally which also have implications for international cooperation and support.

Accordingly, the *Afghanistan Drug Report* is a fundamental platform for:

- Reporting on progress with the implementation of the NDCS;
- Data and information sharing across a number of governmental agencies engaged in Counter Narcotics (CN) efforts;
- Critical analysis of CN data generated through different reporting systems and mechanisms and by different institutions in a harmonized way;
- Understanding the policy implications of current CN trends and conditions thereby enabling evidence-based policy making and implementation;
- Comparing CN data and information from multiple sources for the first time generating critical insights but also gaps in knowledge of CN trends and conditions;
- Identifying challenges in the implementation of CN policies and laws and how these can be addressed through the efforts of the MCN as well as other government agencies engaged in CN with support from international partners;
- Creation of a common platform for policy engagement amongst multiple governmental and non-governmental stakeholders engaged in CN efforts.

\(^1\) MCN/UNODC (2013) Opium Survey 2012, p.13
\(^2\) UNODC (2009), Addiction, Crime and Insurgency: The Transnational Threat of Afghan Opium, p.2
\(^3\) UNODC (2009), Afghanistan Drug Use Survey 2009, p 3-5
By publishing the *Afghanistan Drug Report* on an annual basis, the Ministry of Counter Narcotics will significantly enhance the evidence base for policy making, implementation and amendments. In the process of preparing the report, MCN will substantially improve its capacity to fulfill its obligation to monitor and evaluate (survey and research), and consequently its function to engage in informed CN analysis, policy and advocacy in coordination with other government ministries and institutions.

*Figure 1.1: Regions and Provinces of Afghanistan*

The preparation of the *Afghanistan Drug Report* is also closely linked to the ongoing development of the Afghanistan Drug Reporting System which will serve as the first central repository for CN data, located in the MCN. Eventually, relevant line ministries will have access to feed their information into this database, and will themselves benefit from secure access to relevant data sets in the repository. To date, this CN information was scattered across the line ministries, including in ad hoc databases with limited consistency of design, making research-informed and evidence-based policy difficult. This Afghan-owned centralized data system is able to portray the overall dimension of the counter narcotics problem in the country—the first time such a system was conceived of in Afghanistan solely for the purpose of monitoring the CN situation. Future issues of the *Afghanistan Drug Report* will be directly derived from the data and analyses emerging from the Afghanistan Drug Reporting System.
The preparation of the Report is also directly aligned with the principle of *Afghanization*, or Afghan ownership of its own destiny, which currently forms a key pillar of CN efforts in the country. Through the publication of the *Afghanistan Drug Report*, the Government of Afghanistan will be in a better position to present CN trends and developments and enhance the effectiveness of policy interventions.

The *Afghanistan Drug Report* has been prepared based on extensive technical support and guidance from the Country Office of the United Nations Office for Drugs and Crime. Its preparation has also involved close collaboration with a number of government ministries namely the Ministry of Rural Rehabilitation and Development, the Ministry of Agriculture, Irrigation, and Livestock (MAIL), the Ministry of Public Health (MoPH), the Attorney General’s Office (AGO) and the Ministry of Interior Affairs (MoI). This further strengthens the function of the report as a critical Counter Narcotics policy and advocacy instrument for the Government of Afghanistan.

The main body of the *ADR* is organized in three main chapters (2, 3 and 4). Chapter 2 deals with the supply of narcotics and the interventions which have been introduced to reduce this supply including eradication and alternative livelihoods. As a specific example of a drug supply reduction intervention, a case study on the Hilmand Food Zone Project (FZP) is presented. Subsequently, chapter 3 focuses on the human impact of drugs in Afghanistan by reviewing drug use, treatment and prevention trends and conditions drawing mainly on national drug use surveys conducted in 2005 and 2009. As part of the treatment section, the chapter also reports on a comparative pilot study of individuals accessing drug treatment and those who were not accessing treatment. Chapter 4 reviews narcotics related offences from the point of a crime being committed through the court system to imprisonment in order to highlight positive and negative trends as well as recommend potential areas for improvement. Additionally, it explores the multi-step process and procedures of case management as it pertains to narcotics-related crimes defined in the Afghan Counter Narcotics and Intoxicants Law and the Interim Criminal Code for Courts.

**REFERENCES**


CHAPTER 2: DRUG SUPPLY AND SUPPLY REDUCTION

2.1 INTRODUCTION
This chapter focuses on the supply of narcotics which comes from Afghanistan, and the strategies that have been put in place to reduce this supply. The “supply” of drugs refers to the cultivation of illicit narcotics, which in the case of Afghanistan relates to the cultivation of opium poppy, from which opium gum is extracted, and the cultivation of cannabis, from which hashish is derived. The issues of processing opium into heroin are covered elsewhere in this report, under a Law Enforcement focus.

The chapter is structured into four main sections. The first reviews the status of the supply of narcotics in Afghanistan, analyzing trends and patterns in illicit crop cultivation. Some of the economic and development factors underlying drug supply are also considered. The second section considers interventions and approaches that have been adopted to reduce the supply of illicit narcotics from Afghanistan, including public awareness campaigns, eradication and promotion of alternative livelihoods.

The third section is a case study on the Hilmand Food Zone Project (FZP) and explores this in detail as an example of a major government intervention intended to reduce drug supply. Trends of poppy cultivation in Hilmand since the inception of the program are discussed in this section. The final section highlights key concluding remarks derived from the chapter.

2.2 DRUG SUPPLY

2.2.1 Scale of illicit crop cultivation and production
Afghanistan is the world’s largest producer of opium poppy, supplying 74% of the world’s illicit opium in 2012, and is named among the main source countries for cannabis resin. Opium poppy cultivation has been monitored by UNODC since 1994 and jointly with MCN since 2003. UNODC and MCN have been monitoring cannabis cultivation on a yearly basis since 2009.

In 2012, opium poppy cultivation levels reached 154,000 hectares (an increase of 18% when compared to 2011), making it the year with the fourth highest levels of cultivation since 1994 (see Figure 2.1). The MCN/UNODC Opium Risk Assessment 2013 projects a further expansion of opium cultivation for 2013.

Commercial cannabis production in Afghanistan takes place at smaller scales and cultivation patterns are more erratic. In 2011, the area under commercial cannabis cultivation was estimated to be 12,000 hectares and the majority of farmers stated they grew cannabis every other year and some even less frequently. Cannabis in Afghanistan is transformed into cannabis resin or hashish, which is mainly trafficked in the region, although there are indications that some hashish is trafficked as far as Europe and North America.

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2.2.2 Geographical patterns of drug cultivation and production

Even though an overall increase in levels of poppy cultivation has been observed in the past decade, the higher concentration of cultivation in two regions, the Southern and Western region, has led to a situation whereby in 2012 fewer provinces were affected by illicit crop cultivation than in the time period between 2004 and 2007 (but still more than in 2008-2010).

When considering the regional distribution of area under poppy cultivation from 2004 onwards, the Southern region accounted for an increasing proportion of poppy cultivation, while at the same time the area under cultivation in the Northern, North Eastern and Central region diminished. In 2012, 72% of Afghanistan’s total opium was cultivated in the Southern region of the country alone (as opposed to 37% and 44% in 2004 and 2005, respectively). The geographical shift

Prior to 2004 the provinces of Afghanistan were structured in different regions, see e.g. MCN/UNODC (2003) Afghanistan Opium Survey 2003
in poppy cultivation correlated to a change in the security situation in Afghanistan, where poppy shifted to the most insecure provinces in the South.\textsuperscript{10}

**Figure 2.2: Regional distribution of area under poppy cultivation, 2004-2012**

![Bar chart showing the distribution of poppy cultivation by region from 2004 to 2012](image)

*Source: MCN/UNODC Afghanistan Opium Surveys, 2004-2012*

The spatial distribution of poppy is reflected in the number of poppy-free\textsuperscript{11} provinces, as well (see Table 2.1). While in 2005 and 2006 only eight and six provinces respectively had poppy-free status, in 2009 and 2010, 20 provinces were poppy-free. In 2011, the number declined to 17 and stayed the same in 2012.

A key objective of the national *Alternative Livelihoods Policy*\textsuperscript{12} is to maintain the “poppy-free” status (i.e. prevent the resurgence of poppy cultivation) in communities which have consciously opted not to engage in, or have strived to abandon, illicit cultivation and production of narcotics through social understanding.

It is thus worrying that since 2009, poppy cultivation has spread again into provinces and areas, which have so far had only marginal levels of cultivation. Most prominent is the Eastern and Western region, where a resurgence of poppy cultivation has taken place since 2009.

\textsuperscript{10} MCN/UNODC (2013) Afghanistan Opium Survey 2012, Summary Findings, p. 5
\textsuperscript{11} Poppy-free provinces are those estimated to have less than 100 hectares of opium cultivation, see e.g. MCN/UNODC (2013) Opium Survey 2012
\textsuperscript{12} MCN (2012) National Alternative Livelihood Policy, A Joint Initiative of the Agriculture and Rural (ARD) Cluster, Kabul, February 2012
### Table 2.1: Number of poppy free provinces, 2005-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of poppy free provinces</td>
<td>8</td>
<td>6</td>
<td>13</td>
<td>18</td>
<td>20</td>
<td>20</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

*Source: MCN/UNODC (2013) Afghanistan Opium Survey 2012*

A similar picture presents itself for commercial cannabis cultivation, which has shifted from the north to the more insecure south in the past half-decade. Cannabis cultivation seems to be strongly geographically associated with that of opium cultivation. In 2011, most cannabis-cultivating provinces also produced poppy (15 out of 21 provinces). The number of cannabis cultivating provinces has increased since 2009 (from 17 to 21 in 2011), mainly due to poppy growing provinces commencing commercial cannabis cultivation.

### 2.2.3 The illicit drug economy

#### 2.2.3.1 Scale of the illicit economy

The opiate economy is driven by the production of raw opium, which influences prices through the usual patterns of supply and demand. In turn, farmers’ decisions are at least partially influenced by prices, fear of the government, eradication etc., as to whether they should cultivate poppy and, if so, to what extent. The amount of opium produced in a given year depends on the area under cultivation and the average yield in that year. Yield can vary significantly, e.g. in the presence of diseases and/or adverse weather conditions. Farmers also sometimes hedge against potential eradication campaigns by choosing poor quality or rain-fed land to grow poppy - these fields can be sacrificed for an eradication campaign, but they also produce less yield from poppy crops grown on them.

Opium is purchased by traders directly at the farm-gate and then further trafficked onwards. In recent years, out of the harvested opium an estimated 40%-50% is further processed into either morphine or heroin within Afghanistan; the most part of which is then exported. There is, however, considerable uncertainty attached to the estimation of these shares.

The value chain of opium processing starts at the farmers’ level, going through several steps until opium and heroin/morphine is trafficked out of the country. According to Opium Surveys and Global Afghanistan Opiate Trade reports, Afghan traffickers seem to be heavily involved in shipping opiates across borders, notably to Iran and Pakistan, but less involved in subsequent trafficking. Thus, Afghan traffickers mainly accrue income generated within the country, and benefit less from the significantly larger revenues generated through international trafficking routes. The value of the Afghan opiate economy - as it is relevant for Afghanistan - is therefore all income generated along the value chain from raw opium production at the farmers’ level until the point where the opiates cross the border.

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The size of this illicit economy in Afghanistan is considerable, especially when compared to the value of the licit economy. From 2003 to 2007, the potential gross value of the opium economy including revenues from heroin production and trafficking to the border was equivalent to almost half of Afghanistan’s total licit GDP. In 2003 the value of Afghanistan’s GDP was placed at US$ 4.6 billion\textsuperscript{17}, while the estimated total value of the opiates economy was US$ 2.3 billion\textsuperscript{18}, or 50% of the value of the licit economy. From 2007, the share of illicit opiate revenues to GDP started to reduce steadily, from 41% to a low of 13.5% in 2011.

\textit{Figure 2.3: Total National GDP versus potential export value of opiates}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.3.png}
\caption{Total National GDP versus potential export value of opiates}
\end{figure}

Sources: UNODC Opium Survey Reports 2003-2012 and World Bank\textsuperscript{19}

The decrease of the value of the opiate economy relative to the licit GDP was mainly due to the increase in licit GDP and not due to significant changes in production or cultivation of poppy. In 2011, the GDP of Afghanistan was placed at US$ 19.2 billion\textsuperscript{20}, representing a 318% increase since 2003. However, in 2011, the estimated total value of the opium economy was US$ 2.6 billion\textsuperscript{21}, only a 13% increase from 2003. It is clear therefore that Afghanistan’s expanding economy was responsible for the reduction in the proportion of illicit revenues earned to licit revenues, despite the high levels of production and high farm-gate prices of opium since 2009.

\textsuperscript{18} MCN-UNODC (2004) Afghanistan Opium Survey 2004
\textsuperscript{19} The Opium Survey provided the figures on the potential export value of opiates; the World Bank Databank provided the GDP figures.
\textsuperscript{20} World Bank, World Databank. Please note that the World Bank statistics are not directly comparable with GDP statistics from the CSO; this is partially due to the fact that the CSO reports its GDP figures in the Hijri calendar, while the World Bank reports according to the Gregorian calendar. The UNODC calculations on the potential value of the opiate economy are in the Gregorian calendar. Note also that the World Bank has revised its GDP figures since the publication of the Afghanistan Opium Survey 2012, which is why the percentage of the potential value of the opiate economy as per GDP is different (16%, an expression of GDP then estimated to be US$16.34 billion).
\textsuperscript{21} MCN-UNODC (2013) Afghanistan Opium Survey 2012
While this may indicate that Afghanistan’s economy has become less and less dependent on the income from opium, a large share of the growth of the licit GDP might be attributed to the multiplier effects of international aid and remittances\textsuperscript{22}; and that at the farmers’ level, dependency on the opiate economy may have changed little.

The farm-gate value of opium represents the estimated accumulated gross income of farmers from opium and excludes any revenues from onward trafficking. The farm-gate value has presented erratic patterns since 2002. In 2012, the farm-gate value was estimated to be US$ 717 million, an amount that is similar to the estimated farm-gate value from between 2003 and 2010. Price hikes in 2002 and 2011, due to perceived or real shortages\textsuperscript{23}, caused spikes in the farm-gate value (see Figure 2.4). The farm-gate value in 2012 corresponded to just four percent of GDP. However, when compared to other drug plant producing countries, this is still a very large share. In Colombia, for example, farm-gate value of coca was US$ 420 million in 2011, or only 0.2% of GDP\textsuperscript{24}.

\textit{Figure 2.4: Estimated value of opium production at farm-gate level in Afghanistan, 1994-2012}

Source: MCN/UNODC (2012) Opium Risk Assessment Survey, (Figures for 2006 to 2009 are based on the revised opium production estimates (see MCN/UNODC Afghanistan Opium Survey 2012). Ranges are proportional to the previously published estimates)

\textbf{2.2.3.2 Illicit crops and income}

In the opium and cannabis surveys of MCN/UNODC, farmers were asked for the most prominent reasons for cultivating illicit crops. In 2012, the top three reasons named for opium cultivation were the high sales price of opium, high income relative to plot size and potential for improving living conditions. For cannabis, the high sales price was the dominant reason for cultivation in


\textsuperscript{23} See also Figure 2.7, below.

\textsuperscript{24} UNODC (2012) Colombia Coca Cultivation Survey 2012
2011; additionally cultivation for own consumption, and poverty alleviation, were named as reasons.

Illicit crops are indeed a very attractive source for cash income of farmers. Figure 2.5 shows the estimated net income per hectare for cannabis, poppy and wheat. It clearly shows that in years with high yields and high prices (e.g. 2011) the net income from poppy and cannabis is far higher than the net income from wheat. This is further reflected in terms of household income: on average, poppy-growing households in Afghanistan continue to have higher cash income than households that do not grow poppy. The substantial accumulated income of farmers from poppy cultivation highlights the magnitude of the challenge of promoting alternative livelihoods strategies if opium poppy is to be replaced as an income source for farmers.

Figure 2.5: Net income from cannabis, opium and wheat, 2009-2012

Interestingly, even with higher sales prices for opium than for cannabis, in 2009 and 2010 the net income from cannabis was greater than the net income from poppy. The price hike for opium in 2011, together with good yields, has reversed that relationship. In 2012, per hectare income from opium is only slightly larger than in 2010; it is yet to be seen if cannabis was once again the more attractive cash crop that year.

Cannabis cultivation is so lucrative as it is less labour-intensive than poppy cultivation: the “garda” (resin) is much easier to obtain from the cannabis plant compared to the opium gum from poppy. Garda is obtained by the repeated sieving and threshing of dried cannabis plants; farmers manage to conduct many of these necessary activities with (“free”) family labour without having

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25 At the time of writing, the 2012 Afghanistan cannabis survey had not been published so data for 2012 is not included here.
26 The comparability of income from wheat and opium or cannabis is limited, since wheat is a staple crop whereas illicit crops are cash crops.
27 MCN/UNODC Opium Survey 2012, 2011, 2010
28 At the time of writing, the 2012 Afghanistan cannabis survey had not been published so data for 2012 is not included here.
to hire outside labourers. By contrast, to harvest opium, every individual opium capsule must be manually lanced within a short period of time, and then returned to a few hours later to manually scrape off the raw opium gum. This requires a skilled work force, which has to be hired and thus incurs more costs.

Apart from net income there are differences in the distribution of income sources from poppy-growing farmers and non-growing farmers. The income distribution is thought to be more reliable and suitable to better understand the relative importance and general differences between opium-growing and non-growing households at an aggregated level.

In 2011, overall, farmers reported that about a third of their household income came from wheat, regardless of their opium-growing status (Figure 2.6). This proportion has been relatively stable over the years, which indicates the continuing importance of wheat as the main staple crop for rural households. For opium growing households, however, the relative importance of income from wheat (at 26% in 2011) is smaller than for households which have either stopped growing opium poppy, or never cultivated it at all (30% and 33% respectively).

Figure 2.6: Distribution of income for opium growing farmers, farmers who have ceased to grow opium and farmers who never have grown opium in 2011

The main difference between opium-growing and non-growing households, however, is the composition of the cash component. While opium poppy-growing households have little cash income from sources other than opium, non-opium poppy-growing households rely more heavily on wage labour and remittances. The relative higher importance of remittances for households that had ceased opium cultivation (10%) and an even higher importance for those who had never grown

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30 MCN/UNODC (2013) Afghanistan Opium Survey 2012, p 57. Income in this context refers to the value of all products produced or cash income received in the previous 12 months, including products used for own consumption such as wheat.
it (12%) compared to opium-growing households (3%) has moreover been stable over the past few years. Wage labour constitutes a share of respectively 7% (stopped growing) and 5% (never grown) of income, whereas in poppy growing households it is only 2%. Expressed in another way, opium poppy-growing households rely on 7% of their income from non-agrarian sources; those who have stopped growing opium poppy rely on 22% of their income from non-agrarian sources; and those who have never grown opium rely on 26% of their income from non-agrarian sources. This points towards the need to consider non-agrarian income opportunities – such as labour markets – when developing alternative livelihood policies for poppy cultivating areas.

There are several possible interpretations of these results.

- Farmers who can rely on cash income sources other than opium might be less likely to cultivate it.
- Likewise, farmers who look for wage labour as an alternative cash income source but cannot get enough income from it, might tend to cultivate illicit crops - especially if the opportunities for wage labour in their area are diminished by other factors (such as poor security).
- Opium-growing households might face a trade-off between wage labour and opium cultivation: labour-intensive opium cultivation may already absorb considerable man-power, which is then no longer available for wage labour. Therefore, opium cultivation leads to smaller shares of income from wage labour, not the other way around.

These results are based on all farmers in the annual opium village survey, which also includes farmers in poppy-free provinces. Therefore, job opportunities, security, education and other important factors might be the underlying causes of these differences. For more concrete insights, an in-depth, comparative study on farmer’s decision making with respect to poppy cultivation would be needed.

### 2.2.3.3 Illicit crop prices

Farm-gate prices of opium react strongly to extraordinary events like crop failures or other supply shocks. Figure 2.7 shows the estimated opium production\(^{32}\) between 1997 and 2012 together with average prices at farm-gate\(^{33}\) from 1999 onwards. The first price hike in 2001/2002 was caused by the 2001 Taliban opium poppy cultivation ban, where prices increased to levels of up to US$ 380 per kilogram. After that, as opium supplies steadily increased with increasing cultivation levels from 2001 to 2007, the price of opium in the face of this abundant supply consequently dropped.

After 2007, production levels began to decline due to reduced areas under cultivation and poor harvests. In 2008 and 2009, price levels remained at low levels and even kept dropping.

The next supply shock occurred with the 2010 crop failure. A disease affecting poppy plants reduced harvests significantly\(^{34}\). The marked increase in prices beginning with 2010 is likely connected to this supply shock.

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\(^{32}\) Please note, that the production estimates for 2006-2009 have been revised. MCN/UNODC (2013) Afghanistan Opium Survey 2012.

\(^{33}\) Prior to 2004 no farm-gate prices were available. Here the trade prices were taken as a proxy.

\(^{34}\) MCN/UNODC (2010) Afghanistan Opium Survey 2010
With increasing prices from 2009/2010, poppy cultivation levels started to increase again. This development seems to have been heavily driven by the high sales prices of opium in that period although prices may not be the only influencing factor to which this development can be attributed. After the price hike until the opium harvest 2011, with a comparatively high level of production, price levels reduced moderately but remained at a level still more than two times higher than in 2009 (the bad harvest in 2012 probably being one of the reasons). The high prices continue to make opium an attractive cash crop, which may stimulate a further spread of poppy cultivation. Indeed, a preliminary assessment of opium cultivation risk conducted in early 2013 points to a further expansion of poppy cultivation in 2013\textsuperscript{35}.

*Figure 2.7: Opium production estimates with average farm-gate price (US$/kg), 1997 - 2012*

The national Alternative Livelihood Policy recognizes connection between opium prices and production levels, as well stating the following: “Recent trends in production such as a reduction in 2010 compared to 2008-09 indicate that the occasional reductions may have more to do with a market correction in response to low global prices for opium and heroin, than a permanent or sustainable departure from opium-poppy cultivation”\textsuperscript{36}

\textsuperscript{35} MCN/UNODC (2013) Opium Risk Assessment 2013
Illicit crop prices fluctuate not only in the face of yearly changes in supply; they fluctuate over the course of the year too. Figure 2.8 shows a price index based on farm-gate prices of cannabis and opium from 2005 to 2011. The price index reflects average deviations of the monthly prices from the yearly average. For opium poppy, the highest prices can be observed just before harvest time (which is roughly March to June): at their maximum, prices are about six per cent above the yearly average. During harvest, with opium readily available for being trafficked, prices are lowest: about two to four per cent below the yearly average.

Even more pronounced are the seasonal changes of the cannabis prices. Here, prices before the autumn harvest are up to almost ten per cent higher than the yearly average. During harvest, which usually starts late September/beginning of October and ends in December (depending on the region), prices drop significantly below six per cent of the yearly average.

One of the reasons why the cannabis prices fluctuate more strongly with the seasons is that *garda* and *hashish* cannot be stored as easily as opium and loses quality over time. While farmers often keep some opium after harvest for later sale (potentially to wait for higher prices), *garda* and *hashish* enter the market more quickly thus resulting in a more concentrated supply which reduces the prices paid by traders. This again points to opium poppy being a more appropriate crop for speculative purposes when insecure times are expected; hence both the micro- (and macro-) political situation is a factor which cannot be discounted in terms of opium poppy cultivation.37

*Figure 2.8: Seasonal price indices of opium and cannabis at farm-gate*

![Price indices of opium and cannabis](image)

*Source: MCN/UNODC Opium Price Monitoring Reports, 2005-2011. The 100% line represents a yearly average of prices.*

### 2.2.3.4 Cannabis and opium markets

The economy around commercial cannabis production is far less understood than the one around opium. However, based on recent results from the cannabis and opium surveys and based on

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37 This is a concept which has been discussed in other in-depth longitudinal studies. One report “illustrates just how closely opium poppy cultivation is entangled in the socioeconomic and political fabric of the provinces of Hilmend and Nangarhar.” Mansfield, D., *All Bets Are Off!, Prospects for (B)reaching Agreements and Drug Control in Hilmend and Nangarhar In the run up to Transition*, January 2013, p. 1
monthly prices collected by the MCN, it can be concluded that the cannabis and opium markets are largely integrated.

There is a clear connection between opium poppy and cannabis cultivation both at the household and village level. The 2011 cannabis survey showed that almost 58% of cannabis-growing households also cultivated poppy in the preceding season. In the Southern (69%) and Western regions (67%) it was even more pronounced, with almost seven out of ten cannabis farmers also cultivating opium poppy. It seems that to a large extent farmers who cultivate cannabis in summer are the same who cultivate poppy in winter. In 51% of all poppy-cultivating villages, cannabis was also grown. It is therefore safe to say that the majority of cannabis-cultivating households are involved in poppy cultivation.

This correlation seems to hold down the value chain as well. Information gathered during the 2011 surveyor debriefings indicated that a large proportion of cannabis traders also trade in opium, thus many households have the opportunity to sell both illicit crops relatively easily.

This is substantiated by the price data. Strikingly, prices of cannabis and opium are highly correlated since December 2005 when the collection of cannabis prices began (see Figure 2.9). Since the cannabis prices followed the opium price hike of 2010/2011 it seems plausible that during the opium shortage caused by the crop failure in 2010, traffickers may have shifted from smuggling opium and/or heroin to smuggling consignments of cannabis resin, which was more easily available; but this new-found demand for cannabis also may have had the effect of increasing prices. However, as mentioned previously, there may be aspects of political insecurity driving increased cannabis prices, as farmers stockpile stocks to hedge against future uncertainty (although to a lesser extent than opium, due to the shorter shelf-life of cannabis).

The overall value of the economy around commercial cannabis production has not been estimated yet. The farm-gate value of cannabis production in 2011 was estimated to be US$ 95 million, corresponding to 0.6% of GDP. As cannabis is trafficked at large scales within the countries as well as across the borders, it can be expected that the actual income accrued from the illicit cannabis trade is much higher still.

It can be concluded that there is one illicit crop economy in Afghanistan, rather than two separate markets for each crop. This means that there is one group of commercial cannabis and opium farmers, and one group of cannabis and opium traders, rather than farmers and traders engaging in one of the two crops only.

In spite of the clear connection between cannabis and poppy cultivation, cannabis is cultivated at much smaller scales than opium poppy and less frequently. One of the reasons may be that cannabis is a summer crop\textsuperscript{43} where generally less arable land is available. In summer, farmers have to also grow other licit crops so cannabis faces higher competition from other, licit staple crops.\textsuperscript{44}

One important aspect is the substitution of one cash crop with another. Based on the data available, it seems that cannabis and poppy cultivation are rather complementary income strategies (farmers choose to cultivate both crops) than substitutes for each other (an either/or situation). But this only reflects the current situation since “with increasing pressure on poppy cultivation through eradication and other measures, the possibility of the commercial production of cannabis increases.”

\textsuperscript{43}Cannabis is planted in the spring and matures over the summer months, much like the majority of crops and vegetables. Opium poppy on the other hand is planted in the autumn/winter and matures over the spring. It is therefore possible to use the same land for both opium and cannabis cultivation over the course of the year.

\textsuperscript{44}For a detailed discussion see MCN/UNODC (2012) Afghanistan Survey of Commercial Cannabis Cultivation and Production 2011.
of cannabis gradually playing a much bigger role in the illicit economy of Afghanistan is not beyond the realms of imagination.”

2.2.4 Poppy cultivation, insecurity and development

There is an undisputed link between insecurity and opium poppy cultivation, which has been observed in the annual MCN/UNODC Afghanistan Opium Survey since 2007. Insecurity, through the reduced presence or absence of government institutions and services, not only creates a good environment for farmers to grow opium poppy but also limits the choice of alternative income opportunities available to farmers. This occurs in multiple ways: not only can it prevent farmers from physically accessing government-provided agricultural inputs, insecurity hinders access to markets, health services and educational opportunities (which can be seen as an investment in future economic capabilities). Opium-producing areas often remain too violent and insecure for the state law enforcement agencies to ensure government oversight - allowing an environment which is conducive to both opium cultivation and trafficking - and which also allows income from opium to be considered as compensation for lack of access to development opportunities. Furthermore, poppy cultivation fuels insecurity as it strengthens Anti-Government Elements and triggers security incidents, e.g. during the eradication campaigns.

Similarly, insecurity plays a significant role in limiting the ability of Government of Afghanistan to provide basic services and to offer development opportunities that would help farmers move away from poppy cultivation. The biggest poppy cultivating provinces - Hilmand, Kandahar, Uruzgan and Zabul - are all in the south, which is also considered the most insecure region in the country (Figure 2.10). Farah is also a major poppy cultivating province, and although in the western region, it suffers from similar levels of insecurity as those aforementioned provinces in the south.

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46 See MCN/UNODC (2011) Afghanistan Opium Survey 2011, p. 15
Figure 2.10: Security and opium cultivation in Afghanistan by province, 2012

2.2.4.1 Illicit crops and development levels

Another important correlation with poppy cultivation seems to be education. Figure 2.11 shows school enrolment rates for boys and girls in 2009\textsuperscript{47}. What is immediately apparent is that the Southern Region, where poppy cultivation is concentrated, has the lowest school enrolment rates for both girls and boys in the country. Of the five provinces in the Southern region, four of those provinces have the lowest overall enrolment rates in the country - Uruzgan at 2.2%; Zabul at 5.6%; Hilmand at 6.3%; and Kandahar at 11.6%. It is also the case that in all of these provinces there is a high disparity between the rate of girls’ enrolment and boys’ enrolment.

The hypothesis that lack of formal education and poppy cultivation are related was confirmed more recently by the Afghanistan Opium Survey 2012. This relationship between opportunities for education and poppy cultivation has been established in the Afghanistan Opium Surveys. While in 2012 over 90% of non-poppy-growing villages in Afghanistan had a boys’ school and almost 75% had a girls’ school, these proportions drop to 61% (boys’ school) and 19% (girls’ school) in poppy-growing villages.

\textit{Figure 2.11: Enrolment rates of boys and girls in Afghanistan, 2009}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{enrolment_rates.png}
\end{figure}


There are several possible explanatory factors with respect to this relationship. One factor potentially is security and governmental presence. In many areas the feasibility to establish a

\textsuperscript{47}UNDP (2011), Third Afghanistan National Human Development Report, 2011
girls’ schools depends on the presence of the government and on security; as discussed previously, insecure areas are also those that tend to cultivate poppy. Hence, this correlation might be a more developmental connection. This is certainly worth a future research focus, which should also explore attitudinal factors towards poppy cultivation - this would help confirm if there is weight to the possible theory that opium farmers are motivated to cultivate this cash crop as some form of compensation for the lack of development activities associated with cultivating areas (in turn associated with poor security).

*Figure 2.12: Access to a boys’ school, a girls’ school, in Eastern, Southern and Western regions, by poppy-growing status, 2012*

Furthermore, in some cases there does appear to be a relationship between selected development indicators and poppy cultivation at the provincial level. However, the nature and strands of this relationship are not clear and it is uncertain whether the linkage is direct. For some development indicators, southern provinces do fare worse than others, such as with school enrollment of girls, immunization of children and number of basic services. Yet in Figure 2.13, it is shown that the poppy-producing province of Farah scores relatively highly in immunization rates (as does Nangargar, another province which has historically cultivated poppy) - although the provinces of Hilmand, Zabul, Uruzgan and Kandahar do all score very lowly in this particular indicator.

Also, some provinces in other parts of the country also perform poorly in terms of development indicators but register low levels of poppy cultivation (for example Ghor, Panjshir, Kunar, Nooristan).
Furthermore, in terms of mean expenditure per person per month, southern provinces have much higher spending than other provinces at once suggesting that disposable incomes may be higher in these provinces (see Figure 2.14).

**Figure 2.14: Mean expenditure per person per month, in Afghanis (AFN)**

The fact that the poppy cultivating provinces of Kandahar, Hilmand, Farah and Zabul have relatively high average monthly expenditures per person could indicate increased disposable income, potentially as a corollary to the narco-economy in these areas. However, it could also reflect an increased expenditure to compensate for access to the more limited access to services in these provinces. The presumed association among vulnerability, exclusion for services and development and poppy cultivation requires more careful consideration.
2.3 DRUG SUPPLY REDUCTION

In the previous section to this chapter, the issues surrounding the supply of narcotics from Afghanistan were discussed. In this section, the focus is specifically on the measures and interventions taken to reduce the supply of narcotics in Afghanistan. Following this section is a more in-depth look at a particular intervention aimed at supply reduction, namely the Hilmand Food Zone Program.

2.3.1 Building public awareness

Public awareness campaigns are designed to inform various segments of the population - including farmers, law enforcement professionals, public officials - of the Government’s policies, legislation and available alternatives to poppy cultivation (Figure 2.15, Figure 2.16 and Box 2.1). To promote change in the thoughts and behaviours towards drugs, public awareness campaigns promote not cultivating poppy, celebrate national and international days, and publicise press conferences and press releases. This is done with printed media, other visual media, traditional communications and radio spots.

*Figure 2.15: Counter Narcotics Public awareness billboard*

![Public awareness billboard](image.png)

[Starting from the top left panel (the picture of the wheat), the captions read: “Licit Crops”; “Licit Crops”; “I wish I had cultivated licit crops instead of illicit ones”; “Illicit Crops”; “Dear farmers! Please avoid poppy cultivation for the sake of your family, people and country”; “Illicit Crops”.

*Source: MCN Public Awareness Section, 2012*

The goal of building public awareness among farmers (and the general population) as a policy response is to inform, educate, deter and dissuade the population from involvement in the illicit drugs trade, cultivation of poppy and use of opiates and to contribute to a sustainable decrease in
cultivation, production, trafficking and consumption of illicit drugs. The responsible ministries for public awareness are the MCN; Ministry of Higher Education; Ministry of Public Health; Ministry of Information, Culture & Tourism; Ministry of Hajj and Religious Affairs; Ministry of Women’s Affairs; Ministry of Education; and the Provincial Administrations.

**Box 2.1: Public awareness messages on Billboards**

*Did you know that according to article no. 41 subsection (1) of the National Drug Control Law “a person who cultivates cannabis or opium poppy on one jerib of land will be sentenced to three months of prison”? On the other hand, the government has promised to provide short term loans to those farmers who are not cultivating poppy any more. So, stop poppy cultivation and don’t be a criminal!*

“This message is brought to you by Ministry of Counter Narcotics”

*Dear Farmers! You know that all the security related problems in our country are due to poppy cultivation and opium production, because terrorists and traffickers get the explosives from the opium trade and then destroy our schools, clinics and bridges through suicide attacks.

Do you grow poppy to support terrorism?*

“This Public Service Announcement is by Ministry of Counter Narcotics”

*Muslim Farmers! Cultivation of poppy is not only forbidden in Islam, but it is against the Constitutional and National Drug Law; it causes addiction, bomb blasts, security problems, poverty, imprisonment and fines. Therefore, save the lives of your children from becoming the victims of opium poppy and grow halal crops!*

“This Public Service Announcement is by Ministry of Counter Narcotics”

*H.E. President of the Islamic Republic of Afghanistan, Hamid Karzai has proclaimed that: poppy cultivation and opium production is our real enemy, because our pomegranate and grape orchards were destroyed for poppy cultivation, our wheat harvest is decreased due to poppy cultivation. All the activities which disrupt our stability and security are due to opium production. For development and stability of Afghanistan, we should increase our efforts towards eliminating poppy. So, dear community elders, ulema, farmers, ministers, governors, cabinet members and senators! Let’s work together once again to clean our country from poppy cultivation. We should kill poppy, otherwise poppy will kill us. “If we don’t destroy poppy, poppy will destroy us”*

“This Public Service Announcement is by Ministry of Counter Narcotics”

Public awareness campaigns continue to be an important policy focus. The MCN is planning a comprehensive two-year communication program, the Counter-Narcotics Community Engagement, which will be implemented through a local partner company, Sayara Strategies. The program is a multi-track strategic communication for a counter-narcotics campaign that targets key poppy-producing provinces and districts across Afghanistan. The program maps drivers of counter-narcotics initiatives, and engages target audiences through a combination of catered media products, civil society engagement, and capacity building initiatives for government officials and journalists. Program activities include in-depth baseline research and GIS mapping to identify target audiences; the design of public information and awareness campaigns in partnership with

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49 MCN Public Awareness Department/Sayara Strategies (2013)
the MCN; campaign implementation in targeted provinces and districts across Afghanistan; and a dedicated monitoring and evaluation component to measure the impact of program activities. As a two-year project, Sayara will focus heavily on building the capacity of the MCN in the first year, while using the second year to allow for greater MCN ownership of counter-narcotics communications implementation, oversight and responsibility.

It is difficult to locate data on CN public awareness campaigns in Afghanistan as this is scattered among different implementing agencies and most may not have maintained adequate records of their campaigns. Data on effectiveness and impact of the campaign is even more limited, as there is no systematic assessment of counter-narcotics messaging campaigns on the outcome and impact level. The only exception is a report from the year 2008, in which UNODC conducted an impact assessment of counter-narcotics media campaigns and provided recommendations for the tools and approaches of such campaigns.

One source on messaging performance (the extent to which counter-narcotics messages reached their audience) is the annual MCN/UNDOC Opium Risk Assessment Survey (ORAS), where villagers are asked if they were exposed to a public awareness campaign and whether they intend to cultivate opium poppy in the coming season. However, the survey does not ask for the type of the campaign, and even if it did, the results would not be nationally representative.

In 2012, 77% of polled villages were exposed to a campaign against poppy cultivation. Out of these, 43% planned to abstain from poppy cultivation in the 2013 season and 57% planned to cultivate poppy. Out of the 23% of villages that were not exposed to a cultivation campaign, the situation is different: 30% did not plan to cultivate poppy, whereas 70% intended cultivating. The difference was statistically significant: villages that were exposed to an awareness campaign seem to be less likely to cultivate poppy in the following season.

Table 2.2: Public awareness campaigns in 2012 and expected poppy cultivation in 2013

<table>
<thead>
<tr>
<th>Awareness campaign</th>
<th>No opium poppy cultivation in 2013</th>
<th>Opium poppy cultivation in 2013</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>7%</td>
<td>16%</td>
<td>23%</td>
</tr>
<tr>
<td>Yes</td>
<td>33%</td>
<td>44%</td>
<td>77%</td>
</tr>
<tr>
<td>Total</td>
<td>40%</td>
<td>60%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Opium Rapid Assessment Survey 2013.

Compared to previous years, messaging performance in 2012 was high. In 2012, 81% of villages polled in the ORAS reported to have been exposed to an awareness campaign the previous year, against 2011 where it was only 31%. The most recent figures obtained in 2013 indicated that 77% of villages received a messaging campaign in 2012 - but that the majority of these villages still cultivated poppy anyway (see Table 2.2). Due to the survey methodology, a high variability in the

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51 During the ORAS surveys, a sub-sample of the villages polled for the nationwide village surveys of the main opium survey is used; the results are therefore not representative for the whole country or for a whole region, but rather give qualitative indications for trends in opium cultivation.

52MCN/UNODC (2013) Opium Risk Assessment Survey

53MCN/UNODC (2012) Opium Risk Assessment Survey
data can be expected, which is an indication that more tailored research is needed for more accurate and meaningful results.

In 2011, the MCN updated its previous specific public awareness logo resulting from a branding research exercise with a local media production company.\(^{54}\) All MCN print products which are disseminated in Afghanistan are now branded with this revised logo (see Figure 2.16).

*Figure 2.16: New MCN Logo*

![New MCN Logo](image)

*Source: MCN Public Awareness Section, 2012*

### 2.3.2 Poppy eradication

#### 2.3.2.1 Designing eradication campaigns

Eradication is the physical destruction of established poppy in the field. According to the National Drug Control Strategy (NDCS) eradication of crops has to target areas where alternative livelihoods exist, and should be a “credible threat”\(^{55}\) that incentivizes the shift away from poppy cultivation. Eradication “must only be delivered by manual or mechanical ground based means and no compensation should be made available to those whose poppy fields have been eradicated and that eradication should not be conducted in fields where poppy has already been lanced and ideally should be conducted prior to flowering.”\(^{56}\) Importantly, the NDCS says that eradication should only affect communities who have access to alternative livelihoods.\(^{57}\)

Prior to the start of poppy eradication campaigns, public awareness campaigns are carried out, in cooperation with the line ministries, for the local authorities of those provinces where poppy has been cultivated. The Ministry of Counter Narcotics, in cooperation with line ministries and provincial governors, prepares an annual eradication plan which is based on these public awareness campaigns. The eradication campaign is led and implemented by the provincial governors. Eradication is verified by MCN/UNODC through field visits and satellite imagery.

In certain provinces (in particular those with high cultivation levels) target areas for eradication are agreed upon in the Eradication Working Group chaired by the MCN, and attended by Afghan Law Enforcement agencies, UNODC and foreign government stakeholders. These areas are where

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\(^{55}\) MCN (2006), National Drug Control Strategy p.21  
alternative livelihood opportunities exist, as prescribed by the NDCS, and are defined by a spatial model that uses a set of indicators to identify the potential for licit income (see Box 2.2).

**Box 2.2. Selection of Eradication Areas**

The decision on where eradication campaigns are implemented depends on the extent of access to alternative livelihood opportunities. A systematic assessment of access to livelihood opportunities is undertaken and those areas perceived to have greater access are targeted in eradication campaigns. The extent of access to alternative livelihoods is determined based on the following set criteria for which indicators are fed into GIS models which are used to identify the specific locations for eradication:

1. Distance to Provincial and District centres
2. Distance to market
3. Water availability considering irrigation and area of drought
4. Cropping patterns considering areas of single or double cropping with good yields
5. Diversified agriculture practice including high value horticulture and where poppy consists less than 50% of agriculture
6. Low population density relative to available agriculture
7. Where livelihood ownership is greater than average
8. Areas where there is access to non-farm income
9. Areas which have access to credit other than through opium-related credit
10. Areas where district relative wealth is greater than the provincial average

If the desired data is not available, proxy indicators are used. For example, scoring an area on the basis of its access to electricity is problematic in the absence of official or reliable electricity provision rates. This can be circumvented by taking imagery of lights at night across the country as an indicator of access to electricity. Similarly, satellite imagery can indicate the quality of agriculture, which in itself is an indicator of the presence of irrigation.

All of the components of this “alternative livelihood dataset” are processed through GIS models to allow for a pictorial representation. The final outcome is a map that indicates areas with high access to alternative livelihoods and areas with very little access. Those parts of the country which have the highest access to alternatives livelihoods are considered to be most appropriate for eradication activities.

*Source: Alcis Ltd, 2013*

In 2012, eradication target areas were defined in four provinces, namely in Farah, Hilmand, Kandahar and Uruzgan. Out of the 4,157 hectares eradicated, 864 were verified to be outside of the target area, which corresponds to 16% (Table 2.3). Note that even though eradication should occur as per the guidelines of the NDCS (as mentioned previously), and therefore only inside the target areas, there are still instances of eradication occurring outside the target areas. The reasons why this happens are unclear and merit further investigation.
Table 2.3: Eradication area in targeted provinces (hectares), 2012

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Eradication inside target area (hectares)</th>
<th>Eradication outside target area (hectares)</th>
<th>Eradication area (hectares) - could not be confirmed inside/outside target area</th>
<th>Total eradication verified (hectares)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farah</td>
<td>206</td>
<td>110</td>
<td>0</td>
<td>316</td>
</tr>
<tr>
<td>Hilmand</td>
<td>3,143</td>
<td>495</td>
<td>0</td>
<td>3,637</td>
</tr>
<tr>
<td>Kandahar</td>
<td>485</td>
<td>97</td>
<td>340</td>
<td>922</td>
</tr>
<tr>
<td>Uruzgan</td>
<td>323</td>
<td>162</td>
<td>0</td>
<td>485</td>
</tr>
<tr>
<td>Total</td>
<td>4,157</td>
<td>864</td>
<td>340</td>
<td>5,361</td>
</tr>
</tbody>
</table>


2.3.2.2 Poppy Eradication Levels

In line with the process of “Afghanization”, the Afghan government is in the lead of eradication since 2009, when Governor-Led Eradication (GLE) became the only crop eradicating force (Box 2.3). Before 2009, the “Poppy Eradication Force” (PEF), a centrally-directed eradication force, operated as an additional force for eradication.

Box 2.3 : Governor Led Eradication

The Government’s National Drugs Control Strategy calls for targeted eradication in areas where it is assessed that opportunities for alternative livelihoods exist, against a range of socio-economic indicators based on a wide range of data-sets. Governors are requested to carry out eradication within target zones demarcated by the Planning Cell of MCN, under the programme ‘Survey, Monitoring, Training and Verification ‘. Governors are also able to claim reimbursement on a per-hectare basis for the costs of eradication (e.g. fuel for tractors; policemen’s wages); as such, there is a rigorous verification process.


Table 2.4 shows areas eradicated from 2005 until 2012. During this period, between two and ten per cent of area under poppy cultivation have been eradicated. In only three years (2006, 2007 and 2012) was more than five per cent of total area under cultivation eradicated. During 2009 to 2011, GLE occurred at a relatively small scale, covering between approximately 2,700 and 3,800 hectares. In 2012, eradication increased markedly by 154% compared to the previous year, with 9,672 hectares eradicated. However, the eradication levels of 2012 are still lower than in 2006 and 2007 where GLE accounted for more 13,000 and 15,000 hectares, respectively.
Table 2.4: Poppy eradication and cultivation in Afghanistan, 2005-2012 (Hectares)

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of provinces where eradication was carried out</td>
<td>11</td>
<td>19</td>
<td>26</td>
<td>17</td>
<td>12</td>
<td>11</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Governor-led Eradication (GLE), (hectares)</td>
<td>4,000</td>
<td>13,050</td>
<td>15,898</td>
<td>4,306</td>
<td>2,687</td>
<td>2,316</td>
<td>3,810</td>
<td>9,672</td>
</tr>
<tr>
<td>Poppy Eradication Force (PEF), (hectares)</td>
<td>210</td>
<td>2,250</td>
<td>3,149</td>
<td>1,174</td>
<td>2,663</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Total Eradicated (Hectares)</td>
<td>4,210</td>
<td>15,300</td>
<td>19,510</td>
<td>5,480</td>
<td>5,351</td>
<td>2,316</td>
<td>3,810</td>
<td>9,672</td>
</tr>
<tr>
<td>Net cultivation after eradication (hectares)</td>
<td>104,000</td>
<td>165,000</td>
<td>193,000</td>
<td>157,253</td>
<td>119,141</td>
<td>123,000</td>
<td>131,000</td>
<td>154,000</td>
</tr>
<tr>
<td>Percentage of area eradicated</td>
<td>4%</td>
<td>9%</td>
<td>10%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>No of Personnel dead</td>
<td>15</td>
<td>78</td>
<td>21</td>
<td>28</td>
<td>45</td>
<td>97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of personnel injured</td>
<td>31</td>
<td>100</td>
<td>52</td>
<td>36</td>
<td>20</td>
<td>127</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In 2010, 2011 and 2012, no PEF eradication took place.


In connection with the concentration of poppy cultivation in the south, the largest share of land eradicated was between 2007 and 2012 in the Southern region (Figure 2.17). But while 95% of all poppy was cultivated in the Southern and Western region in 2012, just 68% of eradication was in those two regions. So, proportionally less area was eradicated in the two main poppy cultivating regions when compared to their overall share of poppy cultivation. However, while the MCN has the commitment to the eradication campaign, insecurity limits its implementation - especially in these aforementioned areas. The anti-government elements in these areas also deliberately set out to impede the progress of the eradication campaigns.58

Economically speaking, eradication should increase the risk of farmers and thus reduce the expected income from opium poppy cultivation because of the potential loss of harvests. This should both make licit crops more attractive and deter the farmer from cultivating poppy. In this respect, an eradication campaign in one year is expected to have a deterrent effect the following year.

When farmers were asked to indicate the reasons for not cultivating poppy during the annual opium surveys in 2011 and 2012, five and seven per cent, respectively of all farmers who ceased poppy cultivation in or before the given year, named “fear of eradication” as the principal reason for ceasing. Out of the farmers who had never cultivated poppy, 2.3% and 1.4% (in 2011 and 2012, respectively) named “fear of eradication” as their principal reason for not cultivating.

58MCN, Policy and Planning Department, 2013.
The ban by government was among the top two reasons cited by respondents in the 2011 and 2012 and annual opium surveys for not cultivating poppy (Figure 2.18). Since eradication is closely associated with government bans on poppy, it can be assumed that government bans and by implication enforcement through eradication do influence farmer’s decisions not to cultivate poppy. There is some degree of overlap between all of these reasons - for example, fear of poverty is one of the other reasons stated by farmers why they are influenced to grow poppy, which is very similar to “fear of financial losses” - which is not an option available for the farmers to give in the survey. However, all of these factors can be argued as folding together to evidence some degree of fear of loss of crops from eradication - therefore, eradication does have a significant effect on the farmers’ decisions.
Figure 2.18: Farmers Motivations for Stopping Poppy Cultivation

To further boost the effectiveness of eradication as a policy response, it is important to consider complementary strategies to minimize potential alienation and marginalization of populations. This requires a balanced approach that includes not only law enforcement measures, such as eradication, but also “measures [...] mainstreamed in publicly and privately provided health, education, rural development, agriculture and social services.”

Interventions designed to provide broader alternative development opportunities are indeed a necessary complement to eradication strategies.

59 ‘Others’ includes the following: low price of opium, disease, illegal crop, harmful to human being, lack of experience, low demand, negative impact on society, high price of wheat, satisfied with licit crops income, not common, no land, small land holdings, received support from government, anticipation of support from government and cultivation is labor intensive

60 Commission on Narcotics Drugs, 2009, p.32
2.3.3 Building alternative livelihoods

The concept of “livelihoods” is a complex combination of characteristics for which different definitions exist. In broad terms, livelihoods are more than just the activities which generate income; rather, they are all of these activities and the decisions undertaken to enable a family to live.

There are four aspects for the activities of any household - namely income; expenditure; employment; and risk. Activities which are not generating income directly, but which do nevertheless support livelihoods, also therefore contribute to the livelihoods of the family. Based on such characteristics, livelihoods improvement means: an increase in income and employment, and a decrease in expenditure and risks. Hence, it is important to ensure that any interventions aimed at improving livelihoods are framed in this context: providing wheat seed to farmers will increase their employment (in the context of them originally not having enough wheat seed, not in the context of them requiring more labour than opium - in actual fact wheat requires less labour input than poppy), but it might not necessarily increase their income. Poor prices, either from external factors or local over-supply resulting from the intervention, will decrease the potential income and increase the risk that the farmer will revert to poppy cultivation.

Households use natural, physical, social, human, financial and spiritual capitals to undertake specific activities for their livelihoods. Some of these capitals exist within the household, while a few exist outside the household. Households and individuals pursue livelihood strategies based on the combination of assets they own and the opportunities and restrictions created by the institutional environment. In this regard, access to off-farm income can be a decisive factor in growing poppy: some areas, such as Nangarhar, have better access to off-farm income than others, such as Hilmand. This access can be physical as well as attitudinal: in Nangarhar, there has been precedence for families to allow their sons to serve in the National Army as an extra wage stream. Hilmand, on the other hand, has been less permissive in this use of spare human capital, as their social capital is aligned differently than in Nangarhar.

The livelihoods strategies chosen by a household are not constant and change over time, and new strategies are adopted in response to changing institutions, policies and processes, or to achieve new objectives or outcomes. To be effective, policies aimed at improving livelihoods must therefore be both adaptable and resilient.

The definition of building alternative livelihoods as a counter-narcotics policy response, in the context of Afghanistan, is given by the Agricultural and Rural Development cluster of ministries as:

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61 National Institute of Rural Development and University of Hyderabad (2010), pp 4-8 and 22-27
64 This topic is covered in the section relating to the Food Zone Program in Hilmand below.
66 Mansfield, D. (2011), Between a Rock and a Hard Place, pp 10-11
Rural development activities that provide licit economic alternatives to farmers and other rural workers currently dependent on or vulnerable to opium cultivation and production.  

However, income alone is not the crucial factor; it is the use of the income as how it improves the quality of life that will truly consolidate an alternative livelihood approach. Hence, as equally as attempting to increase the income of farmers to afford them access to food, healthcare, education and security, an alternative livelihood approach can consider how to reduce the cost of such development improvers so as to give the community in question sufficient access.

There is also a need for greater coordination between governmental and non-governmental interventions. In addition to the programs of the MRRD which are now covered under the National Priority Programs (NPPs), and also the MAIL’s programs, there continue to be international NGOs who spend considerable amounts of money on alternative livelihood development programs, but without coordinating with these key line ministries.”

2.3.3.1 Alternative livelihood projects

Over the past decade a large number of alternative livelihood projects have been implemented in Afghanistan. In 2005, in support of MCN’s activities, UNODC implemented a program titled “Mapping of Alternative Livelihoods Programs in Afghanistan” through which a database was developed for compiling available information on alternative livelihood programmes and projects throughout the country.

The Alternative Livelihoods Database contains data that was provided by various sources, such as line ministries. The Ministry of Rural Rehabilitation and Development (MRRD) has been reporting its data on alternative livelihood projects very consistently and regularly. The following data is on alternative livelihood projects implemented through the MRRD, as reported by that ministry.

MRRD’s projects intend to improve the livelihoods, assets and opportunities of households. However, it should be noted that the projects were not specifically designed as counter-narcotics efforts (although it is very possible that their effects were beneficial to such efforts). In that respect it is difficult to determine to what extent projects listed in the database fall into the definition of alternative livelihoods put forward in the National AL Policy.

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68MCN (2012) National Alternative Livelihoods Policy, p. 17
69The National Priority Programs focus on sustainable economic growth, job creation, and revenue generation. They are a result of the Tokyo Conference which has resulted in the Tokyo Mutual Accountability Framework. They are relevant to CN as, through the Counter Narcotics Monitoring Mechanism (CNMM), they will mainstream CN issues and allow the government of Afghanistan to deliver on its Kabul Conference Commitments.
70Information obtained from MCN Alternative Livelihoods Section, 2013.
Table 2.5: Summary of development projects completed as reported by the MRRD, 2002-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of projects</th>
<th>Total cost of projects (in million USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>117</td>
<td>26.6</td>
</tr>
<tr>
<td>2003</td>
<td>1,032</td>
<td>20.5</td>
</tr>
<tr>
<td>2004</td>
<td>5,983</td>
<td>100.7</td>
</tr>
<tr>
<td>2005</td>
<td>8,381</td>
<td>108.3</td>
</tr>
<tr>
<td>2006</td>
<td>6,165</td>
<td>107.1</td>
</tr>
<tr>
<td>2007</td>
<td>11,787</td>
<td>194.4</td>
</tr>
<tr>
<td>2008</td>
<td>11,184</td>
<td>193.6</td>
</tr>
<tr>
<td>2009</td>
<td>8,962</td>
<td>184.7</td>
</tr>
<tr>
<td>2010</td>
<td>4,093</td>
<td>89.6</td>
</tr>
<tr>
<td>2011</td>
<td>2,939</td>
<td>70.7</td>
</tr>
<tr>
<td>2012</td>
<td>247</td>
<td>39.1</td>
</tr>
<tr>
<td>Total</td>
<td>60,773</td>
<td>1,135.3</td>
</tr>
</tbody>
</table>

Source: MRRD

Table 2.6: Summary of development projects with status "on-going" as reported by the MRRD, 2002-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of projects</th>
<th>Total cost of projects (in million USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2003</td>
<td>5</td>
<td>0.8</td>
</tr>
<tr>
<td>2004</td>
<td>99</td>
<td>1.8</td>
</tr>
<tr>
<td>2005</td>
<td>100</td>
<td>2.1</td>
</tr>
<tr>
<td>2006</td>
<td>66</td>
<td>1.6</td>
</tr>
<tr>
<td>2007</td>
<td>196</td>
<td>3.7</td>
</tr>
<tr>
<td>2008</td>
<td>273</td>
<td>6.7</td>
</tr>
<tr>
<td>2009</td>
<td>403</td>
<td>12.6</td>
</tr>
<tr>
<td>2010</td>
<td>1823</td>
<td>53.7</td>
</tr>
<tr>
<td>2011</td>
<td>5103</td>
<td>145.7</td>
</tr>
<tr>
<td>2012</td>
<td>5404</td>
<td>157.8</td>
</tr>
</tbody>
</table>

Source: MRRD
Figure 2.19: Total budget allocated by MRRD for completed and ongoing development projects by province, 2002-2012
Figure 2.20: Budget spends by MRRD on development programs by region, 2002-2012
2.3.3.3 Alternative crops in Afghanistan

Many areas of Afghanistan have potential for producing high-value crops such as cotton, oilseeds, fruits and nuts, and vegetables. These crops also have the potential to create employment at production and processing stages. To design alternative livelihood strategies a comparison of incomes from various crops is important, but it is not the only cornerstone of the strategy. Equally important is the more general consideration on how to improve the quality of life, or to improve the purchasing power of the farmers - such as through better or cheaper service delivery (see also section 2.3.3). Figure 2.21 shows the average per hectare gross income for licit crops and opium in Afghanistan.

The data for farmer’s income analysis for different crops is based on average yield and average unit price, taken from different sources. For opium the average of the per-hectare incomes from 2009-2012 are presented.\(^71\) The other crops compared are wheat\(^72\), maize\(^73\), cotton\(^74\), rice\(^75\), tomato\(^76\), onion\(^77\) and potato\(^78\), with prices calculated at rates from 2010 to 2012 (depending on data availability).\(^79\) There are numerous factors affecting the profitability of any given crop, and it should be noted that the statistics analysed in Figure 2.21 are in terms of gross income, not net income. As has been discussed already, the cost of labour is a significant factor in profitability; so too are the costs of other inputs. These inputs might not be limited to just seeds and fertilisers; pesticides, tools and even irrigation are all ultimately cost factors which will affect the net income of the farmer. The cost of irrigation (which might necessitate expenditure on diesel to run tube well pumps, or on the pump itself) can be an especially influential factor, depending on the crop’s requirement for irrigation.\(^80\)

It is clear that cereal crops are financially less lucrative than vegetable crops, which are the only type of crop which come close to providing comparable levels of income per hectare to poppy. However, there are other advantages to cereal crops, such as their storability and their resilience to transportation - which are also very important factors for the Afghan context.

\(^{72}\)Average of data from Persaud (2012); WFP, 2012; CSO, Statistical Yearbook, 2010; MAIL(2005-2012); and Roots of Peace, 2010
\(^{73}\)CSO, 2010; MAIL (2005-2012); and Roots of Peace, 2010
\(^{74}\)CSO, 2010
\(^{75}\)CSO, 2010
\(^{76}\)Kuhn, 2010; MAIL (2005-2012)
\(^{77}\)Kuhn, 2010
\(^{78}\)MAIL, 2012
\(^{79}\)CSO, 2010; MAIL (2005-2012); and Kuhn, 2010
\(^{80}\)Palau (2012)
Figure 2.21: Farmers gross income (USD) per hectare by crop - 2009-2012 prices

Source: United States Department of Agriculture, WFP, CSO, MAIL, Roots of Peace

There were complexities in calculating the price of opium in comparison with licit crops. As these earnings per hectare are calculated according to the average market rate for the licit crops, so too the same methodology had to be applied as far as possible to calculating the opium prices. The farm-gate prices for opium are not directly comparable with market prices for vegetables; hence, using the information from the UNODC Drug Price Monitoring Reports, the average of the market rates of wet opium between 2009 and 2012 were used to calculate the gross income per hectare for opium.

It is also clear from Figure 2.21 that saffron is one licit crop that competes very strongly with - or even out-competes - opium poppy; but only in terms of gross income. What is not made clear from this data is the differences in net income (this data was not available at the time of the report) - hence before saffron is extolled too heavily as a far more lucrative crop than opium poppy, analysis must be performed on the net income from such crops.

Nevertheless, the gross value of saffron is considerable, with one hectare capable of producing a gross income of USD 6,780; if the farmer has established fields long enough to produce saffron corms (bulbs) he can earn USD 17,000 gross per hectare along from the corms; combined with his saffron stigmas, his gross potential income per hectare is USD 23,780.\textsuperscript{81} In gross (not net) terms, a farmer could theoretically generate almost four times as much revenue from a hectare of saffron as compared to opium poppy.

There is in addition one very important factor in the likely success of alternative agrarian livelihoods strategies: water access. Simple comparisons of gross income per hectare avoid the analysis of all of the other factors that lead to net income; and water is a crucial factor in terms of an essential agricultural input for any crop’s success. Any alternative livelihood proposals must

\textsuperscript{81} Calculated according to data received from the MAIL relating to saffron prices.
take into account the issue of water access/scarcity in the area in which the intervention is being proposed.

2.3.3.4 MCN Food Zone Programme

According to the MCN Food Zone Program documents, after the successful implementation of Food Zone Program in Hilmand, the MCN designed a four-part counter narcotics strategy in 2012, to be implemented in Kandahar, Farah, Uruzgan and Badakhshan provinces. This updated Food Zone approach draws on the lessons learned in Hilmand as well as on the comprehensive studies on other national and international programs. Reduction of poppy cultivation and increased effectiveness and legitimacy of the provincial administration of the mentioned provinces are the objectives of this Food Zone program. The strategy of MCN for these four provinces is an “ink-spot” strategy such as adopted in Hilmand province, during which poppy-free zones will be created and expanded over years to cover greater areas of provinces and will enable farmers to transfer to licit crops over the span of three years. With the experiences from the Hilmand Food Zone and also using concepts and success stories from other countries, any counter-productivity in the Food Zone concept has been eliminated by the design of the latest Food Zone approach. This program will be implemented based on the identified priorities of the community in the planned areas.

The four parts to the Food Zone Program in Kandahar, Farah, Uruzgan and Badakhshan are:

- A robust Public Information (PI) campaign,
- Alternative Livelihood (AL) inputs to subsistence and marginal farmers to reduce their dependency on opium poppy cultivation and to assist diversification of licit sources of income to achieve greater food security,
- Increased Law Enforcement (LE) including eradication of poppy in areas which received both PI and AL assistance; and
- An expanded Drug Demand Reduction (DDR) program.

2.3.3.5 The Counter Narcotics Monitoring and Evaluation Mechanism

The Counter Narcotics Monitoring and Evaluation Mechanism was introduced as part of the requirements falling out from the Kabul Conference (2010) and the declaration of the Tokyo Conference (2012) and ensures the genuine mainstreaming of CN in all of the National Priority Programs (NPPs). The mainstreaming of CN is not just a critical review of the NPPs; CN issues should be mainstreamed in all phases of the NPPs, including in the monitoring and evaluation of programs - to see for example their effect on licit crops.

The Monitoring and Evaluation Mechanism was endorsed on 26 July 2012 by the Joint Coordination Monitoring Board (JCMB) as a strategy for further development. The CN Monitoring and Evaluation Mechanism is comprised of secretariat and monitoring and evaluation committee.

Secretariat is comprised of technical personnel from the MCN and UNODC. It is responsible for the identification of activities (or specific interventions) related to the CN and possible priority areas in the NPPs for improving the current CN efforts (or specific interventions) to achieve the desired goals.
The CN Monitoring and Evaluation Committee consists of MCN, MAIL, MRRD, MeW, MoF, MoEc, UNODC and other cluster interested in CN. The committee is responsible for incorporating CN goals in the NDCS and CN laws and policies.

Please see policy annex for the external and internal organization of the CN Monitoring and Evaluation Mechanism.

### 2.4 CASE STUDY: HILMAND FOOD ZONE PROGRAM

#### 2.4.1 Introduction

The Food Zone Program (FZP) was introduced in 2008 by then Hilmand Provincial Governor, Gulab Mangal, in specified areas of selected districts in Hilmand. The objective of the FZP is to reduce poppy cultivation and increase the effectiveness and legitimacy of the Hilmand provincial governor. The Governor’s FZP was specifically envisaged as an ‘ink-spot’ strategy; the objective was, and remains, to create poppy-free zones which can then be gradually expanded. An agreement was signed between the government and local communities that in return for assistance with agricultural inputs - primarily improved wheat seed and fertilizer - farmers would not cultivate poppy. If farmers nonetheless cultivate poppy, they have explicitly acknowledged (by signing the agreement) that the government authorities do have the authority to eradicate the poppy.

The FZP of Hilmand was launched in the poppy planting season of autumn 2008 and covered the district of Lashkar Gah (the provincial centre) and the most fertile parts of Nad Ali, Nawa-i-Barukzai, Naher-i-Saraj, Garmsir, Gereshk, Sangin and Musa Qala Districts. In 2009, the FZP was expanded to more areas of these districts. In 2010 and 2011, in addition to the seven districts covered in 2008 and 2009, the program was expanded to the river-irrigated areas of Marja, Reg-i-Khan Nishin and Nawzad Districts.

#### 2.4.2 Implementation of the program

The FZP in Hilmand had, under its original design, three pillars for counter narcotics which consist of: robust public information (PI) campaigns; alternative livelihoods interventions through provision of supplies to farmers to promote the cultivation of licit crops; and law enforcement (LE) including the eradication of poppy in areas covered by both PI campaigns and AL interventions. The three pillars were implemented through a phased approach, whereby public information and community agreements comes first, followed by provision of agricultural inputs and, in cases of non-compliance, forced eradication of poppy fields. The three pillar approach has been improved upon considerably by the latest conceptual and programmatic changes in the latest Food Zone designs.

#### 2.4.2.1 Public Information Campaigns

In this first phase, meetings and *shuras* were held with tribal elders and *ulema*, to make the pledge that farmers will not grow poppy in exchange for agricultural inputs. CN messages were delivered through radio, television broadcasts and billboard advertisements to raise awareness among the farmers of the government’s efforts in general, and the governor’s efforts in

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82 Hilmand Provincial Governor Office (2009) *Hilmand Provincial Counter Narcotics Strategy*

83 Hilmand Provincial Governor Office (2009) *Hilmand Provincial Counter Narcotics Strategy*

84 Hilmand Provincial Governor Office (2009) *Hilmand Provincial Counter Narcotics Strategy*

85 A *shura* is the term for a community meeting in Afghanistan, technically with religious authority.
Figure 2.22: Hilmand province with the Food Zone as it was introduced in 2008

Source: MCN/UNODC Afghanistan Opium Survey 2009, pg.30
particular\textsuperscript{86}. These messages also elaborated the threat of eradication for those who broke the pledge. Content included messaging about the illegality of poppy under Islam; the impact poppy has in terms of drug dependency; the overall social cost of poppy; promotion of alternative economic opportunities; example success stories; points of contact for receiving agricultural inputs; and the threat of eradication if farmers cultivate poppy\textsuperscript{87}.

It was reported that elders in rural areas with strong insurgent influence were reluctant to receive public awareness material for distribution in their villages, due to fear of reprisals from insurgents if they were caught with it. In these areas, radio messages and word of mouth played a more important role in informing farmers about the Hilmand FZP.\textsuperscript{88}

\subsection*{2.4.2.2 Agricultural Assistance}

Preceding the poppy planting periods in 2009-2012, fertilizers, certified wheat seeds, and high value horticulture seeds were distributed to farmers in the Hilmand Province Food Zone. In 2008/09, the FZP covered 32,800 farmers from Lashkar Gah, Nad Ali, Nawa-i-Barukzai, Garmsir, Naher-i-Saraj, Sangin and Musa Qala Districts. Each farmer received 100 kg of wheat seed without any cost. Of these farmers, a reported 19,150 farmers received 300 kg of fertilizers each\textsuperscript{89}.

In the autumn of 2009, 37,500 farmers received wheat seed and fertilizer, followed by the distribution of fruit saplings and vines to 1,200 farmers in February 2010\textsuperscript{90}. In autumn 2010, “over 46,000 farmers across Hilmand were provided with access to subsidized inputs and training to support a transition to legal livelihoods”\textsuperscript{91}.

In autumn 2011, 42,020 farmers were provided with a package of improved wheat seed and high value vegetable crops, bringing the total number of beneficiaries for the program to over 160,000\textsuperscript{92}. In 2011, it was stated that Hilmand farmers also had to contribute a co-payment of 2,000 Afghanis per package for the inputs\textsuperscript{93}.

\subsection*{2.4.2.3 Law enforcement}

The farmers were encouraged to self-eradicate their poppy through discussion with elders and the ulema. If the farmers did not eradicate their poppy field, Governor-led eradication (GLE) was then liable to take place.

Table 2.7 shows levels of poppy cultivation in Hilmand province against levels of GLE. Since the introduction of the Food Zone, between 2\% (in 2009) and 5\% (in 2012) of all poppy cultivated in Hilmand province was eradicated. In that period, not only did the relative proportion of land eradicated steadily increase, eradication also continuously increased in absolute terms, from 1,475 ha in 2009, to 3,637 ha in 2012. The eradication campaigns in Hilmand since the introduction of the FZP have seen a total 176 casualties, out of which 80 persons have died.

\textsuperscript{86}Mansfield (2011) Managing Concurrent and Repeated Risks
\textsuperscript{87}Mansfield (2011) Managing Concurrent and Repeated Risks
\textsuperscript{88}Mansfield (2011) Managing Concurrent and Repeated Risks
\textsuperscript{89}Hilmand Provincial Governor Office (2009) Hilmand Provincial Counter Narcotics Strategy
\textsuperscript{90}Hilmand Provincial Reconstruction Team- led Projects, http://www.army.mod.uk/operations-deployments/22807.aspx
\textsuperscript{91}Hilmand Provincial Reconstruction Team, http://www.hilmandprt.com/counter-narcotics
\textsuperscript{92}Hilmand Provincial Reconstruction Team, http://www.hilmandprt.com/counter-narcotics
\textsuperscript{93}http://afghanistan.usaid.gov/en/USAID/Activity/255/Hilmand_Food_Zone_Project_HFZP
Table 2.7: Levels of cultivation and governor-led eradication in Hilmand Province, 2009-2012

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net cultivation after eradication (hectares)</td>
<td>69,833</td>
<td>65,045</td>
<td>63,307</td>
<td>75,176</td>
</tr>
<tr>
<td>Eradication (hectares)</td>
<td>1,475</td>
<td>1,602</td>
<td>1,940</td>
<td>3,637</td>
</tr>
<tr>
<td>Percentage of cultivation eradicated</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Casualties during eradication campaign</td>
<td>77</td>
<td>49</td>
<td>16</td>
<td>34</td>
</tr>
</tbody>
</table>


2.4.3 Poppy cultivation in Hilmand

Figure 2.23 shows poppy cultivation levels in Hilmand Province for the years 2005 to 2012. Poppy cultivation in the province peaked in 2007 and 2008 at 102,770 ha and 103,590 ha, respectively. In 2009, after the introduction of the FZP in the autumn of 2008, Hilmand cultivation levels dropped by 33% to 69,833 ha. Cultivation levels stabilized for the next two years at 65,045 ha and 63,307 ha in 2010 and 2011 respectively.

In 2012, poppy cultivation resurfaced to 75,176 ha, an increase of 19% compared to 2011. However, Hilmand’s contribution to overall poppy cultivation at the national level did decline. When expressed as the share of total cultivation in Afghanistan, Hilmand contributed as much as 66% in 2008 to total cultivation levels, but only 48% in 2011 and 49% in 2012. Moreover, while cultivation in Hilmand dropped by 33% from 2008 to 2009, overall cultivation in Afghanistan dropped by only 22%.

*Figure 2.23: Poppy cultivation in Afghanistan and Hilmand province, 2005-2012*

Source: MCN/UNODC Afghanistan Opium Surveys, 2005-2012
Overall, in the first year after the introduction, cultivation levels in Hilmand reduced much more than in the rest of the country. Since the introduction of the FZP in 2008, the share of Hilmand’s contribution to the country’s overall poppy cultivation has dropped from 66% to 48%. The program thus slowed down the growth and resurgence of cultivation within Hilmand province.

At the same time the food zone was introduced, a significant inflow of national and international military forces was perceived. The resultant upsurge in security infrastructure and presence is thought to have contributed to farmer’s decisions to reduce their level of poppy cultivation, with government commitment and visible assistance to the farmers under a counter-narcotics banner also argued to have had an effect in this regard.

2.4.4 Poppy cultivation inside and outside the Food Zone

In the 2012 MCN/UNODC opium survey, a separate estimate for poppy cultivation in the Food Zone was calculated. Estimated at 24,241 hectares, the area under opium poppy cultivation represented about a seventh of the Food Zone’s total agricultural area. Outside the Food Zone, the extent of poppy cultivation was much greater, as almost a third of available land was under poppy cultivation, showing that relatively speaking, less poppy had been cultivated within the Food Zone than outside it.

This was already the case in 2011, where the 2011 opium survey showed that in most areas in the periphery of the province and those north of the Boghra canal presented a clear increase in cultivation, whereas central Hilmand experienced a definite decrease in poppy cultivation. Poppy cultivation within the Food Zone in 2011 declined 38% compared to 2010. However, the overall percentage decline in Hilmand Province between 2010 and 2011 was just 2.7%. So, in the two years where poppy cultivation remained roughly stable, poppy cultivation shifted from within the Food Zone to outside it. This displacement effect is referred to in general terms as the “balloon effect”.

The increase in cultivation outside of the Food Zone seems to have been fuelled by an expansion of agricultural area, e.g. by the use of pump irrigation. The most prominent example is the expansion of land that took place north of the Boghra canal: the agricultural area increased from only 834 hectares of arable land in 1999 to 26,571 hectares in 2010. In 2012, according to the U.S. government, this had further increased to an estimated 34,720 hectares of available arable land. In this area, which lies outside of the Food Zone, poppy cultivation takes place at a very

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94 Additionally, looking at the rate of expansion of cultivation between 2011 and 2012, the southern region increased at a much lower rate - 9% - compared to the western region (with a 57% increase in area cultivated) and the eastern region (37% increase). Source: MCN/UNODC (2013) Afghanistan Opium Survey 2012, p. 19
95 Mansfield (2011) Between a Rock and Hard Place, p. 30
97 Mansfield (2013) All Bets Are Off, p. 72
99 Mansfield (2011), Managing Concurrent and Risks, p. 3
100 Mansfield (2011) Between a Rock and Hard Place, p. 20
large scale, which contributes to a large extent to overall poppy cultivation levels within Hilmand. This effect has been documented in in-depth longitudinal studies\textsuperscript{101}, and satellite imagery\textsuperscript{102}.

While in 2008 poppy cultivation was relatively evenly distributed between the districts Nawa-i-Barukzai (25% of all cultivation in these districts), Lashkar Gah (14%), Nad Ali (37%) and Naher-i-Saraj (24%), in 2012 cultivation had shifted to a large extent to Naher-i-Saraj (66%). Nad Ali still contributed 24%, but Lashkar Gah, Marja and Nawa-i-Barakzai contributed only marginal amounts.

\textit{Figure 2.24: Distribution of poppy cultivation in five districts of Hilmand province, 2008-2012}\textsuperscript{103}

While in 2009 poppy cultivation was distributed evenly in the whole of the Food Zone, poppy cultivation in 2012 was highly concentrated in a few peripheral areas in Marja, Nad Ali and Naher-i-Saraj districts. This means that the prime land in the centre of Hilmand is now used for alternative crops such as vineyards and fruit orchards (see Figure 2.25).


\textsuperscript{101}E.g. Mansfield (2011) Between a Rock and Hard Place
\textsuperscript{102}Alternative Livelihoods Section, Ministry of Counter Narcotics
\textsuperscript{103}Note that prior to 2011, Marja was not an official district but was actually part of Nad Ali District (which explains not only data for Marja appearing from 2011 onwards, but also explains the marked reduction in poppy cultivation recorded between 2010 and 2011 in Nad Ali in this graph). Subsequent to Operation Moshtarak in February 2010, Marja became an official district and data records began to be collected accordingly.
Both grapes and fruits are crops with a longer planning horizon, and the presence of these crops is de facto indications that there has been an investment by farmers in a licit future in parts of Hilmand. As such there are some indications of a potentially promising sustainable form of alternative agriculture.
Figure 2.2 Geospatial analysis of the agricultural expansion area in Hilmand.

Source: US Government

2.4.5 Income from licit crops

In the MCN/UNODC opium survey of 2012, surveyors visited villages inside and outside of the Food Zone allowing for some comparison between farmers inside and outside the intervention. Statistically, the farmers interviewed showed several differences in key socio-economic indicators, although further research is required to determine whether these farmers stay permanently within or beyond the food zone or shift across the two areas periodically.

The income distribution of farmers inside and outside the Food Zone differs to a noteworthy extent. Overall, farmers in the Food Zone reported to have an income that is about 30% higher than the income reported by farmers outside of the Food Zone. Farmers outside the Food Zone make 36% of their income with poppy, whereas inside the Food Zone, poppy contributes - on average - 30% of income. Licit income sources, mainly wheat, contribute inside the Food Zone more than outside the Food Zone (see Figure 2.27).
Inside the Food Zone, licit incomes have a higher relevance than outside the Food Zone. However, the fact that still 30% of reported income comes from poppy, is worrying as it shows that farmers’ livelihoods within the Food Zone still depend to some extent on poppy, or at least that these farmers continue to hedge, or diversify their portfolio, with opium. The new design of the Food Zone will address these concerns, as it is a completely different approach to sustainable alternative livelihoods.

Further research would be needed into the demographic of labourers to see the extent to which the FZP has affected their income opportunities; Figure 2.27 is only indicative of farmers specifically, not labourers.

Interestingly, remittances played only a marginal role in income of farmers. There would appear to be a correlation between remittances and illicit crops, in that remittances seem to be a reaction to the lack of local income opportunities; where opportunities exist, there is less of a requirement to seek out remittances. It is not clear if farmers that have access to remittances are overall less likely to cultivate illicit crops; more detailed research and analysis of this phenomenon would be necessary before drawing conclusions.

There have been concerns that wheat production in Hilmand would flood the local markets with the introduction of the Food Zone. Figure 2.28 shows average yearly prices of wheat in Hilmand province.

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Figure 2.28: Average wheat price in Hilmand

![Graph showing average wheat price in Hilmand from 2005 to 2012.

Source: MAIL Price Bulletins 2005-2012

It is evident that there was a marked increase in wheat price in 2008, when it reached 29 AFN/kg in Hilmand province. From 2009 to 2012, wheat prices decreased from their high price of 2008. It should be noted that the high wheat prices of 2008 are not necessarily connected to the extremely high poppy cultivation levels from the previous year: in December 2007, Benazir Bhutto (a former Prime Minister of Pakistan, and thought to have been a leading opposition candidate in the 2008 general elections) was assassinated. Shortly after this incident, the borders were closed between Afghanistan and Pakistan; this security reaction (in the context of an already existent Pakistani export ban on wheat to Afghanistan - a measure to improve the food security in Pakistan) resulted in the price of all commodities and foodstuffs rising in Hilmand Province in early 2008. This is not a complete explanation for this specific wheat price fluctuation, but is rather an illustration of the complex of factors that can be at play when calculating the effects of supply and demand in Hilmand.

Encouragingly, since the introduction of the FZP in 2008, wheat prices have climbed slightly from 2010 to 2011. This is an important factor in keeping wheat an attractive crop for farmers; it is certainly the case that the price of wheat in Hilmand must be monitored closely should it start to drop to such unattractive levels that farmers feel tempted to supplement their income with higher-value illicit crops.

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106 As reported to one of the report’s authors by the Civil-Military Cooperation (CIMIC) team in the Lashkar Gah PRT, February 2008.
2.4.6 Conclusions on the Food Zone

The supply reduction measures within the Food Zone, together with increased governmental control in the centre of Hilmand, have successfully reduced poppy cultivation in the areas where it was active. These measures need to be maintained at their current levels or expanded over the coming years to assist farmers in their transition from illicit to licit agriculture. Such efforts will thus need to be accompanied by incentives to ensure that farmers are not tempted to revert to poppy while they wait for their revenue stream to come on line. In the instance of fruit tree projects, for example, there will be a lengthy lead time between planting the orchards and those orchards beginning to produce fruit in meaningful quantities. Any significant reduction of agricultural assistance in Hilmand, together with high sales prices of opium poppy, therefore bears the risk of a further expansion of poppy cultivation in coming years. Indeed, a number of studies have emphasized the need for interventions to reduce and/or ban opium cultivation to be accompanied by commensurate gains in terms of development, rule of law, governance and alternative livelihoods. It is also the case that any of the concerns with the original design of the Food Zone concept have been addressed with the design and implementation of the new concept of the Food Zone. All the recommendations arising from the old design of the Food Zone have been addressed by the Ministry of Counter Narcotics in the new design of the Food Zone concept.

For similar programs in other regions several “lessons learned” can be noted:

- A sustainable reduction is most likely achieved by a comprehensive counter-narcotics approach, integrated with an alternative rural development approach.
- Food Zone interventions should put in place measures to minimize the “balloon effect” where pressure applied in one area (in this case, the centre of Hilmand) pushes cultivation into another area of less resistance (namely, the periphery of Hilmand and possibly neighbouring provinces).
- The intervention area should be less rigidly defined to avoid a situation with “haves” on one side of a border, and “have nots” on the other side - which can encourage the displacement of poppy cultivation (the “balloon effect”).
- The impact on rural labour should be considered so that labour patterns are not disrupted within the Food Zone, preventing certain elements of the population within the FZP from accessing livelihoods.
- Concentrating agricultural assistance programs to districts with poppy cultivation may actually incentivise cultivation in neighbouring districts, since a wrong signal may be sent (“poppy cultivation leads to assistance programs”) - although this concern in particular has been addressed by the improved design of the Food Zone concept.
- Promoting alternative livelihoods goes beyond just an agricultural expansion programme with a counter-narcotics component. The available research points to limited educational opportunities, poor access to health services, a high level of insecurity combined with insurgent influence and limited availability of off-farm income as additional factors playing a role in farm-level decision making when farmers have to carefully weigh needs against opportunities. However, further research is needed to better understand which factors at

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which level of intervention can be influenced in such a way that poppy cultivation is reduced sustainably. The new concept of the Food Zone in Kandahar will address different drivers of poppy cultivation.

- Security is an important factor, as well, and it would appear that any licit livelihood interventions have a greater likelihood for success if security is considered a cornerstone of the intervention.

### 2.5 CONCLUDING REMARKS

This chapter has revealed a number of interesting aspects of the Afghan supply of illicit narcotics. Currently, opium poppy is mainly cultivated in two regions of the country and cultivation appears to be expanding. The size of the illicit economy is significant, and the cash value of illicit crops remains to be one of the principal influencing factors in its cultivation. The market for illicit crops is elastic - prices change according to (perceived) supply. Additionally, there are strong correlations between insecurity and poppy cultivation, as well as strong correlations between cultivation and development indicators.

In terms of supply reduction, both public awareness messaging and eradication have the potential to be effective. Public awareness messaging has significant effects on influencing poppy cultivation, but more specific research would be needed to ascertain the exact extent. Eradication is definitely a positive measure in reducing supply, but requires parallel measures related to alternative rural development. The human cost to the activity is also quite high. More specifically, the Hilmand Food Zone Program has been successful within its boundaries as poppy cultivation indeed decreased.

Throughout this chapter, many issues were discussed where conclusions were difficult to draw with conviction due to lack of data. Thematic areas that merit a future research focus in subsequent Afghanistan Drug Reports include the connection among development (especially education), security and illicit crop cultivation, to better understand the nature of the correlation between these indicators. Research on the effectiveness of CN messaging campaigns would also greatly inform future messaging themes and audiences, as well as answer questions as to how much of an effect a media product can have on society and individual farmers.

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CHAPTER 3: DRUG USE, TREATMENT AND PREVENTION

3.1 INTRODUCTION

Afghanistan is faced with significant challenges related to drug use amongst its population, a phenomenon that has been on the rise over the last decade. Nearly one million Afghans aged between 15 and 64 are estimated to be regular drug users. Afghanistan has a high rate of opiate consumption similar to countries like Russia and Iran, with a prevalence rate of 2.7% in 2009, up from 1.4% in 2005. An increase in injecting drug use has also been observed with reported 6% of all drug users having injected at least once in their lifetime.

However, current capacity for drug prevention or treatment in Afghanistan does not match the needs of the drug using population. What is available predominately takes the form of residential in-patient treatment. There is a need for a comprehensive package of care to address the individual needs of the drug using population. Recognizing the need to increase the availability of drug treatment, the Drug Demand Reduction policy prepared and published by the Ministry of Counter Narcotics (MCN) with the assistance of national and international stakeholders in 2012 sets a target to increase drug prevention and treatment capacity by 30% for heroin and opium users between 2012 and 2016.

This chapter considers the impact of drugs in Afghanistan by reviewing drug use, treatment and prevention trends and conditions and drawing on national drug use surveys conducted in 2005 and 2009. A key focus will be on drug treatment in Afghanistan, looking at what type of treatment is available, where it is located geographically and who supports, co-ordinates and implements it. The chapter also considers drug use in prisons and drug related harm before reviewing drug prevention and treatment issues. As part of the treatment section, the chapter will report on a comparative pilot study of individuals accessing drug treatment and those who were not accessing treatment. In conclusion, the chapter points to key issues and potential future areas of research with respect to drug use, treatment and prevention in Afghanistan.

3.2 DRUG USE

3.2.1 Use of drugs and other illicit substances

Two National Drug Use Surveys have been conducted in Afghanistan in 2005 and 2009. The first survey was conducted in 2005 by the MCN and UNODC providing the first national profile of the extent of drug use in the country. In 2009, a second survey was conducted to update earlier reports. Regular drug users were defined as those who had used opium, heroin, opioids and tranquillizers regularly in the past 12 months and past 30 days. Afghanistan Drug Use Survey, p. 5.

UNODC World Drug report, 2011, p. 52

UNODC-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 6

Drug addiction is a chronic relapsing condition, and to ensure full recovery a treatment plan should consist of a comprehensive package of care as opposed to an individual stand-alone intervention. A comprehensive package should consist of low-threshold interventions, such as outreach services or drop-in-centres; structured interventions, such as outpatient, residential services; and aftercare services. For a list of the types of services in a comprehensive package of care, please see Box 3.1.

MCN (2012) Afghanistan Drug Demand Policy, p. 6

Not including the Afghanistan National Urban Drug Use Survey performed by INL in 2012, as this only applies to urban areas. The rural component of this survey is yet to be published at the time of writing.
findings and address concerns about escalating drug use and also provide further insight into the extent and pattern of drug use in Afghanistan. Although each survey used different methodologies, some broad comparisons can be made regarding trends and changes in drug use practices (Table 3.1). An urban drug use survey undertaken by the US Bureau of Narcotics and International Law Enforcement is due to be published in 2013.

Table 3.1: Comparisons of findings from the 2005 and 2009 National Drug Use Surveys

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Sample</td>
<td>Both recreational and regular/problem drug use including alcohol use.</td>
<td>Regular drug use(^{115}). 15-64 year olds.</td>
</tr>
<tr>
<td>Overall Drug Use</td>
<td>920,000*</td>
<td>940,000*</td>
</tr>
<tr>
<td>Opium Use</td>
<td>150,000</td>
<td>230,000</td>
</tr>
<tr>
<td>Heroin Use</td>
<td>50,000</td>
<td>120,000</td>
</tr>
<tr>
<td>Cannabis Use</td>
<td>520,000</td>
<td>520,000</td>
</tr>
<tr>
<td>Female Drug Use</td>
<td>120,000</td>
<td>111,000</td>
</tr>
<tr>
<td>Children Drug Use</td>
<td>60,000</td>
<td>50% of opium using parents give it to their children (250,000 opium users)</td>
</tr>
</tbody>
</table>

* These figures are not directly comparable due to differences in the population sample, and as the 2009 survey does not include the use of alcohol or other psychoactive substances, whereas the 2005 survey does.

Source: UNODC, Afghanistan Drug Use Surveys, 2005 & 2009

According to the 2009 national drug use survey, there are almost one million regular drug users aged 15 to 64 in Afghanistan representing around 8% of the adult population. A more recent study undertaken in 2012 suggests that there may be even more drug users in the country.\(^{116}\) A trend clearly emerging from the 2005 and 2009 surveys is the significant increase in the use of opium and heroin. Between 2005 and 2009, the numbers of regular opium and heroin users increased by 53% and 140% respectively.

Cannabis is the most widely used illicit substance\(^{117}\) with an estimated number of 520,000 adult users (ranging from 410,000 to 630,000 people) accounting for 51% of all drug users, although its use is less common among women. Opium is the second most commonly used substance in Afghanistan with an estimated prevalence ranging between 1.7% and 2.1% of the population aged 15-64 years. The Western, Eastern and Southern regions have the highest prevalence of heroin use.\(^{118}\)

In terms of opiates\(^{119}\) specifically, the annual prevalence of use is estimated to be 2.7% of the adult population\(^{120}\) (between 290,000 and 360,000 persons). Opium is by far the most commonly

\(^{115}\)“Regular drug users were defined as those who had used opium, heroin, opioids and tranquilizers regularly in the past 12 months and past 30 days” MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 5.


\(^{117}\)MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 13

\(^{118}\)MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 6

\(^{119}\) The term “opiates” refers to opium and its semi-synthetic derivatives (such as heroin and morphine); opioids is generically applied to mean all opiates as well as those synthetic opiates (such as painkillers).

\(^{120}\) Adult population in the text is referred as those aged 15 to 64 years.
used opiate with an estimated annual prevalence of about 1.9% of the adult population. Heroin annual prevalence is estimated to be about 1.0% of the adult population and other opiates users are estimated to make up about 0.5% of the adult population.\footnote{MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 6}

Drug users reported using multiple substances in their lifetime and in the past 12 months. Forty per cent of the drug users had used consecutively or simultaneously two or more substances in the past 12 months preceding the 2009 survey. More than a third had used both opium and cannabis, 18% had used heroin and opium, 15% had used heroin and cannabis, and ten per cent had used opium, heroin and cannabis.\footnote{MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 10}

### Box 3.1: Use of Illicit Substances in Afghanistan

- **Opium**: 60% of drug users interviewed reported having used opium in their lifetime; women constituted 3% of the respondents that had ever used opium; most of the men (40%) started using opium in Iran; opium is traditionally used in Afghanistan for medicinal purposes, especially among women in the north.
- **Heroin**: 30% of interviewees had used heroin in their lifetime (with women constituting 2%); similar to opium, 40% of the respondents starting using heroin in Iran; there was an overall increase in heroin users from 50,000 in 2005 to 120,000 in 2009; a higher number of drug users in the Eastern (40%) and Western (47%) regions had used heroin in their lifetime.
- **Cannabis**: 60% of the drug users interviewed have used cannabis in their lifetime of which 2% were women; the highest proportion of drug users who reported cannabis use were from the Eastern region (83%); only 10% and 7% had started using cannabis in Iran and Pakistan respectively.
- **Tranquilizer**: sedatives and tranquilizers like diazepam, lorazepam, chlordiazepoxide, chlorpromazine and phenobarbital are used without prescription and are available over the counter; 11% of users interviewed had used such substances in their lifetime without a medical prescription; female drug users were twice as likely to have used these substances.
- **Opioid painkillers**: 9% of respondents indicated having used in their lifetime these licit substances which are commonly used as painkillers and available through pharmacies and other retailers; more use reported in Western and Eastern regions (19% and 13% respectively); almost two thirds started using opioids in Pakistan and a quarter in Iran.
- **Alcohol**: 18% of interviewees had used alcohol in their lifetime; 14% of the female drug users interviewed had used alcohol; most alcohol use started within Afghanistan.
- **Other drugs**: Up to 3% of the survey’s respondents had used inhalants in their lifetime, with half having started use in Iran; a very small number had used amphetamine type substances in their lifetime.

*Source: UNODC, Afghanistan Drug Use Survey 2009*

Drug use is also differentiated geographically, at times corresponding to patterns of opium and cannabis production and trading (Table 3.2). There has been reference by experts previously that the scale of supply of narcotics from Afghanistan is connected to the high drug use prevalence rates.\footnote{Palau (2012), pp 1-2; UNAIDS (2004). pp. 11-24} Previous studies have also indicated that the availability of drugs can be a factor in drug...
users transitioning to dependence. There are occasional glimpses into the potential mechanisms by which drug users become habitual users (see for example Box 3.6), but more specific nationwide research would need to be conducted to fully understand if a narcotic oversupply leads to localized addiction.

Drug use prevalence is highest in the Northern and Southern regions, the latter being where most of the drug cultivation takes place. In terms of number of drug users, the Central region, where the capital is located, has the highest number in the country, suggesting the significance of urban drug use (as discussed below). With respect to opium use in particular, evidence so far indicates that this is most prevalent in the Northern region followed by the Central region.

Table 3.2: Number of illicit drug users and annual prevalence by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Number (Estimate) *</th>
<th>Prevalence % (Estimate)</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>253,000</td>
<td>6.5%</td>
<td>8,131,800</td>
</tr>
<tr>
<td>Eastern</td>
<td>87,000</td>
<td>6.3%</td>
<td>2,703,300</td>
</tr>
<tr>
<td>North Eastern</td>
<td>82,000</td>
<td>6.1%</td>
<td>3,410,100</td>
</tr>
<tr>
<td>Western</td>
<td>101,000</td>
<td>5.9%</td>
<td>3,465,600</td>
</tr>
<tr>
<td>Southern</td>
<td>107,000</td>
<td>7.2%</td>
<td>2,925,700</td>
</tr>
<tr>
<td>Northern</td>
<td>171,000</td>
<td>7.2%</td>
<td>3,357,000</td>
</tr>
<tr>
<td>Afghanistan*</td>
<td>800,000</td>
<td>6.6%</td>
<td>23,993,500</td>
</tr>
</tbody>
</table>

* National estimates are rounded to the nearest 10,000 users

Sources: UNODC, Afghanistan Drug Use Survey 2009 and Afghanistan Central Statistics Organization (CSO), Afghanistan Statistical Yearbook 2009 pp7-8

The majority of drug users in Afghanistan started drug use within the country. However, a sizeable proportion of drug users began using drugs as refugees in Iran (28%) and in Pakistan (9%). Among opium and heroin users, up to 40% initiated their opiate use in Iran.

Returning refugees, the majority of whom lived in countries with high drug addiction rates (e.g. Pakistan and Iran), are potentially more likely to be problem drug users. During the past ten years, more than 5.7 million Afghan refugees have returned to Afghanistan, and many of these vulnerable groups are experiencing difficulty in rebuilding their lives. This is nearly one quarter of the Afghan population. There is a high incidence of dependence observed amongst returnees. In addition, almost two million refugees are still living in neighbouring Pakistan and another one million in Iran.

Urban areas are fast becoming home to significant numbers of drug users. Subsequently, this has led to large populations of drug users colonizing particular areas of a city where they can live in
squalid conditions. This has resulted in homelessness and increased harms from drug taking (for example, in 2009 it was estimated that 18.2% of injection drug users (IDUs) in Herat are infected with HIV134). Afghanistan has experienced concentrated drug using ‘hot-spots’ such as the former Russian Cultural Centre in Kabul, multiple areas of Herat city and most recently in the Ankara area of Mazar-e-Sharif, where at times there up to 300 drug users frequenting this location.

Box 3.2: Female and Child Drug Use

In 2009, the three most commonly used substances among women are opium, tranquilizers and opioid painkillers. The highest rate of opium use amongst females was in the Northern region, although this region had the lowest overall prevalence for female drug use. Tranquilizers were identified as the second most used substance amongst women in Central and North Eastern regions - but the lowest rate of tranquilizer use amongst women is in the Northern region. Among the female drug users interviewed for the 2009 survey, 14% had ever used alcohol, while it was estimated that 4,000 females were IDUs135.

Among children, opium use was most widespread in the North and North Eastern regions of the country which correlates to the high rates of opium use among women in these regions - potentially, mothers might be partially responsible for their children’s use136. The South and Central regions had the highest prevalence of tranquilizer use among children.

Source: UNODC, Afghanistan Drug Use Survey 2009

The ready availability of opium in Afghanistan together with the extensive traditional use has led to widespread abuse and dependence within families (Box 3.2 and Figure 3.1). Children and adolescents are often involved at a very young age and become familiar with opiate drugs because of their use in their families.137 Parents often give opium to their children to calm them down to numb their hunger.138 Illicit drugs are also used as self-medication to cope with stress and dramatic psychological conditions.139

Opium, cannabis and heroin were the three main drugs for which the drug users mentioned regular use by at least another family member, and one third of users mentioned that young persons in their families were regularly using opium.140 Furthermore, a report on passive opiate smoke in Afghan homes using hair follicle samples from family members, revealed alarming concentrations of drugs in the systems of family members, especially women and children, including children aged 12 and younger.141 Moreover, medical doctors running six women and children drug

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134 John Hopkins University (2010)
135 MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 32 and 61
136 See Goldberger et al (2013) , a national study was on the effects of second- and third-hand opium smoke, shedding some light on the mechanisms behind which mothers might addict their children
137 The fact that children are given drugs by their family members is discussed in MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 55
138 The extent to which this occurs is not fully known, but there is plenty of evidence this occurs. See for example Malahat, A. (2011)
139 See Recknagel (2010)
140 MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 10
141 Goldberger et al. (2013)
treatment centres in the country reported that 75% of the children showing up at the centres with their mothers are also testing positive for opiates.\textsuperscript{142}

\textit{Figure 3.1: Percentage of drug users who reported to give opium to family members and children, by region}

3.2.2 Factors driving drug use
Factors such easy access to cheap drugs, limited access to drug treatment, combined with over three decades of war-related trauma have contributed to drug dependence in Afghanistan.\textsuperscript{143} Some other general drivers of drug use have been introduced already in this chapter, such as exposure to drug use as a refugee and difficult circumstances as a returnee. Factors such as poverty, joblessness and recreational purposes were mentioned by respondents in their conversations with the surveyors for the access to treatment study (see section 3.4). To more exactly discover which specific factors drive drug use in Afghanistan, a study has been conducted by the UNODC in 2013 which looks at the socio-economic impacts of drug use, and will also include analysis on the drivers of drug use in the country.\textsuperscript{144}

3.2.3 Injection drug users (IDUs)
Injection drug use in Afghanistan is associated with the injection of heroin, opium, tranquilizers and painkillers. The 2005 National Drug Use Survey estimated that are around 19,000 IDUs.\textsuperscript{145} The 19,000 IDUs from the 2005 study were split into 2,000 opium injectors, 7,000 who inject heroin and 18,000 who inject pharmaceutical drugs.\textsuperscript{146} The totals add up to more than 19,000 as such users are often poly-drug users.

According to the 2009 National Drug Use Survey, the majority (80\%) of the injecting drug users in the country are male\textsuperscript{147}. Geographically speaking, the prevalence for injection drug use is highest

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{142} This was mentioned in Goldberger et al (2013)
\item \textsuperscript{143} MCN-MoPH-UNODC, Afghanistan Drug Use Survey 2009, p. 3
\item \textsuperscript{144} The study on the socio-economic and psychological impact of drug use on drug users and their families will be published in 2013.
\item \textsuperscript{145} This increased to 20,000 in the 2009 survey; see MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 32.
\item \textsuperscript{146} MCN-UNODC, 2005 Drug Use Survey
\item \textsuperscript{147} MCN-MoPH-UNODC (2009), Afghanistan Drug Use Survey, p. 37
\end{enumerate}
\end{footnotesize}
in the three western provinces of Herat, Farah and Nimroz, while in absolute numbers, Kabul City is thought to be home to the largest number of opium users, heroin users and IDUs.\textsuperscript{148}

The 2009 UNODC national survey indicates that while the average drug user started his/her habit in Afghanistan, almost one-third reported that they began using drugs in Iran (and around one in ten began using in Pakistan - see also 3.2.1 above). However, just under half (40\%) of all opium and heroin users initiated their habit in Iran, and 27\% of all female heroin users began using heroin in Iran and Turkmenistan. Studies on injecting drug use in Afghanistan clearly specify that while hashish and opium smoking, chewing or inhaling have been, to a certain degree, socially tolerated, injecting of heroin was first reported among Afghan refugees from Iran and Pakistan especially those who returned mainly into the urban areas and frontier provinces.\textsuperscript{149} The results of a preliminary mapping exercise for a proposed study by the UNODC estimated that there were 30,000 recent heroin users among the returnee population; that there are around 8,000 IDUs (of whom about 2,000 are likely to have shared injecting equipment); and that there may be as many as 1,800 regular IDUs among the returnee population.\textsuperscript{150}

Nevertheless, there is also an indication of a generation of IDUs who have started injecting drugs in Afghanistan. A study conducted between 2007 and 2009 references that around two-thirds of IDUs started injecting in the country.\textsuperscript{151}

Both the 2005 and 2009 National Drug Use Surveys point to the alarming rates of high risk behaviour among IDUs, including sharing of needles and syringes, use of other substances, low condom use, and exchange of sex for money and drugs.

From the 2009 survey, it was identified that about 6\% of all drug users had injected at least once in their life.\textsuperscript{152} Many of the injectors were injecting daily or between 2 to 4 days in a week, and the most common drug reported was heroin. Alarmingly 87\% of IDUs had shared a needle and syringe with other injectors and more than a half, (60\%) used needle and syringe that had been used by 2 to 5 people before.\textsuperscript{153}

\subsection*{3.2.4 Drug use/HIV in prisons}

In 2010, a national survey of drug use and associated high-risk behaviour in the prison population of Afghanistan was conducted by UNODC and implemented by Health Protection and Research Organization. The study involved 1,225 male prisoners and 123 females - in total, this is around 10\% of the total national prison population (which was estimated to number at around 13,000 at the time of the study). From the male group, 29\% stated they were imprisoned for using drugs and 8.9\% for supplying drugs.\textsuperscript{154}

There were indications of systematic drug use in all the prisons surveyed. The number of regular heroin users in the national prison population was estimated at 750 (range: 570-931) and the number of systematic opium users in the prison system was estimated at 514 (range: 475-
667).155 Around 5% of the prisoners reported the use of opium or heroin in the previous month156. Amongst regular heroin users, an upper estimate of 20-30% reported injecting drugs in the last year.157

HIV prevalence among prisoners in the country is associated with injecting drug use. In one2010 study, the overall HIV prevalence rate was reported as 0.6% in Kabul prisons and 1.6% in Herat prisons.158 However, when considering just IDUs in the prison population, the prevalence was much higher: 3.2% amongst Kabul prisoner IDUs, and 18.8% amongst Herat prisoner IDUs.159 The Herat prison population showed a significant increase in HIV prevalence since 2008, when 11% among a sample of Herat male prison IDUs tested positive for HIV.160 Also, as per MoPH records, the total number of Hepatitis B Virus cases in both community and prison settings increased from 252 to 425 cases during 2011-2012.161 Additional evidence of practices which may increase risk of HIV transmission were also found as part of the 2010 study, with unprotected sexual intercourse or paying for sex being evident within the sample.162

Some studies indicate that HIV awareness is low amongst prisoners, with only 42% having heard of the disease according to a UNODC study.163 Amongst those who had heard of the disease, it was associated with injecting drug use. Most did not connect condom use with protection against HIV. Specific services such as drug treatment and harm reduction services were negligible within the context of prisons.

3.2.5 Drug related harms

As per the National AIDS Control Program (NACP) of Ministry of Public Health records, the total number of HIV cases increased from 539 cases in 2008 to 1367 in 2011.164 In this context, recent data confirms that Afghanistan has evolved towards a ‘concentrated’ HIV epidemic among IDUs (i.e. where HIV prevalence is above 5% in at least one at-risk population). There is a high prevalence of risky behaviours associated with HIV transmission among injecting drug users (IDUs).165

The highest HIV prevalence is among IDUs with an average of 7.1% of IDUs being HIV positive in three cities (Herat, Kabul and Mazar-e-Sharif) in 2009.166 The majority of IDUs are returnees and they reported that they had lived outside Afghanistan in the past 10 years.167

Drug users among the returnee population were more likely to have engaged in risky behaviour. They were more likely to have visited a commercial sex worker and where they did, visiting sex workers appeared to be a regular occurrence.168

155UNODC (2010)A national survey of drug use and associated high-risk behaviour across the prison population in Afghanistan, p. 3
156UNODC (2010)A national survey of drug use and associated high-risk behaviour across the prison population in Afghanistan, p.3
157UNODC (2010)A national survey of drug use and associated high-risk behaviour across the prison population in Afghanistan, p. 43
158John Hopkins University (2010), p. 29-30
159John Hopkins University (2010), p. 57
160World Bank (2008)
161National Aids Control Program (NACP) and MoPH
162John Hopkins University (2010), p. 57
164National Aids Control Program (NACP) and MoPH
There is no data currently available for overdose rates or overdose deaths. However, the MCN, MoPH, and the UNODC are working together on an information management system which aims to improve reporting systems to more reliably capture relevant drug demand reduction data.

3.2.6 Income sources of drug users

As per the 2009 MCN-UNODC National Drug Use Survey, most of the drug users supplement their income to buy drugs from selling assets or borrowing, followed by begging, theft and other crimes (Figure 3.2). More men engaged in borrowing and theft but there was a higher proportion of women that resorted to selling assets, begging and other crimes (i.e., crime other than theft - this is not to imply that borrowing is being categorized as a crime here). Some drug users also indicated having exchanged sexual services to obtain income for drug use.

Figure 3.2: Distribution of past month supplementary income of drug users by gender

Source: UNODC, Afghanistan Drug Use Survey 2009

3.2.7 Expenditure on drugs

On the whole, drug users are financially burdened by their addiction. To set the following amounts in context, in 2009, the average Gross National Income per capita in Afghanistan (based on purchasing power parity) was $1,080 - which gives an average daily income of just under USD 3.

Alcohol actually causes a significant financial burden, with alcohol users reporting to spend on average 321.77 Afghani (or USD 6.65 at the 2009 exchange rates) on alcohol every day. Heroin use causes thenext highest burden (107 Afghanis per day/USD 2.2), followed by opium (79 Afghanis/USD 1.6) and other opiates (74.15 Afghanis/USD 1.5). Overall, the 2009 survey estimates that drug users in Afghanistan spend on average just over 14.5 billion Afghanis (USD 300

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16UNODC, IOM and UNHCR (2011)
19All subsequent dollar estimates are given at the prevailing 2009 exchange rates when the research was conducted
million) on their drug habit every year. All drug users in the Southern region were spending less for drugs, especially heroin and opium as these drugs are cheaper in that region where most cultivation takes place. All drugs are more expensive in the Central region than in other regions.

_Figure 3.3: Average heroin, opium and cannabis expenditures per day by regions, 2009, per/Afghanis_
3.3 DRUG PREVENTION AND TREATMENT

3.3.1 Drug prevention

Information about drug prevention, drug use and its negative effects are communicated within the country through a range of channels. The MCN plays a key role through its Drug Prevention working group which meets to coordinate activities related to prevention. Under the recently published 2012 DDR Policy of MCN, prevention of drug use will be implemented by launching public awareness and educational programs via the Ministry of Counter Narcotics (MCN); Ministry of Education (MoE) Ministry of Higher Education (MoE); Ministry of Hajj and Religious Affairs (MoHRA); Ministry of Information, Culture and Youth Affairs; Ministry of Labour, Social Affairs, Martyrs and Disabled (MoLSAMD); Ministry of Women Affairs (MoWA); the Afghan National Security Forces; the National Olympic Committee; other sport boards; donors; the public and private sectors; and governmental and non-governmental organizations.

Interventions have focused on both prevention from drug use and prevention from relapse and include the following:

- **Treatment centers**: Awareness programs focused on drug use related harms are conducted by existing treatment centers in the country including through the organization of social events and gatherings, sensitization through outreach teams and sharing of information with drug users and their families within the centers. During 2012, an estimated 1,848,532 individuals have been reached through these activities.\(^{179}\)

- **School-based programs**: From 2005 to 2012, school-based prevention activities targeting both students and teachers were implemented as part of the Colombo Plan Drug Advisory Program funded by the Bureau of International Narcotics Law Enforcement Affairs (INL) and through the collaboration of Ministry of Counter Narcotics and Ministry of Education. These included sharing of information on drug related harms by conducting events in schools, dissemination of publications (books, brochures, banners etc.), inclusion of messages in school curriculum and the training of teachers. In 2012, workshops were organized for teachers of essential literacy courses, schools and Islamic Madrasas to enhance their knowledge and skills in teaching students about drug related harms and prevention. Some 1100 teachers were reached through this initiative.\(^{180}\)

- **Mosque-based programs**: From 2005 to 2012, drug prevention awareness programs have been implemented through mosques in 14 provinces through the Colombo Plan Drug Advisory Program in cooperation with MCN. Through their teachings, Mullah Imams\(^{181}\) share information on drug use related harms and also share publications which provide a religious perspective on drugs use in order to prevent such practice. A total of 23 Mullah Imams have received training inside and outside of the country during this program and 123,292 individuals have benefited in various parts of the country.\(^{182}\)

- **Youth congress programs**: Initiated in 2013 as part of the Colombo Plan Drug Advisory Program with coordination of MCN, the objective of these youth focused initiatives is to

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\(^{179}\)MCN DDR Department, 2012.

\(^{180}\)MCN DDR Department, 2012.

\(^{181}\)Mullah Imam meaning mosque scholar or preacher

\(^{182}\)MCN DDR Department, 2012.
inform the younger generation of the dangers of drugs through sporting, cultural and social events, with specific slogans and statements developed for the audience.  

- **Vocational training:** Implemented through drug treatment centers, vocational and technical training programs are designed to help those who have completed drug treatment from relapsing into use. In 2012, a 6 months pilot program was implemented in Kabul involving 400 drug users who had completed treatment. This program is ongoing.

### 3.3.2 Drug treatment services

Drug treatment services in Afghanistan are provided publically and privately. The MoPH administers the majority of treatment services in the country. The MCN takes a coordinating role, chairing the Drug Demand Reduction working group to discuss treatment issues, and through its multi-sectorial Drug Regulation Committee. The committee discusses issues related to procurement and certification of narcotic and psychotropic substances - for example, it would be their responsibility to approve whether OST (Opioid Substitution Therapy) can be used for drug treatment services.

There are an estimated 1260 clinical staff currently providing drug prevention and treatment services through UNODC-INL and MoPH in Afghanistan, from a range of backgrounds including medical doctors, nurses and social workers. UNODC provides joint training with Colombo Plan on all aspects of evidence based drug prevention, treatment and care. The MoPH also provide training to their drug treatment staff.

By the end of 2012, there were an estimated 102 drug treatment centres in Afghanistan in 28 provinces. Existing treatment centres provide a range of services (including outreach, outpatient, inpatient, and community-based treatment) across the country with total treatment capacity of around 20,800. This is a dramatic increase from 2009, when there were around 43 centres in 21 provinces. Still, current public treatment capacity is very low covering only 5.9% of opium and heroin users. Of the overall national annual health budget for 2011, only 1% was committed to DDR, which is equivalent to around USD 2 million.

A total of 315 beds are available in shelters provided mainly by MoPH and INL/UNODC. Overall, 76 of the programmes provide inpatient services and 32 provide outpatient services. Inpatients are admitted for a period ranging between 45 days to 6 months and they are provided with the following interventions: medication for detoxification, guided self-help groups, brief interventions, motivational interviewing and elements of cognitive behavioural therapy.

Outpatient services are available for a range of interventions, with services being offered for 8 hours a day, six days a week. Patients come at least two times a week for a six to twelve month period. The interventions offered can include the following: on-going psychosocial support,

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183MCN DDR Department, 2012.
184MCN DDR Department, 2012.
185The National Drug Control Strategy (NDCS) was published in 2006 by the MCN and sets out a comprehensive five year strategy for combating narcotics problems in the country, with activities arranged under four main priorities, one priority being “Reducing the demand for illicit drugs and treatment of problem drug users”.
186UNODC-INL and MoPH internal documentation
187MCN (2012) Master List of Treatment Centres in Afghanistan- this figure represents the theoretical maximum number of patients that could be in treatment at any one time.
188Ministry of Finance (2011), Annual report on National Budget Procedures Fiscal year
189MCN (2012) Master List of Treatment Centres in Afghanistan
relapse prevention, brief intervention, facilitation of self-help groups, social assistance, family reintegration services, and vocational training and aftercare services.

Table 3.3: Drug Treatment Services by Region

<table>
<thead>
<tr>
<th>Regions</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Outreach</th>
<th>Harm Reduction</th>
<th>Village Based</th>
<th>Community Based</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>23</td>
<td>14</td>
<td>28</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Eastern</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Northern</td>
<td>12</td>
<td>6</td>
<td>13</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Northern Eastern</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Southern</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Western</td>
<td>16</td>
<td>7</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>32</td>
<td>73</td>
<td>4</td>
<td>5</td>
<td>25</td>
<td>66</td>
</tr>
</tbody>
</table>

Source: Ministry of Counter Narcotics/DDR

There are a total of 73 outreach services available, where specific teams/individuals go to known drug using ‘hot-spots’, and individual’s homes and villages, to provide a range of interventions. This also includes increasing awareness around drug use, its associated risks and providing advice and information on the treatment services that are available.

As a treatment intervention, outreach will generally act as the first point of contact for many individuals to access scientific, evidence-based drug treatment. It is also an important way of reaching the ‘hidden’ populations most affected by drug use, often non-motivated to seek treatment or who have relapsed after a treatment program. Outreach services are particularly important to attract problematic drug users early and to establish contact with the population of people with severe disorders who may not seek treatment because of stigma and marginalization.

There are currently 5 village based drug treatment services operating in remote rural areas of Afghanistan providing much needed services to the remote populations. A key modality to the recovery of drug users is aftercare, where those who have recovered from drug use are assisted to re-integrate back into society. There are a total of 66 aftercare services which are essential to prevent relapse.

The central region has the most in-patient services with 23 and 14 out-patient services (Table 3.3). There are 28 outreach services available in the central region, 6 in the East, 13 in the North, 7 in the North Eastern, 4 in the South and 15 in the Western region. Outreach teams are generally affiliated to other treatment services and they will assist individuals in accessing treatment. In relation to harm reduction services the outreach teams will provide advice and information to drug users.

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190 Discussion paper on the principles of drug dependence treatment, WHO & UNODC, March 2008
Figure 3.4: Drug users and drug treatment services, by region

Source: MCN DDR Section
In terms of demographic coverage, there are 73 treatment programmes for males and 39 available for females. There are also 11 programmes for adolescent males and 9 for adolescent females. A total of 32 programmes are available for children.

One area that deserves specific analysis is the issue of relapsing into drug use following treatment courses. Relapse rates are especially useful as a metric of the overall efficacy of drug treatment - especially when considered as a continuum of care - and can even help explain the efficacy of specific intervention types. However, this data was not available from the MoPH at the time of writing; it is hoped that the MoPH’s nascent Health Management Information System (HMIS) will soon be able to capture such data to provide the opportunity for future analysis on relapse rates.

<table>
<thead>
<tr>
<th>Box 3.3: Definitions and modalities of drug treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment service</strong>: All components of drug treatment services, such as inpatient; outpatient; outreach; shelters; aftercare; are called treatment services.</td>
</tr>
<tr>
<td><strong>Inpatient/treatment centre (residential) services</strong>: Clients are admitted into a facility where they reside for the duration of their treatment.</td>
</tr>
<tr>
<td><strong>Outpatient services</strong>: Clients visit a facility one or more times a week for one or more hours, where they receive substance abuse treatment services.</td>
</tr>
<tr>
<td><strong>Harm reduction services</strong>: Interventions aimed at decreasing the harms associated with drug use, which are listed in the WHO/UNODC/UNAIDS Technical Guide. Harm reduction interventions in isolation do not constitute substance abuse treatment.</td>
</tr>
<tr>
<td><strong>Village-based services</strong>: Treatment services delivered in a rural setting, whereby drug treatment clinical staff from urban areas travel to villages and deliver outpatient services during a defined period of time. The unique model was developed for Afghanistan based on an adaptation of a rural-based treatment model from India.</td>
</tr>
<tr>
<td><strong>Community-based services</strong>: Centres serve as focal point for raising awareness in the community on dangers of drugs. Centres may provide a variety of services, such as prevention as well as referrals for drug users to access health services.</td>
</tr>
<tr>
<td><strong>Aftercare services</strong>: Post-treatment assistance, including relapse prevention and referral to other services.</td>
</tr>
<tr>
<td><strong>Shelter</strong>: Provides temporary housing, food and motivational counselling to refer drug users into treatment.</td>
</tr>
<tr>
<td><strong>Clinical staff</strong>: Individuals who provide some type of psychosocial counselling and support in a treatment setting.</td>
</tr>
<tr>
<td><strong>Home based treatment services</strong>: Clinical staff visit drug users in their home and provide individual and family counselling.</td>
</tr>
<tr>
<td><strong>Outreach services</strong>: Staff will conduct awareness activities in the community, which may include visiting areas of high drug use and motivating drug users to enter treatment. Outreach services in isolation do not constitute substance abuse treatment.</td>
</tr>
<tr>
<td><strong>Opioid Substitution Treatment (OST) services</strong>: Patients are typically administered opiate agonist treatment (such as methadone) to inhibit the desire to use drugs (see also Box3.4).</td>
</tr>
</tbody>
</table>

*Source: MCN DDR Section, Master List of Treatment Centres in Afghanistan, December 2012*
3.3.3 Drug treatment providers

Currently both residential and community based drug treatment centres are supported by several donors and implemented by national NGOs. All drug treatment supported and implemented by NGOs and the MoPH are free of charge. There are also a number of private drug treatment centres that are not supported by any donor funding that operate in Afghanistan, although the exact figure is not known due to their private nature.

The Ministry of Public Health (MoPH) is also involved in implementing drug treatment services and currently has introduced support treatment centres. It has also implemented drug treatment centres and has recently up scaled its involvement in drug treatment provision by taking over the former Jangalak drug treatment centre and turning it into a 300 patient capacity centre.

Drug prevention and treatment services in Afghanistan are also supported by a number of donors. The main donor responsible for drug prevention and treatment in Afghanistan is the US Bureau of International Narcotics and Law Enforcement Affairs (INL). The Governments of Japan, Germany, Sweden, Norway also support DDR activities.

The breakdown of international support to drug treatment programmes is as follows: 45 programmes are supported by INL, coordinated by the Colombo Plan and implemented by NGOs; 27 programmes are supported by INL, coordinated by UNODC and implemented by NGOs; six programmes are supported by the Government of Japan, coordinated by UNODC and implemented by NGOs; two programmes are supported by Caritas Germany; two are supported by Norwegian Church Aid; two by the World Bank; and 17 by the Ministry of Public Health.

Box 3.4: Opioid Substitution Treatment (OST)

In 2009, the MoPH signed a contract with the France-based NGO Medecins du Monde to implement a pilot project of methadone maintenance for injecting drug users in Kabul for a period of 24 months. The project started recruiting patients in early 2010. Although the program is still underway, it has faced two instances where its licenses to import methadone into the country have been withheld. In order to aid decision-making with respect to this challenge, WHO and MCN Drug Regulation Committee was requested by the MoPH to evaluate the project.

The results of the evaluation showed that the pilot project engaged about 60 injecting drug users in its first year of implementation (2010). The average daily dose of methadone has been about 120 mg per user. The retention rate within the programme has been 70% of patients for a six month period. The clients under methadone treatment have shown improvement in their social interaction including better family relations, social integration, and fewer instances of resorting to crime.

The program has been able to attain its goal in spite of running out of methadone stocks three times due to the import license issue. Some Afghanistan-based NGOs are now showing a tendency to offer OST as an additional service to their current drug treatment program. This WHO evaluation concludes that Opioid Substitution Treatment is beneficial in the context of Afghanistan.

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191 UNODC (2012) Continuation of Jangalak drug treatment Centre in Kabul for 2012: Concept Note
192 The Colombo Plan is a “regional intergovernmental organization for the furtherance of economic and social development of the region’s nations” which maintains a Drug Advisory Program. www.colombo-plan.org
3.3.4 Targeted interventions

Targeted interventions describe interventions aimed at specific groups within a drug using population (for example for women, children, IDUs, prisoners). Outreach is also a type of targeted intervention. Targeted interventions among high risk groups, including injecting drug users (IDUs), sex workers and truckers are ongoing in eight provinces reaching a total of around 5,500 IDUs in communities and prisons.\(^{194}\)

Drug treatment in prisons is part of the Prison Health Strategy of the Ministry of Public Health. The Prison Health Strategy will be rolled out in conjunction with the Basic Package of Healthcare Services (BPHS) to eventually cover all 34 provinces. However, the roll-out is still to begin. Drug treatment was offered in Kandahar prison through a UNODC project for a period of one year. The package of services for the prevention, treatment and care of HIV are being offered in Herat, Balkh, Kunduz, Badakhshan, Nangarhar, Ghazni and Kandahar. UNODC is providing the package of services for the prevention, treatment and care of HIV for female drug users in six female prisons in Kabul, Parwan, Hirat, Balkh, Nangarhar and Badakhshan (not including condoms\(^{195}\), Needle Syringe Exchange Programme and opiate agonist treatment).\(^{196}\)

Afghanistan carried out its first ever HIV surveillance study in partnership with Johns Hopkins University in 2010.\(^{197}\) In addition, there is an advocacy and communication strategy and campaign which includes informational, educational and communication materials. While the MCN has also established a working group on Harm Reduction among people who use drugs, the overall coordination of HIV/AIDS activities is done through the HIV/AIDS Coordination Committee of Afghanistan, which is chaired by the Minister of Public Health and is composed of the other technical working groups within the MOPH.\(^{198}\)

A recent pilot project supported by INL, coordinated by UNODC and implemented by local NGOs addresses the need of children in Afghanistan. The project has treatment services in 6 provinces, where a total of 2,417 clients were screened for drug use and drug dependence. Of these, 613 were admitted for in-patient, residential services. Among these, 297 were children, 94 were adolescent boys, 30 adolescent girls and 192 adult females. Clients were found to be addicted to different types of mood altering chemicals which include primarily opium, hashish and heroin. The project provides outreach, outpatient, in-patient or residential drug dependence treatment services and follow-up services for children living and working on the street, children at risk and living at home, children in orphanages and children involved with justice services. Children and families receive prevention services through the outreach and outpatient aspects of the program as well as structured education modules in the orphanages. Children and adolescents are screened and assessed in a scientific way to assess their psychosocial behaviours and are offered need based interventions. Assessment of the mentioned project will be carried out by technical team led by MCN at the end of project.\(^{199}\)

\(^{194}\) These results were published in 2010 - see John Hopkins University (2010)
\(^{195}\) According to the National Drug Demand Strategy, condoms will be provided to married users only
\(^{196}\) Information taken from UNODC-MoPH project documentation
\(^{197}\) These results were published in 2010 - see John Hopkins University (2010)
\(^{198}\) Information taken from UNODC-MoPH project documentation
\(^{199}\) Information taken from UNODC-MoPH project documentation
3.4 PILOT STUDY: DRUG DEPENDENCE TREATMENT

3.4.1 Background
This pilot study aims to explore key factors and challenges in availability and accessibility of treatment services for those with drug dependencies which is also one of 9 key pillars for the development of treatment services for Drug Use Disorders outlined in a WHO/UNODC joint discussion paper entitled ‘Principles of Drug Dependence Treatment’. The study was designed and implemented in close coordination and collaboration with the Drug Demand Reduction (DDR) departments of the Ministry of Counter Narcotics (MCN) and the Ministry of Public Health (MoPH).

Drug dependence is a recurring or relapsing condition; therefore, understanding access to treatment services is a crucial first step towards implementing measures aimed at reducing the incidence of relapse. The study is intended as a pilot study, to provide an initial and broad understanding about potential common issues in accessing drug treatment services in Afghanistan. In turn, this will better inform the implementation of the drug demand reduction component to the MoPH’s Health Management Information System (HMIS), and help lay the foundations for a nationwide database on drug treatment. It is envisaged that the HMIS will then be able to provide reliable nationwide data on treatment outcomes, paving the way for future valuable research on the most effective treatment outcomes in a specifically Afghan context. It also provides the platform for further studies to inform the Afghanistan Drug Report.

A total of six regional provinces (Kabul, Kandahar, Nangarhar, Mazar, Faizabad and Herat) were covered in the study where 161 semi-structured interviews were conducted as well as some focus group discussions with the following two different groups:

- **Group A:** 80 interviews were conducted with drug users who were accessing drug treatment at centres in six targeted provinces. Five of these treatment centres were run by the Ministry of Public Health (MoPH), three of them were funded by UNODC while the remaining two were private treatment centres. 56 interviews were conducted in MoPH treatment centres, 12 in UNODC funded treatment centres, 12 in private treatment centres.
- **Group B:** Another 81 interviews were conducted with drug users who were not accessing drug treatment, at the time of interview. A number of known ‘hot-spot’ drug using areas in each of the 6 provinces were targeted in the study.

The reason for including a respondent group of people not accessing drug treatment was to ascertain whether they had ever accessed treatment in the past and if so, whether the accessibility/availability of drugs had been influential in this regard and what determined cases of relapse into drug use.

It should also be noted that in the majority of questions, multiple responses could be given by the respondents where there was no issue of mutual exclusivity. Thus, many of the questions answered by a group will have a number of responses greater than the number of respondents in the group.

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200 UNODC and WHO ( 2008)
201 A ‘hot-spot’ in the context of this report refers to those specific locations where drug users informally gather to administer drugs. They are usually found in urban areas. However, it should be noted that drug use in rural areas is still considered a problem, and tackling drug use in urban hot-spots should not come at the detriment of tackling drug use in rural areas.
During the field work the survey team also collected eight case studies focusing on the social consequences of drug use and associated illicit employment. Fieldwork was undertaken in December 2012 following a day-long training of surveyors.

3.4.2 Socio-demographic information of respondents
Most of drug users interviewed during the pilot study (either accessing treatment or not accessing treatment) lived in urban areas (62.5% in respondents in each group); the remaining drug users who were interviewed resided in rural areas. The average age of participants from both groups was 29 years of age. All 161 participants in the study were male due to restrictions in recruiting a female surveyor. It was not deemed culturally or religiously appropriate to have male surveyors interviewing female drug users.

In terms of living conditions, 45% of participants interviewed who were currently accessing drug treatment were living in their own family home, and 40% lived in their parents’ house(Figure 3.5). The remaining respondents lived alone (9%) or less commonly with friends or relatives. There was only one reported instance of living homeless/living on the streets amongst those accessing treatment while 26% of those not accessing treatment were indeed homeless/living on the streets. This does not mean that any user not accessing treatment currently is more likely to be homeless than an individual accessing treatment. This is a reflection of the methodology used to find individuals not accessing treatment - by going to hot-spots to interview drug users found on the street, it is more likely that such individuals are also living on the streets.

The majority of drug users interviewed who are accessing treatment currently are married, with 47 out of 80 stating that they were married. In the case of those not currently accessing treatment, almost half (39 out of 81) are unmarried; twenty eight are married; while ten are divorced or separated as a consequence of drug use (none of the drug users interviewed currently accessing treatment are separated or divorced).

About half of respondent drug users who are accessing treatment currently have a regular job, about a third have casual work, while only about 14% of respondents in this category are unemployed. One third of drug users not currently accessing treatment are involved in casual work, and about a quarter are unemployed. Only 18 out of the 81 (about 22%) drug users in this group have regular employment. It should be noted from earlier in this chapter (see 3.2.6) that a general correlation has been observed between drug use and joblessness-although in the 2009 National Drug Use Survey, it was reported that “about 60 per cent of drug users interviewed stated that they were unemployed in the month prior to the interview”202, which is an apparently higher incidence of unemployment than for either of the groups in this study.

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More than half of drug users who are not currently accessing treatment did not go to school (44 out of 81), and 18 respondents in this group had between one and five years of education. Only two members of this group had higher education. A third of the drug users who are currently accessing treatment (25 out of 80) had between six and ten years of education, and another third had between one and five years of education. A sizeable proportion of respondents (25%) in this category did not go to school.

### 3.4.3 Factors determining seeking/not seeking treatment

Those currently accessing treatment (Group A) were asked to indicate the overall factors which were most influential in their seeking drug treatment. As illustrated in Figure 3.6, the most influential factor was deterioration of physical health, followed by pressure from family and/or friends; deterioration in mental health; and a wish to break free of the drug using lifestyle. Combined, these formed the clear majority all of the responses (around 80%) suggesting that many of the principal motivating factors among this group seem to be internal factors, where the respondent felt compelled to seek treatment to avoid personal harm. Therefore, these issues could be emphasized by outreach teams as key messages to encourage drug users to access treatment.

The greatest external stimulus for seeking treatment is clearly due to pressure felt by the respondent from family and friends. However, only 20% of responses given related to any other external factors, such as public awareness, contact by outreach teams or due to specific referrals. Very few of the reasons given for seeking to access treatment were attributed to contact with an outreach team and only one participant stated that he accessed drug treatment following referral by the police or a health facility.
Conversely, individuals in Group B (not currently accessing treatment) were asked why they had not stopped taking drugs or were not currently accessing treatment (Figure 3.7). The top two reasons provided were that the individual did not know that free treatment was available, or that they thought they could overcome the problem without treatment. A sizeable proportion of the reasons related to inability to afford private treatment or perceptions that treatment was unnecessary. Clearly, the (perceived) expense of accessing treatment is a major influence in attempting to access treatment. The fear of stigma associated with drug use and seeking treatment also prevented individuals from not accessing treatment. Anecdotal evidence suggests that malpractice in accessing treatment was a further hindrance.

Figure 3.6 - Influential factors for drug users to seek drug treatment, Group A (individuals currently accessing treatment)

Figure 3.7 - Reasons for not seeking treatment or not stopping drug use, Group B (individuals not currently accessing treatment)
3.4.4 Assistance to access treatment

Most commonly, where Group A respondents received help in accessing treatment, they were helped by their family members (55 of 103 responses), and to a lesser extent by their friends (19 of 87). Sixteen respondents stated other people helped them access treatment - 13 of those indicating that they did not receive help from anyone to access treatment, and of those, nine respondents did not mention any other source of assistance, indicating they decided to access treatment autonomously. Health workers accounted for less assistance than any of these parties in assisting access to treatment, with only ten respondents giving this response. This is in line with the low number of respondents naming outreach teams as an influential factor for accessing treatment. Tribal elders and teachers are considerably lower down the list of parties assisting access to treatment; none of the respondents indicated that either the police or religious figures had encouraged them to seek treatment.

Figure 3.8 - Key persons who helped drug users access treatment, Group A (individuals currently accessing treatment)

Similarly, among Group B, respondents identified family members (40 responses) and friends (19 responses) more frequently as the persons that had helped them access treatment. Some degree of help was also received by Group B respondents from health workers, mullahs/imams, tribal elders and the police.
It should be noted that often family members are required to vouch for a patient in order to secure admission to a treatment centre, and occasionally a community figure’s endorsement is required for an admission to be allowed (Box 3.5). Thus, when respondents frequently indicate that they were assisted by a family member - this might well have been a requirement of the treatment centre for them to obtain admission in the first place.

**Box 3.5: Treatment Centre Admission**

One of the treatment centre personnel interviewed in conjunction with this study gave the following insight into their admission procedures:

> "When we admit a drug user from our waiting list, we ask the user to come to the treatment centre with one of his relatives (mostly a father, brother or son) one month prior to the admission date, or the user must provide a suitable reference (such as from a government worker or a village elder) to guarantee that the admitted drug user will be available during the treatment period..."

> "... In some cases we prioritize self-motivated drug users for treatment rather than those drug users who are ... pressurized by their families (or those drug users who want to quit using on a temporary basis) - because when they are discharged from treatment centres, they will soon start taking drugs again"

**3.4.5 Treatment centre preferences**

From the above sections it is clear that the role of family and friends is critical in participants’ decisions in accessing drug treatment. For participants of this study currently accessing treatment (Group A), the main factor that led them to select the current treatment centre was encouragement or advice from family or friends. Equally important was the provision of treatment
free of charge. The privacy of the centre and the attitude of the centre’s staff were both considered (in 59 of a total 280 responses) to be fairly important reasons in choosing a particular treatment centre. This was followed by the centre having friendly and sympathetic staff, offering services that met users’ needs and being easy to physically access. The responses to this question also confirm a relatively low impact from outreach personnel in the selection of specific treatment centres (only 9 responses indicated outreach personnel were a reason for accessing that particular centre).

Figure 3.10- Reasons drug users decided to come to the treatment centre, Group A (individuals currently accessing treatment)

3.4.6 Trends in past access to treatment
Drug dependence is a chronically occurring condition of recurrence, or relapse. The number of times that a person has sought treatment is an indicator of relapse. In order to get insights into previous treatment experiences, the study examined whether respondents had tried to access treatment in the past and if so, how it went. In the case of Group A (those currently accessing treatment), 51% indicated that they had accessed drug treatment in the past (before their current treatment course). Amongst Group B respondents (those not currently accessing treatment), 48 respondents (59%) had tried to stop drug use in the past. The analysis below focuses on these two groups of respondents.

3.4.6.1 Number of past treatments
The majority of respondents from Group A had accessed treatment once in the past. Over a quarter had however accessed treatment three or more times. Indeed, 12% had tried to access treatment more than 5 times.
Among Group B, of the 48 respondents who decided to try and stop drug use, 29 of them had accessed treatment at least once, seven had accessed treatment twice, and four of them had accessed treatment three times or more. Interestingly, eight respondents who had indicated that they had wanted to try and stop using drugs in the past had never accessed treatment. In the interviews with these individuals, they stated problems (often financial concerns) had prevented them from accessing treatment even if they had wanted to.

Figure 3.11 - Number of times drug users accessed drug treatment in the past, Group A (individuals currently accessing treatment)

Figure 3.12 - Number of times drug users accessed drug treatment in the past, Group B (individuals not currently accessing treatment)
Mr. G. was born in Abdulkhalil village of Achin District (Nangarhar) and grew up in a family which had a long history of opium cultivation and trafficking. The family stopped opium cultivation when forced to migrate to Pakistan during the Soviet war. Whilst living in Pakistan, his father became a small-time trafficker from Peshawar city to Karachi city. Mr. G. was only in the 6th class when he decided to quit education in order to support his family in Pakistan, promising his younger brother that he would work to earn money for his brother’s education and to support him financially. At that time, the average wage for labour was 30 Pakistani Rupees (PKRs) a day, and for about three months he had regular work earning at this rate.

One day, one of his neighbours suggested he could earn more money within the same working hours, 50 PKRs per day. At the time, Mr. G. was overjoyed to hear this, little realising the miserable turn his life would take. The neighbour suggested he go to the Bajaur district of the North West Frontier Province (now known as Khyber Pakhtoonkhwa) to find work in drug processing factories. He, and other labourers, found work on their first visit and aside from receiving the 50 PKRs wages every day, they also received food, accommodation and clothing. Mr. G. considered the job a golden opportunity: here was a job which allowed him to meet his basic needs, and support an average-sized family. During this period he married, and was visiting his family once every two months.

However, from the outset, he could not figure out why his body ached soon after he returned to his family on these visits. He ignored it, putting it down to either a normal illness or from being tired from working so hard, and would take simple analgesic medicines. Over time, the body pain remained a consistent feature of his visits home, and it began to worry him more and more. He visited some local village doctors, and even went to some mullahs to receive blessings, but this did not help him either. Whenever he returned to his job, he felt normal. He began to think that this was some kind of black magic by the factory owner - done so that he would not lose his technical workers. This carried on for a total of 17 years; and all the time, Mr. G. could not work out the root cause of why he felt normal at work, yet would feel sick when he went home.

During the Taliban period, Mr. G. returned to his home village in Afghanistan. But he was not able to find any jobs in his village, and so adopted his old profession again - processing drugs in the many factories that were operating in the nearby villages. After the fall of the Taliban, these factories were closed down by the state law enforcement agencies and he lost his job - however, due to the mobile nature of the drug processing factories, he soon found work in other provinces. Mr. G.’s last job was in Badakhshan province, and again, during his family visits he began to feel very similar to how he had felt in Pakistan. One day Mr. G. felt strong body pain while travelling home on the bus, so he searched his belongings for some pain killers. Instead, he found some heroin in his pocket, left there unintentionally from work; but desperate to relieve the pain he decided to take some. As soon as he sniffed some heroin, he felt normal and his pain disappeared. This was the first time in 20 years that he realized he was addicted to drugs and that the body pain was not caused by exhaustion or black magic.

Over time with the current Afghan government, finding work in drug processing factories was becoming increasingly difficult. But Mr. G. was not able to do any physical work as by now he was a regular drug user. After losing his job in the drug factories, he was not able to access free and pure drugs anymore, and so he bought his drugs on the street. The poor quality of street drugs further worsened his physical and physiological condition. At this point his family realized that he had to enter drug treatment to stop his habit. For the last few months, Mr. G. has been attending the Health and Social Development Organization’s treatment centre and his condition is gradually improving, and he says he is very committed to quitting drug use. He now realizes that his job not only ruined his own life, but that such a job represents a threat to millions of other drug users and their families. He hopes that his case will convey a message to all Afghan people that cultivation of illicit crops, processing and trafficking is not only an individual crime, but also is a social crime which simply destroys the lives of millions.
Forty one respondents from Group A (currently accessing treatment) indicated they had accessed treatment previously. Those respondents from Group A who had accessed treatment in the past most commonly were treated as inpatients - 68% of the responses to this question indicated that inpatient treatment has been accessed previously. When looking at the overall percentage of individuals who had accessed this treatment modality, 36 of the 41 patients indicated previous residential treatment (85%). This is not surprising as this is the most commonly available treatment type in Afghanistan.

Home treatments were the next most common type of previously accessed treatment, with 8 out of 41 respondents (20%) indicating they had received home treatment in the past (representing 15% of the total responses to this question). No respondents indicated that they had undergone a village-based treatment program, or a program in a treatment camp. Treatments under an outpatient system, drop in centres, night shelters or other treatment systems (such as prison-based) were all equally less common than the top two modalities given by the respondents (each at around 4%-5% of the total responses given).

**Figure 3.13 - Types of treatment accessed by drug users during last treatment, Group A (individuals currently accessing treatment)**

Within Group B, the main type of treatment received in the past by the 48 respondents who had decided in the past to stop drug use but were not currently accessing treatment was inpatient, or residential treatment, with N=30 respondents indicating this was the last type of treatment accessed (or 63%, very similar to the responses of those currently accessing treatment - see Figure 3.13, above). Indeed, there is great similarity between the overall responses between this group and that of Group A, indicating that there is generally a commonality to treatment types in Afghanistan.

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Box 3.7: Comments on the Efficacy of Home Treatment

Both drug users and treatment centre staff agreed that inpatient treatment tends to be more effective than home-based treatment (and other types of open treatment approaches, such as camp-based treatment). During inpatient treatment, patients are under the care of treatment centre staff and find it more difficult to easily access drugs. In home-based and camp-based methods, drug users have much freer access to drugs and therefore the user is more vulnerable to relapse.
Afghanistan, with inpatient being the most popular type of treatment, followed by being treated at home and being treated as an outpatient (see Box 3.7).

One respondent indicated his last treatment was in a (Iranian) prison-based setting. Two of the respondents indicating they had undergone inpatient treatment initially described it as being similar to a prison-based treatment indicating their dissatisfaction with the standard of care they received at these centres (which were not specifically named).

Figure 3.14 - Type of treatment facilities accessed by drug users in the past, Group B (individuals not currently accessing treatment)

It was additionally discovered that many drug users were not complementary about home treatments, as they found that the communal atmosphere of inpatient centres greatly boosted their overall morale and their appetite to complete the treatment successfully (see Box 3.7).

Box 3.8: Procedures in Accessing Treatment - Comments from Treatment Centre Staff

“Some treatment centres use a questionnaire to categorise the applicants. On the basis of their responses about their history of drug use, users are scored by the treatment centre and appropriate treatment methods are recommended, such as inpatient or outpatient treatment.

“In the case of outpatient treatment, when a user is admitted we ask him to gradually decrease his normal drug dosage, and instruct him to visit the centre regularly - maybe every second day or at least two times a week. With each visit we ask him to reduce his dosage and record his weight in his file. If after about a month of this process we observe a weight gain then we are confident he has committed to his decision to stop using, as generally we observe that users who reduce their dose tend to put on weight.

“In the case of inpatient treatment, we start with the first phase which is detoxification. This is the most difficult part of the treatment and we would give the drug users pain relief medication in most cases, and substitute medicine in very rare cases. Once the detoxification phase has been completed, we move the patient to the rehabilitation room, where he becomes involved in social and physical activities.”
3.4.6.3 *Duration of stay at last treatment course*

At the centres visited in this study, the drug treatment courses that were offered lasted between 15 and 180 days. In the great majority of cases, drug treatment lasts - or is supposed to last - for longer than a month. However, it seems that often patients will not be able to last the duration of the treatment, as they succumb to the pain from detoxification or simply feel the urge to use drugs again. The following results indicate only the time spent by the individual at their last treatment course; they do not indicate if the course was actually completed (see the following section, 3.4.10).

In Group A, almost 85% of respondents (35 out of 41 drug users who accessed treatment facilities in past) had last spent one month or less in drug treatment centres. Only 7% had last spent two months in treatment centres, while the remaining 8% had last spent three or more than three months in treatment centres. One respondent could not remember how long he had last spent in a treatment centre.

*Figure 3.15 - Duration of drug users’ last stay in treatment centre, Group A (individuals currently accessing treatment)*

In Group B, of the 40 individuals who were not currently accessing treatment (but who had accessed treatment in the past), the majority of respondents (73%) had spent one month or less undergoing treatment at the last time of access. Comparison with the individuals who are currently accessing treatment (see Figure 3.15, above) indicates that there was more average time spent in a treatment course by individuals not currently accessing treatment. Twenty seven percent of the 40 individuals not currently accessing treatment had spent two months or more undergoing treatment during their last access, compared to 16% of the individuals currently accessing treatment.
These results imply that the majority of respondents only spent one month or less during previous attempts to stop using drugs. Due to the fact that many treatment courses are supposed to last more than a month, it can also be assessed that many individuals from both Group A and Group B did not manage to last the duration of their course. Certainly, exactly one third of respondents who had accessed treatment in the past (27 of the total 81 respondents from both groups) had only spent 10 days in their last treatment episode – and with treatments supposedly lasting at minimum 15 days, it appears these individuals did not complete their last treatment course. Only 16 of the total 81 respondents who had sought treatment in the past (20%) had been in treatment for two months or more during their last treatment episode. It is not possible to assess from these results whether shorter courses are more, or less, effective than long ones – these results simply show how long patients managed to last in their last treatment course. There is however some anecdotal evidence that patients think short courses are less effective.

3.4.6.4 Completion of Previous Treatment Course

The majority of respondents in Group A (N=26, or 63% of drug users who had accessed treatment in the past), had not completed their last treatment course. The other 15 individuals in this group (37%) who had accessed treatment in the past said they had completed their last treatment course. In line with the responses to the previous question, the majority of these 15 had completed shorter treatment courses – 13 of them had spent one month or less in their last treatment, which they claimed to have completed (see Figure 3.15). Obviously, the efficacy of their last treatment is under question if they are currently being treated again – relapse and short treatment courses coincide among this group.
Group A respondents were also asked for the reasons why they had not completed their last treatment course, if that was the case. The responses were varied; eight mentioned problems with the “medicine” or tablets given by the treatment centre, complaining of the expense or quality of the medicine. Two respondents indicated that their last treatment was curtailed due to their release from prison where they were undergoing treatment. At least two respondents complained about the treatment centre staff being inhospitable. One respondent claimed that the treatment centre had shut for Eid, forcing him back onto the street and into drug use.

Within Group B, about 90% (36 out of the 40 drug users who accessed to treatment in the past) did not complete their last treatment course successfully. Due to the limitations of this study, Group B respondents were not specifically asked about their reasons as to why they did not complete their last treatment course; instead, this study was more focused on this group’s reasons for never accessing treatment, or not deciding to stop using drugs (please see earlier, section 3.4.3, for the results to this question). However, it is clear from the results that more individuals currently not accessing treatment had not completed their last treatment course (if they had attempted one) than those individuals currently accessing treatment. Further research (with a larger, random sample) would be needed to answer the question as to why this is the case and substantiate this finding.

3.4.6.5 Main interventions in previous treatment course

Within Group A, according to 34 of the respondents (or 84% of respondents who had accessed treatment in the past), medicine for detoxification was the main service they received during their last course. The next most common service provided during the last treatment course was group counselling and HIV-harm reduction advice. At the other end of the spectrum, very few reported receiving aftercare as part of their last treatment course; and only 5 respondents mentioned any other type of treatment services outside of the list of responses (only one, for example, indicated receiving vocational training; and two respondents - both in Kandahar - claimed to have been beaten as part of their last treatment).
The treatment centres which were targeted by this study did not include any traditional treatment centres\(^{203}\), which can offer treatment courses based on hydrotherapy or other outmoded treatment approaches. Nevertheless, the surveyors of the study did obtain some testimony about the practices in these traditional treatment centres (see Box 3.9).

**Box 3.9: Traditional Treatment Centres**

There are number of traditional treatment centres - all of them private - in some parts of Afghanistan (such as in Kandahar and Herat), whose efficiency is not yet clear. Some are not even registered with Ministry of Public Health, and sometimes their treatment methodology is not approved - on either a national or international level - or even known. None of these types of centres were visited for this study; the following is anecdotal responses from the participants.

Respondents interviewed in this study spoke of a treatment centre in a rural area of Kandahar province which they described as just like a prison for drug users. Once the user has been admitted to the centre, he is allowed no contact from his family and is not allowed to leave the centre. The only treatment used in this centre is cold water showers (regardless of the season), with patients kept under cold water for hours. Reportedly, due to this harsh and forceful method of treatment, many patients escape from the treatment centre and soon relapse to drug use.

Conversely, other respondents spoke of a treatment centre in Herat which uses almost the same treatment method, called “\textit{AabDarmani wa Guftaar Darmani}” (“Treatment by Water and Speech”), and which is quite well known in the city. The surveyors reported that the treatment method at this centre was considered very efficient, and that patients were happy with its results. Water is used as pain relief, and speech therapy is used as part of the rehabilitation process, boosting the morale of the patients and helping them sustain their decision to quit drugs.

\(^{203}\) “Traditional” in this context refers to practices which are not scientifically recognised approaches to drug treatment (such as religious approaches) or approaches which are now considered outmoded (such as hydrotherapy or force/coercion).
In Group B, the two main types of intervention experienced by those respondents not accessing treatment currently but who had accessed treatment in the past were “advice and information” and “group counselling” (with 24 responses in each case). HIV harm reduction advice was the next most common type of intervention, while the prescription of medicines was the fourth most common response. The results to this question do seem to vary significantly from responses to the similar question asked to those accessing treatment currently: respondents in Group A indicated that their most frequently-encountered last type of intervention was medication.

*Figure 3.19 - Main intervention during last treatment course, Group B (individuals currently not accessing treatment)*

The design of this study is such that it is not possible to categorically state that there is a connection between medication and accessing treatment – this study was designed to answer questions about access to treatment, not to answer questions about treatment outcomes. Any apparent correlation between receiving medication and likelihood to relapse should be examined through a study which looks specifically into treatment outcomes.

In the case of both groups (individuals accessing and not accessing treatment), aftercare and family based interventions were the least frequent type of intervention during respondent's last treatment course. Aftercare is an important aspect for preventing relapse so the limited role of aftercare in respondent's last treatment course could possibly lead to higher rates of relapse. However, the factors that lead individuals to relapse into drug use including in relation to the role and effectiveness of aftercare services merits further investigation through future studies.

3.4.7 Type of contact by outreach teams

Drug users in both groups were asked if they had ever had contact with an outreach team. The responses from both groups were essentially the same, with around a quarter of each group indicating that they had been contacted by an outreach team, and the majority indicating that they had never been contacted. The fact that marginally more individuals not currently accessing treatment had received contact from an outreach team is in line with the living arrangements of
this group: with a higher incidence of homelessness, it is more likely that the areas in which these individuals reside were targeted by outreach teams.

*Figure 3.20 - Contact with outreach team Groups A and B (individuals accessing and not currently accessing treatment)*

As with the question relating to whether or not individuals had been contacted by an outreach team in the past, there was overall similarity between the two groups in their responses to the type of outreach contact they had received. These responses also corroborate the slightly higher incidence of contact with outreach teams by individuals not currently accessing treatment, with overall more responses received from those not accessing treatment (61 responses in total) than from those currently accessing treatment (52 responses in total).

The most common type of contact was an advisory one, with the most common type of advice received by both groups relating to advice on the harms and risks of drug taking, and advice on obtaining drug treatment. In both cases, the least frequently-encountered type of contact was the more practical type of contact, where the outreach teams either contacted a drug treatment centre on behalf of the individual, or escorted them to a treatment centre, or booked another appointment for the individual at a drug treatment centre.
In terms of the overall impact of outreach teams are still not that influential in the decision-making process of users accessing treatment. A user is far more likely to access treatment due to factors which are more proximate, such as deterioration in health conditions, pressure from his family, or due to the practical reasons of cost (with free treatment being clearly a very influential factor in deciding to access treatment). This was confirmed in a separate question which related to reasons why a respondent had not accessed treatment in the past, despite wanting to: the top answer was that they could not afford treatment (see below). In future, it will be important to assess the effectiveness of counseling programs, and based on the evidence, improve the efficacy of counseling to encourage drug addicts to access treatment through training counselors as well as field and document monitoring of the outreach programs.

3.4.8 Reasons for not seeking prior treatment

In both groups, there was great similarity in their reasons why they had not sought treatment in the past. The primary reason was that the respondent thought that they could not afford to pay for the treatment (treatment is free at public clinics). This reinforces the conclusion above that an important element in promoting drug treatment in Afghanistan is in terms of public awareness about the likely expense of seeking treatment, and that this could be a particular focus for outreach teams.
The low numbers of treatment centres compared to the number of users in Afghanistan does appear to have some impact on the decision of users to seek treatment. Both groups indicated as their second-most frequent response that when they had tried to access treatment previously, they had found the waiting lists to be too long. This might be a potential recommendation to outreach teams in the future: to assist potential patients in accessing a treatment centre that does have spare capacity or which has a shorter waiting list than others in the area.

The only significant variance in response to this question between the two groups was in terms of the privacy of the centre. More respondents currently accessing treatment found this an important factor than did those not currently accessing treatment - again, it would be suggested here that with more ties to family and friends because of less homelessness, those currently accessing treatment found the privacy of their treatment activities to be more important than the group which had less social standing to lose if they were identified as accessing drug treatment services.

Box 3.10: Availability of Space in Treatment Centres - Comments from Staff in a Kandahar Treatment Centre

“Our waiting list is excess of 3,200 names now, but our treatment capacity is about 200 to 250 patients per year. During the last five years we were able to treat about 1,300 drug users through both [inpatient and home-based] treatment methods.

“At the end of each quarter, when we start the process of admitting new drug users, some of the government officials and some highly influential people (such as members of provincial council, heads or members of tribal councils etc.) introduce and recommend patients for treatment - family members, friends and relatives - so we cannot admit the drug users from our waiting list. Sometimes there are very few beds left for the drug users on our waiting list.”
3.4.9 Main factors encouraging seeking treatment

Both sets of respondents were asked as the final question which factors had been influential in encouraging them to seek treatment (in the case of those currently accessing treatment) and which factors would be influential in deciding to access treatment (in the case of those not currently accessing treatment). These responses differ from those in 3.4.3 as both groups could give the same responses to the same question, allowing greater insight into the more general external factors that encourage drug users to seek treatment.

Looking at Figure 3.23 below, broadly speaking the influential factors in having sought or potentially seeking treatment are the same for both groups. Advice on drug harms is clearly an extremely important factor - but it is slightly more important for those currently accessing treatment (in 53 cases) than it is for those who are currently not accessing treatment (in 46 cases). For this latter group, a more decisive factor is that the service provided is free - with 49 responses from this group compared to 43 responses from the group currently accessing treatment.

*Figure 3.23 - Factors which are/would be influential for drug users to seek treatment*

As is expected, and as has been discussed already, it is somewhat to be expected that Group B was less influenced by family and friends than Group A, due to the demographic differences already explained. But what is unexpected, is that Group B claims in more instances than Group A...
that the privacy or discreetness of a treatment centre is important - when according to the responses as to why they had not accessed treatment in the past, privacy was about half as important to this group compared to the other (11 responses compared to 20). It might be the case that this was a more aspirational answer given to this final question by Group B; or it might be the case that the respondents desired to vary their responses from responses given to earlier similar questions. A more focused study with a wider scope would be required in order to comprehensively ascertain the extent to which privacy is an important factor. What is clear is that the concept of privacy, relative to the other responses, is a reasonably significant factor in respondents claiming what influences their seeking treatment.

Figure 3.23 provides important information on the factors which are important for drug users to access treatment. In doing so, it illustrates the kind of additional interventions that are needed while providing drug treatment services and points to issues that should be reflected in the communication interventions of outreach teams to more effectively convince drug users to access treatment. It further indicates the structure/type of treatment services in a drug treatment centre or treatment modality.

For both groups (those currently accessing and not accessing treatment), advice on drug harms was the most influential factor for accessing drug treatment followed by availability of free services, encouragement by family or friends, privacy, advice on drug treatment and knowledge on the location of treatment centers. These issues should form a key part of outreach team messages as well as counseling interventions in order to encourage drug users to access treatment. For example, the presence of free treatment services is a key factor of concern for drug users so outreach teams should consider this issue in their messages and communication with drug users. Similarly, privacy and discreetness is another concern for drug users seeking treatment so it would be important to convey to drug users that their treatment will be confidential. The other factors influencing drug users to access treatment should similarly be reflected in outreach team messaging and communication.

Other factors which were comparatively less significant for drug users as per figure 3.23 are also worth considering in the design of treatment modules and treatment planning. These include the following: opening hours of out-patient treatment centers, aftercare provision and diversity of treatment services and having someone at home to care for drug users family while they are in treatment.

3.4.10 Pilot study conclusions
This study focused on the first key principle for the development of services for the treatment of Drug Use Disorders, namely “Availability and Accessibility of Drug Dependence Treatment”. In particular, a desired focus was on outreach services and influential factors in users seeking treatment services. The study has revealed a number of trends with respect to drug dependence treatment:

- Amongst the respondents in this study, drug users currently not accessing treatment are more likely to be homeless than those users currently accessing treatment. It is also the case that, among the respondents in this study, drug users not currently accessing treatment are less likely to have as developed social support networks as those users currently accessing treatment. However, this observation might well be more related to
the mode of respondent recruitment\textsuperscript{204}, and hence to substantiate such a claim, a study with a larger sample size and a randomized method of respondent recruitment would be recommended.

- The role of family and friends is important in users seeking access to treatment. This is not only in the case of being an encouraging party to the user to seek treatment for drug dependency; it is also the case that in many cases, such people are required to vouch for the user in order for him to be able to obtain treatment. It may thus be effective for outreach teams to work with drug users' families and friends to convince drug users' to access the treatment.

- The perceived cost of accessing treatment is an important factor in users seeking treatment. Free services are crucial in motivating users to seek access to those services.

- The majority of respondents in the study have not had any contact with outreach teams; and where outreach teams have had contact with users, their most effective contact has been in an advisory role, and not so much in a practical role (such as escorting patients to available centres or making appointments on their behalf).

- Shorter treatment courses (one month or less) appear to be the norm in Afghanistan - the most common intervention being medicines to assist with detoxification, followed by group and individual counseling (or a combination of these with medicines). Relapse and HIV advice is offered less frequently as part of the package of interventions than are these previous intervention types. Anecdotal evidence indicates that many users do not consider treatment courses of less than one month to be effective.

- There is a shortage of treatment centre coverage. This shortage could be tackled a number of ways, and not only by attempting to increase the number of treatment centres; outreach teams could increasingly fulfill some of the roles performed by treatment centres.

3.5 CONCLUDING REMARKS

Overall the chapter highlights a number of issues within drug demand reduction in Afghanistan. The country’s one million drug users pose significant demands for drug use prevention and treatment which have so far not been met. Existing treatment services are able to address the needs of less than 5.9% of opium and heroin users implying the substantial need for more interventions in this respect. Even more pressing is the need for the monitoring and evaluation of prevention services, about which information is lacking. Encouragingly, the number of treatment centres and services has been on the rise through the concerted efforts of both governmental and non-governmental entities but there is still a long way to go if the impact of drug use is to be significantly reduced in the country.

The complementary pilot study undertaken for the purposes of this report has shed critical insights into the availability and accessibility of treatment services for drug users. Key factors encouraging drug users to access treatment included deterioration in physical and mental health as well as encouragement and advice from family and friends. A significant proportion of those involved in the study had undergone treatment 2 or 3 times in the past. The majority had undergone shorter treatment of a month or less in the past. Lack of knowledge regarding the

\textsuperscript{204}Namely, the respondents were found in known “hot-spots” for homeless drug users to congregate and take drugs.
availability of free treatment was a key factor preventing access to treatment and the expense of private treatment was a hindrance. Most had never been contacted by outreach teams and those who were more likely to receive advice rather than more concrete assistance (e.g. contacting treatment centres on behalf of users, escorting users to treatment centres etc.). In general, outreach teams did not appear to be influential in determining decisions to access treatment centres. Respondents indicated that advice on drug harms, free service, encouragement by family/friends, privacy and discreetness of centres would be influential in determining their decision to access treatment suggesting potential areas of focus for future interventions and programmes with respect to drug use and prevention.

The analysis in the chapter also points to some potential future areas of research including the following:

- effectiveness of different treatment services and duration of treatment courses;
- drug use amongst specific vulnerable groups such as children, women and prisoners;
- relapse rates and the efficiency of treatment modalities (i.e., further research into treatment outcomes);
- harmonization of service provision between implementing agencies, and between the government ministries overseeing the service provision;
- methods of enhancing knowledge and awareness amongst drug using populations regarding treatment centres and services; the efficacy of treatment courses as relates to the duration of the treatment;
- how to enhance the influence that outreach teams have on the (autonomous) decision by the user to access treatment;
- Develop and expand regional and international cooperation networks for drug demand reduction;
- The possibility of establishing a resource center for the coordination of studies and research on drug demand reduction;
- Develop a regular reporting system to improve the reporting on drug demand reduction - to include ensuring that the scope of the upcoming Health Management Information System (HMIS) is complete;
- methods to improve the tracking of drug prevention services;
- and ways to harmonize the reporting of future data between the solar year format and the Gregorian calendar.

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CHAPTER 4: LAW ENFORCEMENT AND CRIMINAL JUSTICE

4.1 INTRODUCTION

Law enforcement and criminal justice form key pillars of Counter Narcotics efforts in Afghanistan and their strength, capacity and effectiveness remain of great importance in the forthcoming transition period. This chapter will look at available data concerning narcotics related offences from the point of a crime being committed through the court system to conviction in order to highlight positive and negative trends as well as recommend potential areas for improvement.

The chapter starts by examining the policies and legal frameworks through which the Ministry of Counter Narcotics (MCN) and Ministry of Interior (MoI) use to monitor and report arrest of traffickers and seizure data. It then analyses some of the seizure data available followed by lab destructions and precursors finishing with data related to seizure arrests.

The second section of the chapter focuses on the criminal justice system. It looks at the role of the criminal justice task force and the data related to the Criminal Justice Task Force (CJTF) before looking at the three levels of Afghan courts; primary, appellate and the Supreme Court and counter narcotics case data related to these courts. This section also examines the issue of the threshold dividing minor and major crimes and looks at the debate to either raise or lower the threshold. The criminal justice section concludes by looking at imprisonment data in narcotics-related crimes for both adults and juveniles and analyses patterns in this data over several years.

The final section of the chapter is a study of the case management system for narcotics-related crimes within the country and looks at the process a case makes from the point of detection and arrest through conviction. This case study was undertaken with the idea that in order to initiate change in processes or in order to improve them, it is first important to understand the current system. The conclusion of the chapter presents recommendations for further studies based on the findings of this report and the areas where gaps were identified.

Throughout this chapter, the Hijri calendar is used as the majority of the data was received officially from the Government of Afghanistan counterparts. In the few instances where information was not available on the Hijri calendar, data is provided in the Gregorian calendar. Throughout the report, where the Hijri calendar dates are used, approximate Gregorian calendar dates are given for March of the equivalent year on the Gregorian calendar for ease of reference.
4.2 DRUG SEIZURES

4.2.1 Monitoring and reporting

The Ministry of Counter Narcotics monitors and evaluates the implementation of the Anti-Drug Trafficking Policy through its Law Enforcement Coordination Directorate. Since September 2012, an implementation monitoring mechanism has been put into place to monitor progress made by law enforcement agencies toward the goals set in the policy which relates to the arrest of low value, mid-value and high-value traffickers (Box 4.1). These agencies--CNPA, National Directorate of Security (NDS), the Afghanistan Border Police (ABP), the Ministry of Defense (MoD), the International Security Assistance Force (ISAF) and Customs--are all required to send updates on arrests (see Table 4.1), seizures (Table 4.2), destruction of drug laboratories and joint operations to the Counter Narcotics Police of Afghanistan and the Counter Narcotics Police of Afghanistan is

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**Box 4.1: Definition of low, mid, and high level traffickers in Afghanistan**

The MCN Anti-drug Trafficking Policy does not explicitly categorize the drug traffickers in Afghanistan, rather provides broad definition of the drug traffickers as highlighted below.

**Low-value traffickers**

Those who traffic due to lack of social opportunities, unemployment, and poverty. They normally traffic small amounts of drugs and sell in exchange for a small amount of money.

**Mid-value traffickers**

Generally don’t establish ties to terrorist groups because they traffic narcotics for their own personal profits and so they have a considerable role in the trafficking process.

**High-Value drug traffickers**

- Lead and control major narcotic trafficking activities and are members of organized drug trafficking groups-also referred to as major traffickers;
- Have a direct connection with serious international criminal groups and attempt to influence high ranking government officials in a direct or indirect manner;
- Often manage and control their networks from outside of Afghanistan;
- Have significant economic, technical and political and even military facilities;
- Manage to transport large quantities of drugs in and out of country;
- Can be further divided into two categories: (1) those linked to terrorist groups, (2) Profit motivated traffickers
- Based on the definition of drug traffickers as stated in the MCN policy, it is difficult to distinguish the low-value traffickers that have been caught for trafficking large amounts of illicit substances due to lack of social opportunity and poverty with the mid or high-value traffickers, and vice versa as there are no thresholds tied to these definitions. However, based on the policy, the law enforcement agencies in coordination with MCN have set the targets for arresting the three types of drug traffickers in the anti-drug trafficking implementation and monitoring mechanism, and the targets are revised through the Law Enforcement Working Group meetings on regular basis.

*Source: MCN (2012) Anti-Drug Trafficking Policy, p.15-18*
required to send its monthly updates to the Law Enforcement Coordination Directorate of the Ministry of Counter Narcotics. Based on these monthly updates, the Directorate prepares monthly progress reports on the implementation process and shares this within MCN and with other institutions and actors concerned with law enforcement and criminal justice. The Law Enforcement Coordination Directorate and the related law enforcement agencies also meet monthly to review progress and strategize on the way forward including setting targets for subsequent months.

Targets for seizures and arrests of traffickers (low-, mid-, and high-value) were designed to increase on a monthly basis since the start of the anti-drug trafficking implementation and monitoring mechanism. Since September 2012, reporting indicates that law enforcement agencies have been successfully meeting targets for several months. This is especially true in the case of high-value and low-value drug traffickers. Most of the arrests have been carried out by CNPA followed by NDS with the rest of the agencies reporting few if any.

The collective agencies have not been meeting the monthly targets set for arresting mid-value traffickers as compared to the other two categories of traffickers. The average monthly arrest over 7 months shows that low-value traffickers still account for most arrests at close to 156 arrests monthly with 42 and 36 average monthly arrests for high and mid-value drug traffickers respectively. According to CNPA Annual Report 1391, ten major traffickers those who were having links with international Mafia were arrested in 1391 (March 2012- March 2013).

The law enforcement agencies also set monthly targets for seizures of opiates, alcohol and precursors by volume in order to monitor progress towards targets related to seizures set out in the Anti-Drug Trafficking Policy. Assessment of achievements since September 2012 illustrate that with the exception of September, all monthly targets for opiates have been met. Seizures of alcohol were also met for most months except for two. Targets set for precursors however were not met for all months with the exception of January 2013. CNPA seizures accounted for most seizures on a monthly basis and also the bulk of the total seizures (89%). NDS and ABP were also to some extent active in seizing opiates and precursors.

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205 This reporting is specifically to monitor the Anti-drug trafficking policy and is different from the seizure reports submitted by CNPA to the Directorate.

Table 4.1: Monthly arrests for drug trafficking by LE agency (September 2012 - March 2013)

<table>
<thead>
<tr>
<th>Arrest</th>
<th>Months</th>
<th>Law Enforcement Agencies</th>
<th>Target (Total number for all agencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High-Value Drug Traffickers</td>
<td>Sep 2012</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>102</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>293</td>
<td></td>
</tr>
<tr>
<td>Mid-Value Drug Traffickers</td>
<td>Sep 2012</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>40</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>254</td>
<td></td>
</tr>
<tr>
<td>Low-Value Drug Traffickers</td>
<td>Sep 2012</td>
<td>69</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>176</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>141</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>160</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>178</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>270</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1091</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that ISAF HQ is not part of the Government of Afghanistan’s counter narcotics response. ISAF hands over any seizures/suspects captured as the result of an operation to the Government of Afghanistan along with any relevant information.
Table 4.2: Monthly seizure amounts by law enforcement agency (September 2012 - March 2013)

<table>
<thead>
<tr>
<th>Seizure</th>
<th>Months</th>
<th>Seizures by law enforcement agency</th>
<th>Target per Month (liters/kg)</th>
<th>Total (liters or kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>Sep 2012</td>
<td>4,748</td>
<td>155</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>31,923</td>
<td>1,614</td>
<td>356</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>77,782</td>
<td>9</td>
<td>625</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>18,258</td>
<td>110</td>
<td>2695</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>26,626</td>
<td>627</td>
<td>437</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>21,209</td>
<td>313</td>
<td>1437</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>28914</td>
<td>655</td>
<td>1047</td>
</tr>
<tr>
<td>Precursors</td>
<td>Sep 2012</td>
<td>4,222</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>2,321</td>
<td>810</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>22</td>
<td>324</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>530</td>
<td>592</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>15,649</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>5,007</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>1,044</td>
<td>0</td>
<td>450</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Sep 2012</td>
<td>61</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Oct 2012</td>
<td>2,466</td>
<td>0.3</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Nov 2012</td>
<td>2,603</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Dec 2012</td>
<td>1099</td>
<td>0</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Jan 2013</td>
<td>17460</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Feb 2013</td>
<td>2,440</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mar 2013</td>
<td>558</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN

208 It should be noted that ISAF HQ is not part of the Government of Afghanistan’s counter narcotics response. ISAF hands over any seizures/suspects captured as the result of an operation to the Government of Afghanistan along with any relevant information.
4.2.2 Monitoring seizures

Based on article 14 of the Law Against Intoxicating Drinks and Drugs and Their Control (2010), relevant government ministries and organizations are required to report seizures to the local CNPA. The local CNPA then reports to CNPA HQ in Kabul, which reports to the Law Enforcement Coordination Directorate of MCN. Therefore, in a reporting process which is independent from the “Anti-Drug Trafficking Reporting Mechanism” described above, the Law Enforcement Coordination Directorate of MCN also receives detailed information on all individual seizure cases including the substance, type, date, geographical location and seizing agency. The data also contains information on arrests, destruction of clandestine laboratories, eradication and casualties related to each seizure case.

The local offices of various law enforcement agencies report seizures to the respective local CNPA unit. The local CNPA unit then shares seizure data with the 34 Directorates of Counter Narcotics (DCN) and the Tactical Operations Center (TOC) in Kabul. The DCN in turn reports to the Provincial Affairs Directorate of MCN. The forensics lab of CNPA also receives samples from the local CNPA units to test the substances which are presumed to be illicit. The Tactical Operations Center also receives seizure information from ISAF. The Law Enforcement Coordination Directorate of MCN receives seizure data from both its own provincial directorates and the TOC. Most of the data is received in hard copy and is converted into electronic format at MCN. As planned by the MCN, going forward, this data will be incorporated into the Afghanistan Drug Reporting System, housed within the Research Directorate of the Ministry of Counter Narcotics (MCN). Figure 4.1 illustrates the flow of data from the ground to the Law Enforcement Directorate at MCN.

Figure 4.1: Flow of Seizure Reports to MCN

![Flow of Seizure Reports to MCN](image)

Source: Law Enforcement Coordination Directorate, MCN

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209 From this point onwards, the Law Against Intoxicating Drinks and Drugs and Their Control (2010) will be referred to as the CN Law.

210 It should be noted that ISAF HQ is not part of the Government of Afghanistan’s counter narcotics response. ISAF hands over any seizures/suspects captured as the result of an operation to the Government of Afghanistan along with any relevant information.
4.2.3 Drug seizures: cases and amounts

4.2.3.1 Major substances: Heroin, opium, hashish, morphine and alcohol

Since 1388, the number of seizure cases has been increasing (Figure 4.2). Between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), the following increases in the number of seizures were observed: heroin (250.4%), opium (212.6%), hashish (328%), morphine (88.9%) and alcohol (1900%).

Figure 4.2: Number of cases of illicit substance seizures, 1388 (March 2009- March 2010)-1391 (March 2012-March 2013)

Source: Law Enforcement Coordination Directorate, MCN

When considering amounts of substances seized in terms of total weight between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), there has been constant increase for all substances -heroin 200%, opium 496%, and the most significant increases were in amount of morphine, and hashish seized 883%, 785% respectively (Figure 4.3). However, from 1390 (March 2011-March 2012) to 1391 (March 2012-March 2013) the amount of heroin and hashish seized declined by 44% and 17 % respectively (Figure 4.3). This decline in seizures may be related to the opium crop failure in 2010. It is also possible that the decline in heroin seizures is tied to the manufacture of heroin outside Afghanistan. The amount of alcohol seized annually increased steadily from 1389 (March 2011) to 1391 (March 2013).
Morphine extraction is the first step in heroin production. In the past three years, both the number and amount of morphine seizures have increased. Half the morphine seizures weighed more than 29 kgs, with the largest recorded seizure weighing 21.2 tons. Relative to the small number of cases, the total sum of morphine seizures is substantial bringing the average amount seized per case to 980kgs.

At the same time, data shows that heroin is seized in smaller quantities than morphine and hashish. Although heroin seizures account for the highest number of cases, half of them were smaller than 0.04kg. These small quantity heroin seizures seem to be indicative of street-level seizures rather than from high value traffickers. In contrast, the case of opium and hashish, half the seizures weighed over 10.8kg and 2.5kg respectively.

These issues could be further studied by testing purity levels by location in samples seized and matching purity levels to trafficking routes to create a clearer picture of illegal substances and their routes in and out of Afghanistan.

4.2.3.2 Methamphetamine

The number of methamphetamine seizures samples tested by the CNPA forensics lab has been increasing since the first seizure in 2008, rising by 300% from 2011 to 2012. The first case of a methamphetamine seizure in Afghanistan, locally referred to as Shisha (“glass”), contained 4

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211 In this section, the data on the number of seizures was taken from the Forensic Lab, which maintains data on the Gregorian Calendar, where the weights of seizures by year is kept on the Hajiri calendar by the MCN Law Enforcement Coordination Directorate, thus the two figures can’t be compared precisely.

212 Counter Narcotics Police of Afghanistan/ Forensics Lab Unit (March 2013), Laboratory information Bulletin March 2013, page 5
grams of the drug. According to data from MCN LE Coordination Directorate, the number of methamphetamine seizures has increased since then, as illustrated in Table 4.3. Between 2010 and 2012 there were 17 seizures of methamphetamine primarily in the Western region. Between 2011 and 2012, the number of methamphetamine samples analyzed by the lab increased from 16 to 48 representing an increase of 300%, which further illustrates the growing occurrence of the drug in the country. In 2012, the forensics lab received 43 samples containing a total of 1,516 kg of methamphetamine representing the largest total annual seizure in this three year period. Seizures were from Herat, Farah, Faryab, Kandahar, Balkh and Kabul provinces, the largest of which was from Faryab province which contained 530 grams of methamphetamine and the second largest seizure was in Kandahar province comprising 240 grams of the drug. These represent significant increases as compared to the first seizure of 4 grams in 2008.

Table 4.3: Seizures of Crystal Methamphetamine “Shisha” (kg) by region 1388 (March 2009- March 2010)-1391 (March 2012- March 2013)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.00</td>
<td>0.00</td>
<td>0.059</td>
<td>0.00</td>
<td>0.059</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Northern</td>
<td>0.00</td>
<td>0.00</td>
<td>0.002</td>
<td>0.00</td>
<td>0.002</td>
</tr>
<tr>
<td>Southern</td>
<td>0.00</td>
<td>0.00</td>
<td>0.168</td>
<td>0.00</td>
<td>0.168</td>
</tr>
<tr>
<td>Western</td>
<td>0.04</td>
<td>0.011</td>
<td>2.36</td>
<td>0.118</td>
<td>2.529</td>
</tr>
<tr>
<td>Grand Total</td>
<td>0.04</td>
<td>0.011</td>
<td>2.589</td>
<td>0.118</td>
<td>2.758</td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN

Figure 4.4: Seizures of Crystal Methamphetamine “Shisha” (kg) by region 1388 (March 2009- March 2010)-1391 (March 2012-March 2013)

Source: Law Enforcement Coordination Directorate, MCN
Figure 4.4 shows crystal methamphetamine “shisha” seizures by region 1388 (March 2009-March 2010)- 1391 (March 2012- March 2013). It shows high methamphetamine seizures in the Western region followed by Southern, Central and Northern Regions.

Under the current Law Against Intoxicating Drinks and Drugs and their Control 213, the threshold for methamphetamine seizure is 50kg for it to be considered a major crime. Sentencing is inadequate to address the seriousness of the crime. Therefore, the tables should be revised in line with international conventions and sentencing guidelines in order for it to be in line with the threat posed by the substance.

In addition, further research should be done into the origins of the methamphetamine and patterns in the trafficking of the synthetic substances.

4.2.4 Geographical distribution of drug seizures

In terms of overall seizures (by weight) the highest figures are in the southern, western and northern provinces with Hilmand, Nimroz and Uruzgan reporting the greatest seizures. Figure 4.5 looks at the distribution of drug seizures across the country by region and by type of drug. Based on the amount of drugs seized the following can be understood.

- Heroin is being seized in Hirat, Nimroz and Hilmand but also in large quantities in eastern and central provinces like Kabul and Kapisa.
- Morphine seizures in Kabul are very low with seizures of morphine mainly occurring in the southern provinces of Kandahar and Hilmand but also in some eastern and northern provinces.
- Hashish seizures are predominant in central province of Paktika, Logar, Paktya, Khost, Parwan, and Panjshir, and the eastern and north-eastern provinces of Nangarhar and Takhar.

The high number of overall drug seizures in the south can be compared to the large amount of opium poppy being grown there, along with the high levels of insecurity and low levels of government access or control allowing the south to become an area where drug producers and traffickers can operate with little threat from government officials. High levels of morphine and heroin seizures in the south could also be tied to the proportionally large number of labs dismantled there as compared with the rest of the country, suggesting the highest percentage of production centers exist in the south. High levels of heroin seizures but few morphine seizures in Kabul (fourth largest among provinces) could suggest that Kabul is central to the country’s trafficking routes but not in production facilities. However, to better understand these patterns and in order to draw more conclusions, further research is required.

213 Official Gazette, Law Against Intoxicating Drinks and Drugs and Their Control (2010), Issue No: 1025, June 2010, (Dari), available online at: http://mcn.gov.af/Content/files/Drug.pdf, Articles 6, 18 (3), Table 2
Figure 4.5: Drug seizures amounts by region, 1388 (March 2009-March 2010)-1391 (March 2012-March 2013)

Table 4.4: Drug seizure cases by region, 1388 (March 2009-March 2010)-1391 (March 2012-March 2013)

<table>
<thead>
<tr>
<th>Region</th>
<th>Opium cases</th>
<th>Opium tons</th>
<th>Heroin cases</th>
<th>Heroin tons</th>
<th>Morphine cases</th>
<th>Morphine tons</th>
<th>Hashish cases</th>
<th>Hashish tons</th>
<th>Alcohol cases</th>
<th>Alcohol (1000 ltr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>203</td>
<td>6</td>
<td>553</td>
<td>6</td>
<td>47</td>
<td>4</td>
<td>575</td>
<td>75</td>
<td>107</td>
<td>26</td>
</tr>
<tr>
<td>Eastern</td>
<td>150</td>
<td>10</td>
<td>157</td>
<td>3</td>
<td>30</td>
<td>23</td>
<td>167</td>
<td>15</td>
<td>39</td>
<td>12</td>
</tr>
<tr>
<td>North-Eastern</td>
<td>117</td>
<td>7</td>
<td>148</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>124</td>
<td>36</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Northern</td>
<td>222</td>
<td>7</td>
<td>202</td>
<td>1</td>
<td>17</td>
<td>2</td>
<td>182</td>
<td>3</td>
<td>81</td>
<td>11</td>
</tr>
<tr>
<td>Southern</td>
<td>662</td>
<td>200</td>
<td>439</td>
<td>7</td>
<td>48</td>
<td>68</td>
<td>326</td>
<td>213</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Western</td>
<td>569</td>
<td>66</td>
<td>606</td>
<td>13</td>
<td>42</td>
<td>5</td>
<td>227</td>
<td>3</td>
<td>47</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>1923</td>
<td>295</td>
<td>2105</td>
<td>32</td>
<td>191</td>
<td>105</td>
<td>1601</td>
<td>345</td>
<td>338</td>
<td>81</td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN
4.2.5 Lab Destructions and precursors

4.2.5.1 Precursor seizures: Amounts

Seizures of liquid precursors increased by 170.2% from 1388 (March 2009-March 2010) to 1390 (March 2010-March 2011) but declined 63.2% in 1391 (March 2012-March 2013). Seizures of solid precursors also rose by 287.2% from 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013). The only precursor of all those tested by the forensic lab which is essential in the process of converting opium into morphine into heroin is acetic anhydride (see Box 4.2). Every other precursor described in the following section can be used in the process, but can also be substituted by other similar chemicals or omitted.

In 2012, the CNPA forensics laboratory analyzed the following solid precursors: ammonium chloride (total 15.4 tones), sodium carbonate (total 2 tones), along with smaller quantities of ammonium phosphate, calcium hydroxide, calcium oxide, calcium sulfate.

Calcium hydroxide, also known as slaked lime, or calcium oxide, also known as quick lime, is used in the extraction of morphine from raw opium. However, other substances containing lime can be substituted in this process if neither calcium hydroxide nor calcium oxide are available. Ammonium chloride, and sodium carbonate or calcium carbonate are also needed in the morphine production process.

Box 4.2: Precursors and Heroin Production

Acetic anhydride is the only precursor which is essential for heroin production and is a controlled substance\(^\text{214}\). Acetic anhydride is not produced in Afghanistan and is not used for any licit purposes and therefore must be smuggled into the country.\(^\text{215}\) For producing one kilogram pure heroin, about 1.5 litres of acetic anhydride is needed\(^\text{216}\). With 2.4 tons of acetic anhydride, approximately 1.6 tons heroin could be produced; for 1.6 which about 16 tons of opium are needed\(^\text{217}\). Sulfuric and hydrochloric acid are also controlled substances\(^\text{218}\). These two liquids are not essential, but can be used in the process to make heroin. Sulfuric acid is used in the purification process and makes the heroin soluble and hydrochloric acid is used to turn heroin base into heroin hydrochloride. Ammonia is not a controlled substance in Afghanistan\(^\text{219}\). It can be used in the process to convert opium into morphine or in the purification process to take it back to heroin base, but like sulfuric and hydrochloric acid are not essential to create heroin.

The liquid chemicals analyzed by the CNPA Forensics laboratory in 2012 included 2.4 tons of acetic anhydride, 18.4 tons of sulfuric acid\(^\text{220}\), 51.6 tons of hydrochloric acid, 2.8 tons of ammonia and also smaller quantities of acetic acid.

\(^\text{214}\) Official Gazette, Law Against Intoxicating Drinks and Drugs and Their Control (2010), Issue No: 1025, June 2010, (Dari), available online at: http://mcn.gov.af/Content/files/Drug.pdf; Regulation of Substances (Precursors) In Table 4

\(^\text{215}\) CNPA Forensic Laboratory Information Bulletin, LIB 1/2011, p5

\(^\text{216}\) For a detailed discussion see e.g. OS2011.

\(^\text{217}\) The current conversion ratio of 10:1 has been used. See e.g., MCN/UNODC (2011) Afghanistan Opium Survey 2011.

\(^\text{218}\) Official Gazette, Law Against Intoxicating Drinks and Drugs and Their Control (2010), Issue No: 1025, June 2010, (Dari), available online at: http://mcn.gov.af/Content/files/Drug.pdf; Regulation of Substances (Precursors), Table 4

\(^\text{219}\) Ibid

\(^\text{220}\) It should be noted that CNPA ties the seizures of sulfuric acid to making IEDs or other purposes other than the manufacture of heroin. Sulfuric acid can be used in the processing of both morphine and heroin—to make morphine sulphate and heroin sulphate instead of the morphine hydrochloride and heroin hydrochloride. It is included in this section for that reason. It seems unlikely that it is used for heroin manufacture in Afghanistan, but in order to prove this, further research needs to be done.
4.2.5.2 Geographical distribution of precursor seizures
The largest amounts of precursors are seized in the southern and eastern provinces both in terms of liquid and solid chemicals. This is not surprising as the majority of opium is produced and potentially processed to heroin in the Southern region. Seizures of precursors are much lower in Northern regions as compared with southern and western regions.

Further analysis of the exact type of chemicals seized in different provinces by the CNPA Forensics lab in Kabul provides interesting insights. Samples of precursors used for the production of heroin (acetic anhydride, hydrochloric acid, ammonium chloride and calcium oxide) were coming predominantly from seizures made in the southern and eastern regions further implying that heroin production takes place mainly in these areas or that it is being trafficked through these areas to bordering countries where it is then turned into heroin.

4.2.5.3 Lab destruction
As illustrated in Figure 4.7, most of the drug-processing labs destroyed nationally between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013) were located in the Southern region (68%) followed by the Eastern and North-eastern region (13%). Out of 128 drug-processing labs destroyed, 87 were in the southern region followed by 17 in North-eastern region, 16 in the eastern region, three in the western and central regions and two in the northern region.
4.2.5.4 Seizure of precursors and lab destruction
Looking at the number of labs discovered and destroyed, it is not possible to make any concrete conclusions due to the small number of labs dismantled. However, when considering the percentage of labs destroyed by region compared to the seizures of precursor chemicals, several hypotheses emerge for which further research would be recommended. Firstly, the largest percentage of labs destroyed (68%) and precursor chemicals seized were in the southern provinces. This is not surprising, as this is also where insecurity is high and government access and control is weak. Therefore, it would seem that not only is the southern region the highest producer of opium, but it is the largest manufacturer of heroin. Using the same figures to look at the northern and north-eastern regions, it would seem a lower proportion of labs destroyed (15%) and the smaller amount of precursor chemicals seized would indicate that less heroin production takes place in these regions. However, ultimately it is unclear how much heroin is produced in the country. The small number of labs dismantled suggests that the answer is not a lot of heroin is produced in Afghanistan. This is supported by the relatively low amounts of acetic anhydride seized. Therefore, further research should be done to determine the levels of heroin produced in country and where production is actually occurring.

4.2.6 Arrests and amounts of seized
Arrests for all cases, above and below the threshold, have been made for most seizure cases between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013). However, 22% of the seizures did not involve any arrests in 1391 (March 2012-March 2013). Most of those arrested were male Afghan nationals (7606) with far fewer females (43). Only 24 foreigners were arrested.
Table 4.5: Number and percentage of seizure cases with and without arrest by year and drug, 1388 (March 2009-March 2010)-1391 (March 2012-March 2013)

<table>
<thead>
<tr>
<th>Period</th>
<th>Arrest</th>
<th>Opium</th>
<th>Heroin</th>
<th>Morphine</th>
<th>Hashish</th>
<th>Alcohol</th>
<th>Sum</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1388 (March 2009-March 2010)</td>
<td>With arrest</td>
<td>186</td>
<td>208</td>
<td>8</td>
<td>124</td>
<td>6</td>
<td>532</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>Without arrest</td>
<td>61</td>
<td>28</td>
<td>10</td>
<td>37</td>
<td>2</td>
<td>138</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>247</td>
<td>236</td>
<td>18</td>
<td>161</td>
<td>8</td>
<td>670</td>
<td></td>
</tr>
<tr>
<td>1389 (March 2010-March 2011)</td>
<td>With arrest</td>
<td>306</td>
<td>405</td>
<td>93</td>
<td>249</td>
<td>33</td>
<td>1086</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>Without arrest</td>
<td>35</td>
<td>24</td>
<td>11</td>
<td>38</td>
<td>4</td>
<td>112</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>341</td>
<td>429</td>
<td>104</td>
<td>287</td>
<td>37</td>
<td>1198</td>
<td></td>
</tr>
<tr>
<td>1390 (March 2011-March 2012)</td>
<td>With arrest</td>
<td>441</td>
<td>554</td>
<td>29</td>
<td>364</td>
<td>110</td>
<td>1498</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Without arrest</td>
<td>122</td>
<td>61</td>
<td>7</td>
<td>100</td>
<td>24</td>
<td>314</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>563</td>
<td>615</td>
<td>36</td>
<td>464</td>
<td>134</td>
<td>1812</td>
<td></td>
</tr>
<tr>
<td>1391 (March 2012-March 2013)</td>
<td>With arrest</td>
<td>514</td>
<td>751</td>
<td>18</td>
<td>511</td>
<td>140</td>
<td>1934</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>Without arrest</td>
<td>258</td>
<td>76</td>
<td>16</td>
<td>178</td>
<td>20</td>
<td>548</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>772</td>
<td>827</td>
<td>34</td>
<td>689</td>
<td>160</td>
<td>2482</td>
<td></td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN

In terms of the geographical distribution of arrests, as illustrated in Figure 4.8, the majority of arrests for narcotics-related crimes took place in the central, western, and southern regions. Likewise the majority of cases at the CJTF for investigation and prosecution are from these same regions. This corresponds to the numbers of seizures in the same period of time, where most seizures took place in the Central, Southern and Western region.

Figure 4.8: Number of suspects arrested for narcotics-related crimes by region, 1388 (March 2009-March 2010)-1391 (March 2012-March 2013)

Source: Law Enforcement Coordination Directorate, MCN
4.3 CRIMINAL JUSTICE SYSTEM

4.3.1 Counter Narcotics and Intoxicant Law

The Ministry of Counter Narcotics (MCN) in coordination with relevant line ministries drafted the first Afghan Counter Narcotics and Intoxicant Law (2005) based on the article 7 of the Afghan Constitution to prevent the cultivation of opium poppy, cannabis plants, and coca bush, and the trafficking of narcotic drugs, and to control psychotropic substances, chemical precursors, and equipment used in manufacturing, producing, or processing of narcotic drugs and psychotropic substances.\(^\text{221}\)

The law consisted of fifty eight articles under eight chapters: general provisions, classification and regulation of drugs, licensing provisions, drug trafficking offenses and penalties, adjudication of drug-related offenses, techniques of search, seizure, and investigation, ministerial duties and responsibilities, and final provisions.\(^\text{222}\)

In June 2010, the Afghan Counter Narcotics and Intoxicant Law was amended. The updated law consists of five chapters with sixty eight articles, and was enacted by (158) the Afghan National Assembly in Act 158. The amended law, the “Law against Intoxicating Drinks and Drugs and Their Control” focuses on the following objectives\(^\text{223}\):

- To prevent the cultivation of opium poppy, cannabis plants, and coca and other narcotics plants
- To prevent the production, preparation, processing, purchase, sale, distribution, commissioning, import and export, transportation, supply, demand, storage, and concealment of any substances or compounds, which includes one of the substances in the Table 1, 2, and 3 of CN law
- To regulate and control narcotic drugs, psychotropic substances, chemical precursors, and substances and equipment used in the manufacture, production, or processing of narcotic drugs and psychotropic substances in order to prevent their use for illicit purposes and to ensure their use for medical, scientific, research and industrial purposes in accordance with the provisions of the law
- To prescribe the penalties for the convicts of drug and intoxicant related crime\(^\text{224}\)
- To establish coordination among the government and non-government organizations in the area of counter narcotics and intoxicants, and monitor and evaluate the implementation of National Drug Control Strategy
- To encourage farmers to cultivate licit crops instead of opium poppy, coca bush, and cannabis plants
- To attract the cooperation and assistance of national and international organizations in the task of combating cultivation, trafficking and use of narcotic drugs, psychotropic


\(^{222}\) Ibid


\(^{224}\) The term drug trafficking in the Law Against Intoxicating Drinks and Drugs and Their Control (2010) is specified as cultivation of seeds of drug producing plants or production, preparation, process, purchase, sell, keep, distribution, commissioning, import and export, transport, supply, demand, storage, and conceal of any substances or compounds, which includes one of the substances set forth in the Table 1, 2, and 3 of CN law.
substances, and the chemical precursors used in their production, manufacturing, and processing

4.3.2 Criminal Justice Task Force

Once an arrest has been made, cases equal to or above the threshold as designated by weight and substance are referred to CNPA headquarters in Kabul. Through the CNPA HQ, the cases are sent to CJTF. Those cases that are below the threshold are referred to the provincial level CNPA and then to the local AGO.

After the completion of an investigation by CJTF, cases are referred to CJTF’s primary court and then can go to appellate courts and eventually the country’s Supreme Court. The total number of incoming cases at the CJTF has been increasing continuously from 395 in 1388 (March 2009-March 2010) to 635 in 1390 (March 2011-March 2012) representing a significant rise of 61 %. Overall increases during this period were observed across all regions of the country. The Southern region accounts for the highest proportion of the incoming cases followed by the Western and Central regions.

Box 4.3: The Illicit Substance Threshold in Afghanistan

<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin, Morphine, Cocaine, or any mixture</td>
<td>2 kg</td>
</tr>
<tr>
<td>Opium or any mixture containing opium</td>
<td>10 kg</td>
</tr>
<tr>
<td>Hashish, methamphetamine or any mixture except with heroin, morphine, cocaine, and opium</td>
<td>50 kg</td>
</tr>
<tr>
<td>Alcohol and Precursors</td>
<td>50 liters</td>
</tr>
</tbody>
</table>

Throughout this chapter and the study which follows, cases are divided by whether or not they are above or below a threshold determined by weight and substance. This threshold determines which court a narcotics offence is referred to and whether it is tried on the provincial or national level. The definition of substances and weights can be found in the table above. Seizures equal to or above the threshold go to the Criminal Justice Task Force (CJTF) in Kabul, while seizures below the threshold are tried on the provincial level.

Source: Law Against Intoxicating Drinks and Drugs and Their Control, 2010

The increasing number of incoming cases is a positive trend with respect to the capacity of law enforcement agencies to arrest individuals for counter narcotics offenses. However, this does not account for the capacity of the CJTF to handle all the cases being transferred by CNPA. If the number of cases being referred to CJTF is increasing, so too should resources allocated to CJTF to handle these cases in a fair manner within the timeline designated.
Looking at CJTF incoming cases between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), most of the suspects are male with very few females whose numbers have been progressively declining (Table 4.6). The majority of the suspects were non-officials with a comparatively low number of officials. Interesting however, there was an increase in the
injection and prosecution of officials from 23 in 1388 (March 2009-March 2010) to 31 in 1390 (March 2011-March 2012) and again decreased to 20 in 1391 (March 2012-March 2013). Suspects who were not Afghan were few in number and declined from 21 in 1388 (March 2009-March 2010) to 12 in 1391 (March 2012-March 2013).

Table 4.6: Total number of suspects for narcotics-related crimes at the CJTF for Investigation and Prosecution per year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>487</td>
<td>628</td>
<td>811</td>
<td>667</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>502</td>
<td>631</td>
<td>817</td>
<td>669</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009-March 2010) to 1391(March 2012-March 2013), Kabul

When it comes to the total amount of drugs and intoxicants seized from suspects at the CJTF per year, the amount of heroin was much lower compared to other drugs. Morphine seizures from suspects registered an increase of 385% from 1388 (March 2009 to March 2010) to 1391 (March 2012-March 2013) again signaling its growing presence in the country and possibly signaling a shift in manufacturing trends whereby morphine is produced in Afghanistan, but heroin outside the country. Opium accounted for the largest in total weight of and was far higher than other illicit drugs.

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225 Employees of the Government of Afghanistan
226 Afghan nationals not employed by the Government of Afghanistan
Table 4.7: Total weight of seizures from suspects accused of narcotics-related crimes at the CJTF under Investigation and Prosecution

<table>
<thead>
<tr>
<th>Type of Substance</th>
<th>1388 (March 2009-March 2010)</th>
<th>1389 (March 2010-March 2011)</th>
<th>1390 (March 2011-March 2012)</th>
<th>1391 (March 2012-March 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>2.5 tons</td>
<td>9 tons</td>
<td>7 tons</td>
<td>4.11 tons</td>
</tr>
<tr>
<td>Morphine</td>
<td>7.5 tons</td>
<td>5 tons</td>
<td>37 tons</td>
<td>36.43 tons</td>
</tr>
<tr>
<td>Opium</td>
<td>59 tons</td>
<td>44.5 tons</td>
<td>60.5 tons</td>
<td>71.63 tons</td>
</tr>
<tr>
<td>Hashish</td>
<td>23 tons</td>
<td>93.5 tons</td>
<td>80.5 tons</td>
<td>120.52 tons</td>
</tr>
<tr>
<td>Solid Precursor</td>
<td>417 tons</td>
<td>34.5 tons</td>
<td>87.5 tons</td>
<td>43.90 tons</td>
</tr>
<tr>
<td>Liquid Precursor</td>
<td>40,000 liters</td>
<td>30,000 liters</td>
<td>55,500 liters</td>
<td>29,330 litres</td>
</tr>
<tr>
<td>Alcohol</td>
<td>N/A</td>
<td>44,350 liters</td>
<td>59,000 liters</td>
<td>42,780 litres</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009-March 2010) to 1391 (March 2012-March 2013), Kabul

After the completion of detection and arrestment by CNPA, narcotics cases are referred to CJTF for trial and prosecution. Figure 4.10 shows the total number of narcotics cases referred to CJTF Primary, Appeal and Supreme courts for trial and prosecution. Again, the number of cases being referred to these courts has been increasing between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013).

4.3.3 Afghan courts

Arrests involving seizures below the threshold are sent to Afghan Courts through the provincial level CNPA, Attorney General’s Office (AGO) and subsequently can be referred to primary and appellate courts (separate and different from CJTF’s primary and appellate courts). Subsequently, cases can also go to the Supreme Court. The following analysis uses data from CJTF (or those cases above the threshold) as data for those cases below the threshold is not available. However, the process followed by cases above and below the threshold is the same. In 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013), a total of 951 and 1406 cases went to Afghan courts respectively representing an increase of 47%.

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Weights are represented by year of prosecution, not necessarily year of seizure.
In terms of the type of narcotics and intoxicants cases sent to Afghan Courts for trial and prosecution, the highest numbers of cases are opium, followed by heroin and hashish (Figure 4.11). The increase in the number of morphine cases referred to CJTF (Figure 4.11) as well as the large growth in amount of tones seized from suspects (Table 4.7) again illustrates the significance of morphine as an illegal substance present in Afghanistan and something which should be closely monitored by the authorities as well as studied more closely in future research. According to Figure 4.10, in 1388 (March 2009-March 2010) and 1389 (March 2010-March 2011), more cases went to the Supreme Court than were referred to the Primary Court. This is unusual as the caseload should decrease as it moves to higher courts.

Figure 4.11: Number of narcotics cases referred to CJTF Courts by drug in 1389 (March 2010-March 2011) and 1390 (March 2011-March 2012)

Source: CJTF Annual Reports 1388 (March 2009-March 2010) to 1391 (March 2012-March 2013), Kabul
4.3.4 Primary court

Table 4.8 shows the total number of narcotics cases at the CJTF primary court by year, and by total number of convictions and acquittals. The number of suspects at the Primary Court level increased from 1388 (March 2009-March 2010) to 1391 (March 2012-March 2013), at the same time the number of acquittals decreased during the same period. It should be noted, that overall the number of acquittals when compared with convictions is very low.

Table 4.8: Total Number of narcotics cases at CJTF Primary Court (by convictions and acquittals)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Convictions</td>
<td>Acquittals</td>
<td>Convictions</td>
<td>Acquittals</td>
</tr>
<tr>
<td>Afghan Officials²²⁸</td>
<td>21</td>
<td>0</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>Afghan Non-Officials²²⁹</td>
<td>412</td>
<td>41</td>
<td>585</td>
<td>24</td>
</tr>
<tr>
<td>Foreigners</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>440</td>
<td>41</td>
<td>621</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009- March 2010) to 1391(March 2012-March 2013), Kabul

4.3.5 Court of Appeals

Table 4.10 shows the total number of CN cases heard at the CJTF Appellate Court level by year, and by total number of convictions and acquittals. As with the CN cases at the Primary Court level, the number of CN cases increased since 1388 (March 2009-March 2010), while the number of total number of acquittals decreased.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Convictions</td>
<td>Acquittals</td>
<td>Convictions</td>
<td>Acquittals</td>
</tr>
<tr>
<td>Male</td>
<td>432</td>
<td>41</td>
<td>616</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>440</td>
<td>41</td>
<td>621</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009- March 2010) to 1391(March 2012-March 2013), Kabul

²²⁸ Employees of the Government of Afghanistan
²²⁹ Afghan nationals not employed by the Government of Afghanistan
Table 4.1: Total Number of narcotics-related cases at the CJTF Appellate Court (by convictions and acquittals)

<table>
<thead>
<tr>
<th>Category</th>
<th>Convictions</th>
<th>Acquittals</th>
<th>Convictions</th>
<th>Acquittals</th>
<th>Convictions</th>
<th>Acquittals</th>
<th>Convictions</th>
<th>Acquittals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan Officials</td>
<td>35</td>
<td>6</td>
<td>39</td>
<td>3</td>
<td>35</td>
<td>2</td>
<td>37</td>
<td>1</td>
</tr>
<tr>
<td>Afghan Non-Officials</td>
<td>551</td>
<td>43</td>
<td>575</td>
<td>17</td>
<td>692</td>
<td>12</td>
<td>663</td>
<td>2</td>
</tr>
<tr>
<td>Foreigners</td>
<td>13</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>599</td>
<td>49</td>
<td>623</td>
<td>20</td>
<td>731</td>
<td>14</td>
<td>713</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009 - March 2010) to 1391 (March 2012 - March 2013), Kabul

Table 4.11: Total Number of narcotics-related cases at the CJTF Appellate Court Level by gender

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Convictions</td>
<td>Acquittals</td>
<td>Convictions</td>
<td>Acquittals</td>
</tr>
<tr>
<td>Male</td>
<td>594</td>
<td>48</td>
<td>617</td>
<td>19</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>599</td>
<td>49</td>
<td>623</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: CJTF Annual Reports 1388 (March 2009 - March 2010) to 1391 (March 2012 - March 2013), Kabul

4.3.6 Supreme Court

Figure 4.12 shows the total number of narcotics-related cases heard at the Supreme Court for by region and year. Overall, the number of cases heard seems to be rising steadily in all regions, apart from the southern region where the number of cases spiked in 1389 (March 2010 - March 2011). Most narcotics-related cases at the Supreme Court level are from the southern region followed by the western and central regions.

4.3.7 Thresholds of narcotics and intoxicants

There is an on-going policy discussion surrounding the thresholds of narcotics and intoxicants in Afghanistan, as established by the Law Against Intoxicating Drink and Drug as well as Controlling them. Cases below the threshold (as classified by substance in article 18 of the Law Against Intoxicating Drink and Drug as well as Controlling them) are dealt with at the provincial level, cases above the threshold are referred to the Criminal Justice Task Force (CJTF) in Kabul.

During the consultation workshops on the Afghanistan Drug Report (ADR) and the creation of Afghanistan Drug Reporting System (ADRS), participants raised the issue of the established thresholds. There is currently a debate in the Government of Afghanistan whether the thresholds

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230 Employees of the Government of Afghanistan
231 Afghan nationals not employed by the Government of Afghanistan
should be raised, meaning fewer cases would be referred to CJTF, whether the threshold should be lowered resulting in more cases sent to CJTF or whether the thresholds should remain as they are. The reasoning behind raising the threshold would be to lower the caseload for CJTF and to have only larger case seizures make it to the national level. Lowering the threshold would have the opposite effect, greatly increasing the caseload for CJTF but also preventing local-level corruption in the prosecution of cases.

The debate is one for high-level officials within the Government of Afghanistan however, it is clear that the capacity of CJTF must match the number of cases received by the organization. If the thresholds were to be lowered, allowing for more cases to be referred to CJTF at the national level, the staff capacity of CJTF must be raised to manage the new workload. If the thresholds were to be raised, allowing for more cases to be referred to related provincial AGOs and courts, which need that the capacity of provincial offices to be raised for fair and free An in depth discussion on the feasibility of amendment in article 18 of Law Against Intoxicating Drinks and Drug as well as Controlling them is beyond the scope of this report. However, the data available can be used for assessing the changes in the case loads for the CJTF for various threshold levels.
Figure 4.12: Number of Narcotics-related cases by region heard at the Supreme Court of Afghanistan
Table 4.12 shows the percentage of drug seizures based on the current illegal substance thresholds. It also illustrates how many cases seized are above or below the illegal substance threshold for various scenarios and how these percentages would change if the threshold was increased or decreased.

In the case of heroin the majority of seizures are smaller than the illicit substance threshold of 2kg, therefore a change in the threshold by 50% to 1kg would lead to an increase in major narcotics related cases by 11 per cent. Based on four years data as of 1388 (March 2009 - March 2010) to 1391 (March 2012 - March 2013), this would mean that the number of cases above the threshold increases from 493 to 546. For drugs that are seized in larger quantities, e.g. opium, a reduction of the threshold by 50% would lead to an increase of cases by 17%. For four year data as of 1388 (March 2009 - March 2010) to 1391 (March 2012 - March 2013, this would have implied an increase from 742 to 865 cases for the Criminal Justice Task Force.

Based on available seizure data, it can be concluded that only a significant change of the thresholds by more than 50% would lead to a substantial increase in cases for the CJTF. Minor changes of the threshold would not lead to a re-classification of a large proportion of CN cases.

Where heroin is concerned, it has to be stressed, that about 57% of the cases are smaller than 0.02 kg. Here, if all cases were handled by the CJTF, the case load would increase by more than four-fold.

Therefore, it seems that only a substantial change in the threshold would affect the overall number of cases sent to CJTF courts. Smaller changes may be a political signal but would not strongly affect the actual number of cases. Before deciding for a significant policy change there is a need to carefully consider the capacity of the CJTF courts, including the capacity of the agencies organizing the transport of suspects. Currently, CNPA is responsible for the transport of suspects between the provinces and the court in Kabul within 12 days of arrest for which they have an allocated budget (approximately 15-18 million Afghani or 300,000 USD - 360,000 USD per year). For the current year 1392 (March 2013 to March 2014), they have requested 18 million Afghani (or 360,000 USD), but yet they have not been allocated the requested amount.

232 This figure is calculated based on the average Afghani to USD exchange of 50 Afs to 1 USD
Table 4.12 Seizure data 1388 (March-2009 - March 2010) - 1391 (March 2012 - March 2013): Case load based on different hypothetical thresholds

<table>
<thead>
<tr>
<th>Substances</th>
<th>Threshold</th>
<th>Number of cases above threshold</th>
<th>Percentage increase of cases compared to threshold</th>
<th>Percentage of cases above threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>0.02</td>
<td>921</td>
<td>87%</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>0.3</td>
<td>623</td>
<td>26%</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>546</td>
<td>11%</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>493</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Opium</td>
<td>0.5</td>
<td>1124</td>
<td>51%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>995</td>
<td>34%</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>865</td>
<td>17%</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>742</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>Hashish</td>
<td>2</td>
<td>639</td>
<td>206%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>422</td>
<td>102%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>295</td>
<td>41%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>209</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>2</td>
<td>241</td>
<td>156%</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>173</td>
<td>84%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>132</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>94</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Precursor (Solid)</td>
<td>2</td>
<td>139</td>
<td>38%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>122</td>
<td>21%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>109</td>
<td>8%</td>
<td>69%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>101</td>
<td></td>
<td>64%</td>
</tr>
<tr>
<td>Precursor (Liquid)</td>
<td>2</td>
<td>124</td>
<td>59%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>109</td>
<td>40%</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>91</td>
<td>17%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>78</td>
<td></td>
<td>56%</td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN

To date, CNPA was given 3 million Afghanis (60,000 USD) by special permission of the Minister of Interior to transfer some suspects from the provinces to Kabul. This will not allow for a majority of suspects arrested this year to be brought to trial in Kabul unless further funds are allocated for transport. Therefore, any decisions to allow changes in the illicit substance threshold should be done with an assurance that there is a budget available to handle the associated costs with the change in threshold, such as transport of suspects.
Table 4.13: Total number of seizure cases 1388 (March 2009- March 2010)-1391 (March 2012-March 2013)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>2107</td>
</tr>
<tr>
<td>Morphine</td>
<td>192</td>
</tr>
<tr>
<td>Opium</td>
<td>1923</td>
</tr>
<tr>
<td>Hashish</td>
<td>1601</td>
</tr>
<tr>
<td>Alcohol</td>
<td>339</td>
</tr>
<tr>
<td>Precursor solid</td>
<td>241</td>
</tr>
<tr>
<td>Precursor liquid</td>
<td>178</td>
</tr>
</tbody>
</table>

Source: Law Enforcement Coordination Directorate, MCN

4.4 PRISONS AND JUVENILE REHABILITATION CENTERS
This section will provide a brief summary of the current structure and system of prisons, detention centers and Juvenile Rehabilitation Centers with a special focus on juveniles and adults detained and incarcerated for narcotics-related crimes. At the end of 1390 (early 2012), management and oversight of Detention Centers and Prisons was transferred from the Ministry of Justice (MoJ) to the Ministry of Interior (MoI) by Presidential Decree234 whereas oversight of the Juvenile Rehabilitation Centers remained under the Ministry of Justice.

There are three major adult prison centers, or national prisons, located at the central region in Kabul; Puli-e-charkhi Prison Center, Badam Bakh Kabul Female Detention and Prison Center and Counter Narcotics Detention Center (CNJC). As national prisons, they house prisoners transferred from all provinces. There are Prison and Detention Centers in 33 provinces, with Kabul having a separate Detention Center in addition to the national prison. There are Juvenile Rehabilitation Centers in 33 of the 34 provinces, with the Nooristan Juvenile Rehabilitation Center currently not operational.

4.4.1 Detention centers and prisons in Afghanistan
Based on the law on Prisons and Detention Centers, the General Directorate of Prisons and Detention Centers, or as it is more commonly referred to, the Central Prisons Directorate (CPD), under the Ministry of Interior (MoI) is responsible for administration and supervision of all national prisons and the provincial prisons and detention centers.235 Based on this law, the detention center is where accused individuals, or detainees, are held while awaiting trial. Those convicted, or sentenced prisoners, are then sent to provincial and national prisons.236

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233 This refers to the total number of cases in Afghanistan, both above and below the illicit substance threshold.
234 Legislative Decree No. 85, 17 December 2011
4.4.2 Current situation in Afghanistan
In general, the conditions in prisons and detention centers does not meet the minimum standards necessary for the prisoner’s safe, secure and humane accommodation as predicated by both national law and as further outlined in the Standard Minimum Rules for the Treatment of Prisoners. A majority of those detained or imprisoned suffer from high rates of overcrowding and a lack of space. As a consequence, the separation of pre-trial detainees from sentenced prisoner, which is codified in the Law of Prisons and Detention Centers, is not implemented in the majority of prison and detention centers.

Although the law further requires suitable conditions and treatment of prisoners and detainees based on Islamic values and UN minimum standards including as related to floor space, lighting, ventilation, heating and other basic conditions, the Government of Afghanistan should allocate more financial resources to prison construction, management, control and rehabilitation of the prisons and detention centers to ensure compliance with international norms and standards to which Afghanistan is a signatory. The basic needs of prisoners, including access to clean water and to washing and sanitary facilities, but also to better heated accommodation, are often not met. Health care services and rehabilitation-related activities, such as educational programs, are equally insufficient.

According to surveys conducted by UNODC and the Health Protection and Research Organization, drug use is a challenge in prisons and detention centers. For example, in Sarpoza Kandahar Prison, almost one-third of prisoners, or 290 out of 910, require treatment for drug use. The participants of consultation workshops organized by UNODC/MCN at national and regional level suggested treatment programs for drug users in prisons and detention centers, and suggested that the government should take action in keeping incarcerated drug traffickers separate from drug users. Similarly, the Anti-Drug trafficking Policy emphasized the need to avoid drug traffickers building links with other prisoners and to separate first-time offenders from repeat offenders.

4.4.3 Prisoners incarcerated for narcotics-related crimes
Based on the available Central Prisons Directorate (CPD) data, information on detainees/prisoners is not separated, therefore, the prisoner data presented here refers to both number of detainees and prisoners in custody. For the purposes of brevity, we will refer to them hereafter as the incarcerated.

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242 See more in UNODC (2010) A national survey of drugs and associated high-risk behavior in the prison population in Afghanistan
243 Drug Users Survey in Afghanistan, Sarpoza Prison Kandahar, UNODC, June 2010
244 Criminal Justice working group, Western region consultation workshop, Research project, UNODC, 30 May 2012, Herat, Tujarat Hotel, and other six regional consultation workshops.
In addition, CPD data does not allow for separation by offence, thus including offences related to possession as well as trafficking of illicit substances.

Figure 4.13 shows prisoners detained or imprisoned for narcotics-related crimes as of 1388 (March 2009-March 2010). The graph shows a slight increase in number between 1388 (March 2009-March 2010) and 1389 (March 2010-March 2011), but indicates a much larger increase between 1390 (March 2011-March 2012) and 1391 (March 2012-March 2013).

Figure 4.13: Number incarcerated for narcotics-related crimes in Afghan prisons from 1388 (March 2009-March 2010) - 1391 (March 2012-March 2013)

Source: Central Prisons Directorate (CPD)

Figure 4.14 shows the number of prisoners incarcerated for narcotics-related crimes compared to the total number of prisoners between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013). The figure demonstrates a steady increase in the total number of prisoners each year. The prisoners incarcerated for narcotics-related crimes accounts average 14% of total prisoners incarcerated in Afghanistan.
Overall, Figures 4.13 and 4.14 demonstrate that the increase in the number of those imprisoned for narcotics offences is increasing, but so is the total number of prisoners for all crimes, therefore conclusions cannot be drawn directly about the efforts of CN policies.

Figure 4.15 addresses prisoners incarcerated for narcotics-related crimes in Major Prison Centers located in the Kabul from 1388 (March 2009-March 2010) through 1391 (March 2012-March 2013). The figure shows an increase in the number of narcotics-related prisoners in 1389 (March 2010-March 2011) as compared to 1388 (March 2009-March 2010). The figure also shows a significant increase in narcotics-related prisoners as of 1390 (March 2011-March 2012) and 1391 (March 2012-March 2013) as compared with the previous two years.

Source: Central Prisons Directorate (CPD)
Figure 4.16 disaggregates prisoners incarcerated for narcotics-related crimes between 1388 (March 2009-March 2010) and 1391 (March 2012-March 2013) by region. The figure indicates the number of prisoners convicted for narcotics crimes are highest in the western region followed by the southern region, northern region, eastern region, north-eastern region with the fewest number found in the central region. This is interesting because the number of suspects arrested (Figure 4.8), is high at the central level, where those incarcerated is low suggesting that most suspects are acquitted. This could inconsistency could be due to the figures coming from two different sources, but is perhaps worth looking into. Over the period of 4 years, the most significant increase in the number of cases by year and the total number of cases countrywide happened in the western region.

Figure 4.16: Prisoners incarcerated for narcotics-related crimes in Afghan prisons compared by region from 1388 (March 2009- March 2010) through 1391 (March 2012- March 2013)

Source: Central Prisons Directorate

4.4.4 Juvenile Rehabilitation Centers (JRCs) in Afghanistan
The Juvenile Code “Procedural law for dealing with children in conflict with the law”, adopted in 2005, provides the key framework in reforming the Afghan Justice System to ensure children’s rights are protected within the Afghan justice system. Based on the Juvenile Code, those in conflict with the law under 18-years of age who committed any type of crime defined in Criminal Code of Afghanistan are called juveniles. Juvenile Rehabilitation Centers (JRC) are operational in 34 provinces of the country under the authority of Ministry of Justice (MoJ).

4.4.5 The current situation in Juvenile Rehabilitation Centers
The majority of JRCs are located in rented residential properties outside prison compounds. Conditions of most JRC’s is generally inadequate\textsuperscript{246}, and those detained suffer from lack of space, heating, recreational equipment and blankets, shoes and warm clothes in winter. Similarly, almost one third of those in juvenile facilities experienced symptoms consistent with post-traumatic

\textsuperscript{246} Justice for children in conflict with the law, a training manual for judges and prosecutors, UNODC, 2009
stress disorder. In addition, there is a lack of educational and recreational activities in JRCs and facilities lack basic education equipment like pens, books and other materials. In some cases, children are detained with adults in detention facilities.

### 4.4.6 Juveniles imprisoned for narcotics-related crimes

The data on juveniles presented here refers suspects/accused and convicted. Based on the JRCs data, the juveniles incarcerated for narcotics-related crimes have not been separated according to offence (trafficking/possession of heroin, morphine, opium, etc.). Data presented here refers to all types of drug-related crimes committed by juveniles from 1387 (March 2008-March 2009)-1391 (March 2012-March 2013).

**Figure 4.17: Number of Juveniles incarcerated for narcotics-related crimes as compared with total number of juveniles incarcerated**

![Bar chart showing the number of juveniles incarcerated for narcotics-related crimes and total juveniles from 2008-2013.](chart)

Source: Juveniles Rehabilitation Directorate/ Ministry of Justice

Figure 4.17 shows number of juveniles in JRCs from 1387 (March 2008-March 2009)-1391 (March 2012-March 2013). The figure shows a gradual increase in the total number of juveniles each year. The total number of juveniles in 1391 (March 2012-March 2013) is over double the total number of juveniles in 1387 (March 2008-March 2009). Although the number of juveniles incarcerated for narcotics-related crimes has increased, the increase is not quite as great as the increase for the total number of juveniles detained for overall crimes and still represents a fairly small percentage average (4.5%) of those incarcerated overall.

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Figure 4.18 shows narcotics-related juveniles detained by region from 1387 (March 2008-March 2009) through 1391 (March 2012-March 2013). The figure indicates that overall the number detained is highest in the western region followed by the Southern region, Central region, Eastern region, Northern region with the fewest detained in the North-eastern region. As was seen with the adult offenders, over the five year period, the Western region appears to have the largest problem with juveniles detained for narcotic-related offences.

4.5 CRIMINAL PROCEEDINGS AND NARCOTICS RELATED- CRIMES
This section will explore the multi-step process and procedures of case management as it pertains to narcotics-related crimes defined in the CN Law and the Interim Criminal Procedure Code (ICPC), in order to demonstrate the current practice of case management as it relates to narcotics cases in Afghanistan. It will also analyze the available narcotics case management dataset of the different stages with the aim of illustrating the challenges, strengths and weaknesses at each stage and provide recommendations to improve and strengthen the narcotics case management system in Afghanistan.

4.5.1 Law enforcement and criminal justice agencies
The overall responsibility for coordinating counter narcotics policy in Afghanistan lies with the Ministry of Counter Narcotics (MCN) while the Ministry of Interior (MoI) is the responsible party for
implementing policy (see Figure 4.19). The MCN was established to coordinate policymaking, monitoring and evaluation of all counter narcotics activities and efforts in Afghanistan. The MoI is the implementing agency for implementation of counter narcotics policies and strategies, and has a designated police force, the Counter Narcotics Police of Afghanistan (CNPA), which is mandated to deal with narcotics. The Ministry also created the position of Deputy Minister for Counter Narcotics to focus on issues of cultivation, production and trafficking of narcotics in Afghanistan. CNPA works under the Deputy Minister as the lead counter narcotics agency with specialized units at central and provincial level.

Figure 4.19: Institutional Framework for Law Enforcement

As the part of CN efforts in Afghanistan, law enforcement and criminal justice agencies are responsible for preventing opium cultivation, disrupting drug trafficking through arrest and prosecuting those who are involved in drug crime. As Article 3 of the Afghan Counter Narcotics and Intoxicants Law specifies those who cultivate, supply, process, sell or purchase, store, distribute, take commission, import or export, and use opiates are drug criminals.

In order to arrest and prosecute those suspected of drug-related crimes in Afghanistan, law enforcement and criminal justice agencies are involved in a multi-step process which starts from the point of detection and arrest, conviction and ends with imprisonment of the drug-related offenders. The Law Against Intoxicating Drinks and Drugs as well as Controlling them as well as the Interim Criminal Procedure Code (ICPC) define the role and responsibility of law enforcement.

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249 See more information on MCN, MoI and other agencies roles in Counter Narcotics efforts, Article 4 and 65 of the Counter Illicit Drug Law, Official Gazette, June 2010.
251 Counter Narcotics in Afghanistan, Civil-Military Fusion Center (CFC), August, 2012, page 50. www.cimicweb.org
252 Article 3, Law Against Intoxicating Drinks and Drugs and Their Control, Official Gazette, Issue No. 1025, 14th June 2010
and criminal justice institutions to avoid overlap in their efforts and activities, and to enable coordination and collaboration throughout the process.

Similarly, the goal of National Justice Sector Strategy of the Afghanistan National Development Strategy (ANDS) has been the establishment of an improved case management system (both manual and automated) to better coordinate the functions and activities of criminal justice institutions for improved oversight, monitoring and tracking of cases to ensure that a crime is promptly investigated, the accused are provided with prompt and fair trials, convicted persons serve their assigned sentences, and release happens once sentences are served.  

<table>
<thead>
<tr>
<th>Box 4.4: Law Enforcement Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A number of government agencies are involved in law enforcement efforts which include conducting interdiction missions to seize the illicit drugs, arresting drug traffickers and disrupting drug trafficking networks. All law enforcement agencies are required to share information on their activities and achievements to the Law Enforcement Coordination Directorate of MCN and CNPA on a monthly and annual basis. The roles and responsibilities of these agencies are elaborated below.</td>
</tr>
</tbody>
</table>

**Afghan National Police:** The primary responsibility of the Afghan National Police (ANP), which has four pillars (Afghan Uniform Civilian Police - AUP, Afghan National Civil Order Police, Afghan Border Police - ABP and Afghan Anti-Crime Police - AACP) is maintaining civil order and law enforcement, as outlined in the Afghanistan National Police Strategy. The police aim to actively combat crime and disorder (including terrorism and illegal armed activity); prevent the cultivation, production and smuggling of narcotics; fight corruption and ensure the sovereignty of the State and protect its borders.

**The Counter Narcotics Police of Afghanistan (CNPA):** As per the Afghanistan National Police Strategy, the CNPA is responsible for collecting intelligence and conducting investigations with respect to the cultivation, smuggling and illegal production of drugs. CNPA is also engaged with active detection, eradication operations, and interdiction of the flow of narcotics. In addition, arrests of drug traffickers and seizures of illicit drugs by any agency are referred to the CNPA which in turn refers narcotics cases to related criminal justice agencies for prosecution and trial. With 2985 personnel, it is the lead agency designated to fight narcotics and other illicit drugs.

**The Afghan Border Police (ABP):** The ABP is responsible for the security of the national border and the border security zone (50kms into the territory of the Afghanistan), as per the Afghanistan National Police Strategy. The ABP prevents the illegal smuggling of weapons, ammunition, goods, drugs, historical artifacts and humans. This includes individuals trafficking narcotics and other illicit substances. To date, there are only six counter narcotics police officers in the Afghanistan Border Police (ABP) nationwide. The Anti-drug Trafficking Policy recommends a massive increase of the Counter Narcotics Division of ABP to 1200 personnel nationwide.

**The Afghan Customs Police (ACP):** The ACP work to prevent crime and drug trafficking within the territory of the customs at major entry points throughout the country. According to Article 164 of Afghanistan Customs Law, the ACP are the part of MoI but managed jointly by the Ministry of Interior (MoI) and the Ministry of Finance (MoF) to prevent crimes against the Customs Law and the Counter Narcotics Law within the territory of customs. The Anti-drug Trafficking Policy emphasizes the coordination of the ABP and the ACP in countering narcotics efforts.

**Afghan National Army (ANA):** The Counter Narcotics Division of the Ministry of Defence (MoD) operates

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256 CNPA Tashkil structure, Meeting with Capacity Development Unit (CDU) office, CNPA, Kabul, 23 January 2013.
258 Chapter 8, Capacity development of CN institutions, Anti-Trafficking Policy, page 61, May 2012
with twelve counter narcotics specialists, three based in Kabul and the remaining nine working as counter narcotics focal points in each battalion “Qualwardo” located in the six regions of the country. Officers working within the “Qualwardo”’s coordinate CN efforts and refer arrest and seizure cases to the local CNPA. The Anti-drug Trafficking Policy also recommends the dedication of 3,000 to 5,000 soldiers in the ANA across four zones throughout the country to support the CNPA in transportation and logistics as well as interdiction missions.

The National Directorate of Security (NDS): The NDS is the intelligence agency of Afghanistan with its primary role being to gather information on anti-government activities and drug trafficking. As per article 65 of the Counter Narcotics Law, the NDS works to prevent criminal activities threatening national security by disrupting drug trafficking through seizure of illicit drugs and arresting drug traffickers or through passing intelligence to MoI/CNPA and MCN.

Box 4.5: Criminal Justice Agencies

The responsibility of upholding the rule of law with respect to counter narcotics in Afghanistan falls with criminal justice institutions. An overview of these institutions follows.

The Ministry of Justice (MoJ): The MoJ is responsible for ensuring the rule of law and for drafting, reviewing and proposing amendments in the law to be congruent with the Constitution, Islamic legal principles and international treaties to which Afghanistan is a party. It has 11 departments and 7,180 staff including 1,971 professionals, and has departments in provincial centers and offices in 365 districts of the country.

The Attorney General’s Office (AGO): The Office of the Attorney General, or “Loyi-Saranwali” was first established under the authority of the MoJ in 1967 later becoming an independent organ in the formal justice system of Afghanistan. The police report all criminal cases to AGO for investigation and prosecution including narcotics and intoxicants cases which are below the threshold as defined by the CN Law. According to Article one hundred and thirty four, Ch. 7, Art. 19 of the Constitution, AGO is part of executive branch and is independent in its performance of investigations and prosecutions. The office has four Deputy Attorneys, 23 Departments in the capital, 34 Appellate Departments in provinces, 365 Primary Attorney’s Offices in districts and communities, 45 Military Attorney’s Departments, 38 Attorneys Departments of The National Security’s Presidency, 2,500 attorneys and 2,000 administrative staff throughout Afghanistan.

The Criminal Justice Task Force (CJTF): The Criminal Justice Task Force (CJTF) is a specialized counter narcotics institution established in May 2005 to investigate and prosecute all narcotics and intoxicants cases which are above the threshold set in the Afghan Narcotics and Intoxicants Law (see Box 4.3). The task force consists of 28 prosecutors of the Attorney General’s Office (AGO), 50 investigators of the Anti-Drug Police, 64 administrative staff, and 156 civil servants. The CJTF is the first institution in Afghanistan which has seconded staff from the Supreme Court, the AGO, the MoI, and the Ministry of Justice (MoJ) in one location. The CJTF is located at the Counter Narcotics Justice Center (CNJC) which has a Central Narcotics Tribunal (CNT) and a detention center for 36 detainees. Due to the large amount of detainees a detention center with 150 person capacity is currently under construction. CJTF also has a police investigation unit and a semi-autonomous forensics laboratory.

261 Chapter 8, Capacity development of CN institutions, Anti-Trafficking Policy, page 61, May, 2012.
264 Ibid.
265 Law on Attorney General’s Office (Saranwali) of 1967, Official Gazette No. 73, 6 March 1967
266 Article One Hundred and Thirty Four, Ch. 7, Art. 19, the Constitution of Afghanistan 1382
268 Dufour, C and Kauffmann, D, Strategies to Counter Opiate Production in Afghanistan: Are we on the right track?, Urgence Rehabilitation Development, June 2010, p. 66
269 CJTF Annual Report, 2011
Box 4.6: The Supreme Court

The Supreme Court is the highest judicial organ comprised of eight justices and one Chief Justice, appointed for a period of ten years by the President with the approval of the lower house of the parliament. As per the Constitution, the Supreme Court is authorized to consider all cases filed by real or incorporeal persons, including the state, as plaintiffs or defendants, before the court. All cases including narcotics cases which have been challenged in the appellate court are referred to the Supreme Court for a final verdict, which is non-appealable. It contains four divisions (dewans); criminal, public security, civil and commercial. The court has 408 primary courts, 34 appeals courts and employs 6,126 judicial and administrative staff including 1,700 judges.

The Supreme Court is also authorized to review the laws, legislative decrees, international treaties as well as international covenants for their compliance with the Constitution and their interpretation in accordance with the law.

4.5.2 Criminal proceedings

In some materials, The Law Against Intoxicating Drinks and Drugs and Their Control supersedes the ICPC, and the Criminal Procedure Code of 1965 (amended in 1974) with respect to provisions relating to intoxicating drinks and drug offences. However, in case the Law Against Intoxicating Drinks and Drugs and Their Control lacks the required provisions related to a trial and penalty, the Interim Criminal Penal Code of 2004 is applied. The Law Against Intoxicating Drinks and Drugs and Their Control defines the offenses related to drug trafficking and sets out the procedure for investigating, prosecuting and adjudicating these cases. It also set up specialized law enforcement agencies and specialized jurisdiction.

Unlike other criminal cases which are investigated and prosecuted based on the ICPC, depending on the severity of narcotics and intoxicants crime, the cases go through two different investigation and prosecuting channels which are determined by the amount of illicit substances seized on the suspects in the state of flagrante delicto of narcotics or intoxicants crime. Article 18 of the Law Against Intoxicating Drinks and Drugs and Their Control sets a threshold for the narcotics and intoxicants cases which is illustrated in Box 4.3.

Law enforcement agencies are responsible for inspection and detection of drug trafficking and other related crimes, and are bound to compile a comprehensive arrest and seizure “Mahzar nama Form” report (which includes the name of agency at the point of arrest or seizure, details of seized substances, date, place, name of suspects, date of birth, address, signatures and photos of suspects, details of the situation at the point of arrest, and other necessary information), and will have to refer it to the provincial CNPA officials. The weight of the substance is taken at the point of detection. If the case is below the designated threshold, after completing the investigation the provincial CNPA officials are to report the case to the Primary Prosecutor of

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270 The Supreme Court is illustrated in box 4.6 because it is an independent body, which can have narcotics-related cases referred to it but is not part of CJTF and is not a criminal justice agency.
271 Article 120, the Afghan Constitution 2004
273 Article 121, the Afghan Constitution 2004
274 Article 1,2, Law Against Intoxicating Drinks and Drugs and Their Control, Official Gazette, Issue No. 1025, 14th June 2010
275 The perpetrator who is caught during or after the commission of crime
276 Article 18, Law Against Intoxicating Drinks and Drugs and Their Control, Official Gazette, Issue No. 1025, 14th June 2010
277 Ibid, article 15
province within 72 hours.\textsuperscript{278} Whereas for cases which are equal or above threshold, the provincial CNPA officials are supposed to transfer the suspects along with the seized substances and evidence to CNPA Headquarters within 12 days.\textsuperscript{279}

**Box 4.7: Structure of the CNPA**

Being the largest and primary policy force tasked with counter narcotics, the CNPA is the law enforcement agency. The following are the key elements of the CNPA:

- **Directorates:** The CNPA has four main directorates namely, general, central, provincial and special unit Directorates.

- **Special Investigation Units:** The CNPA established three elite investigation units namely the National Interdiction Unit with capacity of 58 law enforcement officers\textsuperscript{280} which conducts interdiction raids and seizures across Afghanistan, the Sensitive Investigation Unit with capacity of 23 law enforcement officers\textsuperscript{281} which gathers evidence and develops the case for narcotics investigations, and the Information and Investigation Unit with capacity of 21 law enforcement officers\textsuperscript{282} which develops intelligence used by the unit.

- **Tactical Operation Center (TOC):** responsible for coordinating daily CNPA activities among the provincial offices, specialized units and the headquarters.\textsuperscript{284} The TOC produces materials to support counter narcotics operations, including the development of procedures to satisfy operational requirements\textsuperscript{285}

- **CNPA Development Unit:** with a capacity of 10 staff (4 international and 6 national), is responsible for coordinating capacity-building activities and preventing repetition by which different organizations supporting CN efforts in the preparation of CNPA/MoI for the transition of 2014. The CDU also supports CNPA/MoI in the preparation of the Ministerial Development Plan based on the National Police Strategy and National Police Priorities and supports CNPA in the formulation of policies and guidelines\textsuperscript{286}

- **The Laboratory:** The Laboratory Department with a capacity of 10 staff is responsible for examining and analyzing a variety of seized narcotic drugs including opium, morphine, heroin, cannabis products, and precursor materials, adulterants and cutting agents pursuant to Afghan law.\textsuperscript{287}

As the officials of CNPA Headquarters receive the suspects along with the seized substance(s), they weigh the illicit substances and take a sample of each substance to check the type of substance at the Forensic Laboratory. Once the laboratory sends the result, CNPA officials are to complete the investigation within 72 hours and should transfer the suspects along with the

\textsuperscript{278} Article 14, section 2, and 5 of the Law Against Intoxicating Drinks and Drugs and Their Control, Official Gazette, Issue No. 1025, 14\textsuperscript{th} June 2010

\textsuperscript{279} Ibid

\textsuperscript{280} CNPA Tashkil structure, Meeting with Capacity Development Unit (CDU) office, CNPA, Kabul, 23 January 2013.

\textsuperscript{281} CNPA Tashkil structure, Meeting with Capacity Development Unit (CDU) office, CNPA, Kabul, 23 January 2013.

\textsuperscript{282} CNPA Tashkil structure, Meeting with Capacity Development Unit (CDU) office, CNPA, Kabul, 23 January 2013.

\textsuperscript{283} Counter Narcotics in Afghanistan, Civil-Military Fusion Center (CFC), August, 2012, page 51. www.cimicweb.org


\textsuperscript{286} CNPA Tashkil structure, Meeting with Capacity Development Unit (CDU) office, CNPA, Kabul, 23 January 2013.

substances to CJTF. After taking photos of the seized substances, re-weighting and comparing the substances with the samples, prosecutors of the CJTF keep the samples and the results as evidence, and request the destruction of seized substances which is done in the presence of representatives from the MCN, CNPA, and AGO/CJTF. CJTF prosecutors are bound to complete investigation of a case within 15 days, and if the investigation requires more time due to technical problems during the collection of evidence or in lack of cooperation of a suspect(s) during the interrogation, the investigation period can be extended for another 15 days. CJTF prosecutors shall complete the investigation within one month and refer the case to Primary Court for trial; meanwhile, suspect(s) are kept at the Detention Center at CJTF.

**Figure 4.20: The Flow of Counter Narcotics cases in Afghanistan**

The timeframe for the trial proceedings of the cases below and above the threshold are the same whereas the latter is proceeded at the Primary and Appeal Courts of the CJTF called the “Counter Narcotics Tribunal” and the former is led by the Primary and Appeal Courts of the province where the case was detected (Figure 4.20).

As CJTF prosecutors refer a case to the Primary Court, the Primary Court is bound to conduct a fair trial within two months and provide a verdict with its reasons. If a suspect is found innocent,

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288 Ibid, article 16  
289 Ibid, article 16, section 4,5  
290 Article 5, the Interim Criminal Procedure Code for Courts, 2004  
291 Article 36, the Interim Criminal Procedure Code for Courts, 2004  
292 Article 18, section 3, 4, 5, 6 of the Law Against Intoxicating Drinks and Drugs as well as controlling them, Official Gazette, Issue No. 1025, 14th June 2010, also see article 42 of the Interim Criminal Code for Courts, 2004
they are to be released. If found guilty, suspects have the right to appeal against the decision of the Primary Court by submitting an application to the Appellate Court within 15 days. If the Court of Appeals deems that the activities accomplished in the previous procedure were insufficient in making a sound decision, it conducts a hearing to provide a verdict for either an order of arrest or release.\textsuperscript{293}

Figure 4.21: The stages of a CN Case

<table>
<thead>
<tr>
<th>Suspect Location</th>
<th>Pre-Arrest and Detection</th>
<th>Arrest</th>
<th>Detention and Imprisonment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Diagram</strong></td>
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<tr>
<td><strong>Stage (Max Time)</strong></td>
<td>Monitoring (Ongoing)</td>
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<tr>
<td></td>
<td>Investigation (3 days)</td>
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<tr>
<td></td>
<td>Investigation &amp; Interrogation (15+15 days)</td>
<td></td>
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<tr>
<td></td>
<td>Primary Trial (2 Months)</td>
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<tr>
<td></td>
<td>Appellate (2 Months)</td>
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<tr>
<td></td>
<td>Cassation (5 Months)</td>
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<tr>
<td></td>
<td>Prison and/or Fine</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>(0-3mo, 3mo-5yrs, 5-20yrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Institution</strong></td>
<td>CNPA, ANP, NDS, ANA, ABP, Custom Police</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>AGO, CJTF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Court</td>
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</tr>
<tr>
<td></td>
<td>Appellate Court</td>
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<tr>
<td></td>
<td>Supreme Court</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ministry of Interior Central Prisons Directorate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the suspect contests the decision of the Appellate Court, they then submit their application to reverse the decision within one month, and if Supreme Court considers the application, the court will conduct a hearing within five months to produce a verdict which will be final and non-contestable. After the trial, if the Supreme court finds the suspect innocent, it orders the release of the suspects. On the other hand, if the suspect is convicted, the court declares the penalty and punishment as a sentence of imprisonment, and transfers the suspect to the Central Prison Directorate which controls all prison facilities in Afghanistan.\textsuperscript{294} Those convicted of narcotic and intoxicant crimes under eighteen years of age, are tried in the normal court of law but detained or serve sentences at a Juvenile Rehabilitation Center.

Throughout the legal process, the suspect has the right to legal representation by defense lawyers, fair trial, access to witnesses, and an adequate notification in advance of each proceeding. While detained or imprisoned, the suspect and the accused shall not be subjected to intimidation or any form of physical or psychological pressure, and has certain rights and privileges in detention based on the international conventions to which Afghanistan is a signatory.\textsuperscript{295}

The timeframe of narcotics and intoxicant cases below the threshold from the point of detection to imprisonment (if the case goes all through supreme court) lasts ten months, whereas the cases

\textsuperscript{293} Ibid, see Article 52 of Interim Criminal Code for Courts, 2004
\textsuperscript{294} Ibid, see Article 72 to 83 of Interim Criminal Code for Courts, 2004
\textsuperscript{295} Article 5 and 18 of Interim Criminal Code for Courts, 2004
above the threshold last ten months and twelve days, the twelve days are dedicated for the transportation of suspects or accused from provinces to CNPA Headquarters in Kabul. However, as per the ICPC, if the duration of the above mentioned trials expires, the arrested persons are to be released.

4.5.3 The current scenario/case management system

In the past decade of international assistance in Afghanistan, donors have funded a number of projects to improve and strengthen the law enforcement and criminal justice systems in Afghanistan. One of the key areas of improvement has been the establishment of a Case Management System (CMS) which has been one of the goals of the National Justice Sector Strategy of the ANDS to improve the quality of justice by focusing on the processes and practices in the justice institutions to facilitate citizen’s access to quality justice services.296

The Department of State Bureau of International Narcotics and Law Enforcement Affairs (INL) funded the CMS program to collect, store, and manage relevant information on all criminal cases in Afghanistan. The CMS tracking forms and database have been developed by the Justice Sector Support Program (JSSP) and Corrections System Support Program (CSSP) management teams in consultation with seven ministries who have signed the Memorandum of Understanding for the implementation of the components of the system.297

The main aim of the CMS is to establish an effective case management and tracking system to ensure transparency, accountability and efficiency in the Afghan criminal justice system. Frequently, there have been reports of constitutional and interim criminal code violations in the criminal justice system as the cases are not processed in line with the standard timeframe, there is a lack of defense representation, an absence of prosecutors at trial, and a disparity in case record keeping which causes difficulty in tracing the exact status and/or location of a defendant or detainee.298

The CMS was developed and designed a both a paper-based and computer-based system as in most provinces it is difficult to implement a computer-based CMS due to the lack of reliable electricity infrastructure. In addition, moving forward, it will be difficult for the government to support the high cost of reliable and efficient internet access for the implementation of this system across the country. The CMS has unique criminal tracking forms for each stage of case management which are sent from ministry to ministry as a criminal case proceeds from arrest, to prosecution, to courts, and then to prison.299

The Justice Support Sector Program (JSSP) implemented the CMS in Kabul, Herat, and Balkh; and operates to collect, store, and manage the CMS forms from all stages of case management cycle (from arrest to imprisonment), whereas the Corrections System Support Program (CSSP) only assists at the Central Prison Directorate (CPD) level to support the corrections system and implements the CMS at detention centers and prison facilities in 34 provinces of Afghanistan for

298 JSSP – Access to Justice Section, Afghanistan Case Management System, June 2012, p. 2
299 Ibid
tracking both pretrial detainees and sentenced prisoners with the aim to allow defendants to be tracked as they enter and move through various stages of the justice system.\footnote{Wyler, S.L and Katzman, K, Afghanistan: U.S. Rule of Law and Justice Sector Assistance, Congressional Research Service, November 9, 2010, p. 30}

Despite the implementation of the CMS program in Afghanistan, the current CMS does not cover all stages of case management in all provinces as it has been only implemented in three provinces (Kabul, Herat and Balkh). In the remaining 31 provinces, CMS is only implemented at the detention and prison facilities. Therefore, it is difficult to track and manage the narcotics and intoxicant cases from the point of arrest to conviction and prison in Afghanistan.

With the establishment of the CJTF in Kabul, the tracking and management of narcotics and intoxicants cases above the threshold have improved, but there is no central reporting system connecting law enforcement and criminal justice institutions involved for overall tracking of the cases above the threshold. The tracking and management of narcotics and intoxicant cases below the threshold is far more difficult as less attention has been given to minor cases and lack of coordination and reporting mechanism between the law enforcement and criminal justice agencies.

The implementation of the CMS in all provinces of Afghanistan to cover all stages of narcotics and intoxicant cases above or below the threshold equally will be an important step. In this respect, improved coordination between the law enforcement and criminal justice institutions including with respect to information and data flows will play a key role. In turn, this will simplify access of legal practitioners and researchers to information related to narcotics and intoxicants all over Afghanistan, and will ensure the accurate and timely implementation of law during the processing of cases.

**4.6 CONCLUDING REMARKS**

The chapter has shown that there have been encouraging developments with respect to CN law enforcement in Afghanistan. Law enforcement agencies are generally meeting set seizure targets, with CNPA and NDS in the lead for reporting the highest numbers of seizures. The total number of cases and amounts seized (for most substances) are on the rise, with the bulk of these taking place in the southern provinces of the country.

With respect to criminal justice as well, there are positive trends indicating law enforcement and criminal justice agencies are increasingly improving their capacities to deal with the narcotics problem. The number of CJTF cases as well as number of suspects at the primary and appellate court levels has been steadily rising. Likewise, the number of prisoners incarcerated for narcotics-related crimes has been increasing, most coming from the Western region. This does not however indicate whether there has been a commensurate increase in the capacity of these institutions. There may also be a need to revisit the thresholds for narcotics-related cases although this requires careful consideration of the implications of effecting changes.

In terms of future research, the findings of the chapter suggest an important area of further examination: to take the precursor seizures and lab destruction numbers and match it to seized
substances to get a clearer picture of where exactly the heroin is being produced. Further research into the origins of methamphetamine and patterns of trafficking would also be relevant. Given that the data in this chapter suggests limited levels of heroin production in Afghanistan, further research should be done to determine the levels of heroin produced in country. In relation to this also, further testing of purity levels by location in samples seized and matching purity levels to trafficking routes to create a clearer picture of illegal substances and their routes in and out of Afghanistan would be useful.

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CHAPTER 5: POLICY IMPLICATIONS

5.1 INTRODUCTION
The first issue of the Afghanistan Drug Report has reviewed key elements of the counter narcotics policy sphere in line with the thematic priorities of the National Drug Control Strategy. By jointly examining trends and conditions with respect to the supply and use of illicit substances as well as measures taken in response, the report provides an insight into the state of affairs with respect to the drugs challenge in Afghanistan. Not only does this provide the evidence-base to guide counter narcotics policies and interventions but it will also facilitate the monitoring a policy coordination mandates of the Ministry of Counter Narcotics across relevant governmental and non-governmental actors.

The production and consumption of illicit substances remains perhaps the most critical challenge for the country with complex linkages with the social, economic and political fabric of the country in turn complicating counter narcotics efforts and interventions. Creating the knowledge and evidence base to guide both policy and operational strategies to respond to this challenge should form and key pillar of the country's counter narcotics framework. The publication of the Afghanistan Drug Report is based on recognition of this requirement.

Despite substantial efforts and resources that have gone into counter narcotics efforts in the last decade, the country remains the world’s top supplier of opium poppy. The size of the illicit economy is still considerable with direct implications for national economic development planning. A two way relationship exists between poppy cultivation and insecurity which is a cause for concern especially at the time when the country is experiencing the transition from ISAF to Afghan security forces. Of particular concern is the human cost incurred with close to a million drug users, and a growing phenomenon of use within families and by children within a context of inadequate capacity for treatment nationally. Whilst gains have indeed been registered in some provinces that are now poppy-free in terms of law enforcement and criminal justice responses to the challenge, there is still a long way to go before considerable and sustainable impacts can be recorded.

Importantly the analysis in this report has also identified knowledge gaps which require further research and examination some of which will be undertaken as part of the preparatory process of future issues of the Afghanistan Drug Report. As such, this further justifies the need for regular and systematic monitoring of drugs trends, conditions and drivers of change by the Ministry of Counter Narcotics to guide policy implementation. Towards this end, the Ministry is currently establishing the Afghanistan Drug Reporting System to serve as a central repository consolidating counter narcotics data across relevant government Ministries and institutions.

As a cross cutting issue with widespread implications for development in general, counter narcotics cannot be considered in isolation from the existing framework for national development policy. In this respect, the Ministry of Counter Narcotics together with the UNODC has applied considerable efforts to integrate counter narcotics into the overarching framework for development policy and planning in Afghanistan, namely the Afghanistan National Development Strategy and its National Priority Programme clusters (Box 5.1).
Box 5.1: Mainstreaming Counter Narcotics into the National Priority Programmes

Approved during the Kabul Conference of 2010, the NPPs aim to streamline development projects and investments under a coherent and focused framework emphasizing prioritization and longer-term sustainability. Accordingly 22 NPPs identified as part of this process are clustered into the following clusters to facilitate coordination: Infrastructure Development, Private Sector Development, Human Resource Development, Agriculture and Rural Development, Governance and Security.

In order to mainstream counter-narcotics in the National Priority Programs, the Counter Narcotics Monitoring Mechanism (CNMM) was created. The overall goal of the CNMM is to ensure genuine mainstreaming of CN in the NPPs so that the Government of Afghanistan delivers on its Kabul Conference commitments and to monitor, evaluate and document the impact of NPPs on CN outcomes.

To date, the CNMM has reviewed and analysed all NPPs and identified specific activities through which CN can be mainstreamed. It has also succeeded in the incorporation of counter narcotics and alternative livelihoods objectives in NPP 1 (National Water and Natural Resource Development Program) and NPP 2 (National Comprehensive Agriculture Production & Market Development Program). The Food Zone Concept has been integrated under the Food for Life Component of NPP 2. MCN and MRRD are also considering how Alternative Livelihood objectives can be integrated into NPP 4 (Strengthening Local Institutions).


The findings of the report point to a number of more specific policy implications which can usefully guide ongoing and future counter narcotics interventions and strategies. A number of these are aligned with the recommendations made by the CNMM to mainstream counter-narcotics into broader development processes.

5.2 DRUG SUPPLY AND SUPPLY REDUCTION

Drug supply

Injecting risk into opium value chains
Levels of poppy cultivation show a high sensitivity towards opium prices, and a high sales price of opium was named by farmers among the top three reasons for opium cultivation in recent years. Indeed, occasional reductions in poppy cultivation may be attributed to market corrections in the face of abundant supply during the years 2006 to 2008. Policies and interventions aimed at sustainable reduction of opium poppy cultivation could also consider the price mechanism of opium cultivation rather than solely on reducing the area under cultivation. Specifically, injecting risk into opium cultivation processes through eradication can be complemented by the injection of risk into the value chain through interdicting opium just after it has left the farm gate. For example, interdicting opium just after it has been bought at the farm-gate will inject risk into the traffickers’ complex of purchasing decisions, with the anticipated result that prices will have to remain depressed in order for traffickers to accept this ratio of risk and return. This way, the risk is transferred to the trafficker - and in order to lessen the potential consequences of interdiction,
traffickers would be thereby influenced into offering lower prices for opium to minimise the financial burden in the case a consignment is seized.

**Linking cannabis and opium interventions**

Drug supply reduction policies should holistically examine the implications of reducing the drug supply from all illicit crops. Policies aimed at opium cultivation reduction should also be aimed at cannabis cultivation reduction - and vice versa. This might have the specific element of tackling the farm-gate prices of both illicit harvests - i.e. having a greater emphasis not so much on the direct reduction of cannabis/opium cultivation, but on the sustained reduction of the value of cannabis/opium to make for a more natural economic disincentive to Afghan farmers.

**Drug supply reduction**

**Improve the tracking of CN messaging campaigns**

Although there are a number of CN messaging campaigns and efforts at work in Afghanistan there is limited understanding of their effectiveness. In order to adequately track the effectiveness of such messaging, it is first required to know the performance of such messaging. Towards this end, it would be advantageous to establish a consolidated database of CN Public Awareness initiatives, which details the ownership of messaging campaigns, their geographic spread, their messages and slogans, their intended target audiences, the type of media employed to reach the audience, etc. With such a database set up to allow for the tracking of such messaging campaigns, the next step - measuring the effect of such campaigns - could be done on a far more consistent basis year-on-year. Such a messaging tracking system would require coordination across a number of ministries (such as MoPH, MRRD, MAIL - i.e. Line Ministries with thematic input to the messaging campaigns; but also MoIC, MoE and the other ministries with a coordination/approval function) as well as across a number of actors (such as the Colombo Plan, ISAF and other NGOs who are also directly promulgating CN awareness products).

**Eradication coupled with development assistance**

The achievements registered through eradication campaigns should be sustained through the uptake of lessons and best practices in future interventions. In particular, eradication should be accompanied by development assistance to create tangible alternative livelihood opportunities if it’s impact is to be maximized. The linkages between eradication and security also require careful consideration given the evidence so far that the two are closely associated.

**Alternative livelihood policies**

A household’s livelihoods strategy will evolve as fast as the conditions on the ground are changing. Therefore, it is recommended that as a general approach to designing Alternative Livelihood strategies, flexibility and resilience are core features of the policy. Alternative livelihood policy interventions must thus be flexible enough to cope with new developments on the ground, and resilient enough to stay relevant over a long period of time. This would allow the policy to maintain its effectiveness over the cycle of its design, implementation, review and modification. In general, a successful alternative livelihood program should enhance the access of farmers and rural labourers to markets, land, water, credit, food security and employment - at least in adequate measure to provide a minimum legal livelihood.
Hilmand Food Zone Program
The lessons learnt from the implementation of the Hilmand Food Zone Program as well as best practices from other countries as captured through the new Food Zone Concept will help to enhance the effectiveness of future similar programs. Some of the observations from the Hilmand FZP have led to the following potential recommendations:

- Other agricultural zoning initiatives might do well to be vague in the geographic delineation of the project to avoid the polarization of “haves” and “have-nots” inside and outside the project.
- Aligned or integrated interventions both inside and outside targeted areas of Food Zone to eliminate the “balloon effect” if faced on the ground will be important.
- Agricultural assistance should be given to both poppy-cultivating and non-poppy-cultivating districts, to avoid setting up the impression that only cultivating districts receive assistance (and thereby perversely encourage poppy cultivation).
- “Livelihoods” should not be deemed purely in terms of agrarian interventions. Security, educational opportunities and availability of off-farm income are other livelihood aspects that should be addressed by such interventions.
- Security appears to be one of the main drivers for poppy cultivation reduction, and other interventions would do well to place security improvement measures as a leading principle of the intervention.

5.3 DRUG USE, PREVENTION AND TREATMENT

Drug prevention

Broadening scale and scope of prevention efforts
- There is continued need for further expansion of drug prevention efforts and interventions in the country. It would also be beneficial to strengthen monitoring and evaluation of preventive measures to enable evidence based assessment of their impact and sustainability. With the necessary evidence, strategies to specific measures to enhance preventive efforts can be determined. The national Drug Demand Reduction Policy has a section on drug prevention, but focuses on public awareness. Drug prevention goes beyond public awareness with scientific evidence demonstrating that raising awareness and basic knowledge does not prevent drug use. Preventing drug use requires addressing vulnerabilities, developing skills in individuals and families and changing community norms to reflect a prevention message. Current drug prevention efforts would benefit from incorporating these elements.

Drug treatment

Enhancing access to treatment
- Drug dependence and its associated social and health problems can be treated effectively in the majority of cases if people have access to a continuum of available and affordable
treatment and rehabilitation services in a timely manner. One of the main elements of the National DDR policy is to increase drug prevention and treatment capacity by 30% for heroin and opium users between 2012 and 2016. To this end, barriers limiting accessibility to treatment services need to be minimized for people to have access to the treatment that best fits their needs. Given the scale of the problem in Afghanistan and the limited resources available, a clear and coherent approach to service planning is required. There is a need to develop services that can reach the maximum number of individuals and have the greatest impact at lowest cost\textsuperscript{301}.

**Drug treatment as a component of national healthcare focus**

- Drug treatment needs to be identified as a basic package of healthcare and be implemented into the BPHS and EPHS(Essential Package of Health Services) in Afghanistan to ensure sustainability. Under NPP5 - Health for all Afghans - the effort is being made to mainstream DDR and HIV prevention and care services into the health care framework. Continued discussions are taking place with the Health Management Information System (HMIS) in Afghanistan to ensure that this happens.

**Diversified and comprehensive treatment services**

- While the type of treatment available in Afghanistan has increased, diversified and expanded over recent years, it is still limited. Treatment provision is mostly dominated by residential and home-based approaches. These tend to focus on detoxification, residential rehabilitation and aftercare which happens to be of low intensity and infrequent. Other models of treatment are available in only very few centres. Treatment services should include a comprehensive package of evidence-based and integrated drug treatment (both long acting opioid agonists and psychosocial therapies) at both the community (structured psychosocial interventions, outreach and low-threshold outpatient services) and residential (initial detoxification followed by structured inpatient) level. In addition, adopting a tiered approach to drug treatment ensures that a comprehensive package of evidence based drug treatment is available. When treatment services are delivered in a structured tiered way, there is clear distinction and referral pathway between different modalities.

**Continued need for targeting returnees and refugees**

- There are an estimated 30,000 recent heroin users among the returnee population. The prevalence of drug use and associated risks amongst this population is ever increasing and more services need to be implemented to address this need. Currently there a sub-regional project providing DDR services to Afghan returnees in Herat and Badakshan and similar projects provide DDR services to Afghan refugees in Iran and Pakistan. The recommendation is that further research needs to be conducted in the area of drug use amongst refugees, returnees and IDPs and DDR projects need to be designed to meet the need.

**Streamlining drug use monitoring**

- At present drug use monitoring system is very weak. Different drug treatment providers have individual data recording and monitoring systems, which can be used to monitor drug users who attend their clinic but these remain local and specific to either that treatment centre or organization. The data that is recorded by individual governmental and non-governmental

\textsuperscript{301} Discussion paper on the principles of drug dependence treatment, WHO & UNODC March 2008
organizations is generally used locally, and does not provide a comprehensive picture of drug use in Afghanistan. There is a need for a streamlined process of data collection and analysis on a scientific basis, which will provide a better understanding of drug use nationally and assist in future planning for decisions makers. MCN's recently published Drug Demand Reduction (DDR) policy has proactively highlighted the need for drug treatment to be identified as a basic primary health care service in Afghanistan, and already advocated its inclusion on the Basic Package of Health Services (BPHS). Furthermore, MCN's Afghanistan Drug Reporting System will contribute to improved data reporting in this respect..

**Drug use in prisons and drug related harms**

- HIV surveillance system is in its initial stages and surveillance coverage is limited. There have been two Integrated Behavioural Biological (IBBS) studies conducted in Afghanistan in 2010 and 2012. In order to determine prevalence and most importantly new infections a comprehensive surveillance system needs to be implemented. The Health Management Information System (HMIS) team is currently working to have all health related data stored in a new warehouse. The recommendation is that HIV and DDR data should also be stored in this warehouse and the vehicle used to gather this data should be the DDRIS.

- Research to date has largely described behaviour and sero-prevalence of syphilis, HIV and hepatitis B and C among urban populations in Kabul, Herat, and Mazar-i-Sharif, with little information for eastern and southern Afghanistan. There has been little attempt at enumeration of urban populations of non-injecting drug users in Afghan urban settings and there is no sero-prevalence or behavioural data specifically of non-injecting drug users in Afghanistan. A recommendation is to conduct some research into behaviour of urban non-injecting drug users.

- HIV prevention and care services are available in very few prisons in Afghanistan – Kabul, Herat, Balkh, Kunduz, Badakshan, Nangarhar, Ghazni and Kandahar. UNODC is providing a comprehensive package for the prevention, treatment and care of HIV services for female drug users in 6 female prisons (not including condoms, Needle Syringe Exchange Programme and opiate agonist treatment). Such provision of HIV prevention, treatment and care services needs to be upscaled in prison settings.

**Institutional coordination and capacity**

- According to the Afghanistan Counter Narcotics Law, MCN has the leading role in counter narcotics policy coordination including with respect to DDR. This involves coordination amongst relevant Ministries and other actors in the role of developing networks of DDR and HIV services. There is need for further strengthening such co-ordination. Drug treatment efforts would also benefit from capacity development efforts. Although there is regular ongoing training on evidenced based intervention on DDR/HIV prevention and treatment in Afghanistan, it would be beneficial to develop government owned national resource centers as already highlighted in MCN's National DDR policy to not only function as learning centres but also as resource libraries affiliated to national medical universities, where possible. This would assist in the long-term development and sustainability of learning in the field of DDR/HIV.
prevention, treatment and care. Furthermore, national treatment guidelines need to be reviewed and updated to ensure they are in-line with international standards and evidence based as indicated in MCN’s National DDR policy. With respect to capacity, while there have been great improvements in government and civil society treatment capacity, further efforts and investments will be necessary including with respect to professional staff, training, infrastructure and coordination mechanisms across different actors and interventions.

5.4 LAW ENFORCEMENT AND CRIMINAL JUSTICE

Seizure targets
• Since September 2012, law enforcement agencies have been meeting set targets for seizures as per the Anti-drug Trafficking Policy developed by MCN and its monitoring initiated by MCN. It may thus be useful for law enforcement agencies to revisit set targets for seizure to ensure that they are not set too low.

Planning responses to the emergence of synthetic substances
• The rise in Methamphetamine seizures suggests that it will potentially become a challenge in Afghanistan in the near future. In order to stem the problem before it gets out of control, training should be provided for addressing this issue.

Revisiting narcotics case thresholds
• There is currently a debate in the Government of Afghanistan whether the thresholds should be raised, meaning fewer cases would be referred to CJTF, whether the threshold should be lowered resulting in more cases sent to CJTF or whether the thresholds should remain as they are. Lowering the threshold would greatly increase the caseload for CJTF but also preventing local-level corruption in the prosecution of cases. Thus, the capacity of CJTF would need to be increased to must match the number of cases received by the organization. Also, it seems that only a substantial change in the threshold would affect the overall number of cases in the CJTF courts. Smaller changes may be a political signal but would not strongly affect the actual number of cases.

Capacity of criminal justice institutions
• The number of CJTF cases as well as number of suspects at the primary and appellate court levels has been steadily rising. Likewise, the number of prisoners incarcerated for narcotics-related crimes has been increasing, most coming from the Western region. This will need to be matched by commensurate increases in the capacity of these institutions—both in terms of personnel and space.
5.5 LOOKING AHEAD

As a key pillar of effective counter narcotics policy and operations, the Afghanistan Drug Report will be published annually from now on and form an important mechanism for the Ministry of Counter Narcotics to fulfill its mandate to monitor drug trend and conditions nationally. The report will be supported by the Afghanistan Drug Reporting System which is currently being established within the Ministry to consolidate counter narcotics data into a central repository. This will greatly facilitate the accurate compilation and sharing of counter narcotics data across key governmental actors but also inform the work of other stakeholders and actors engaged in counter narcotics efforts in the country.

The coming year entails significant changes to the political landscape of Afghanistan. Given the evidence of complex linkages between the drugs challenge and security, governance and stability, even greater attention and strategic investments are required with respect to counter narcotics. A heightened focus on counter narcotics is necessary to avoid far reaching governance, economic and social repercussions. The gains that have already been made should be consolidated rather than eroded and used as platform to scale up counter narcotics efforts for a poppy free future in Afghanistan. The sustainability of counter narcotics efforts is also intricately linked to regional and international dynamics and drivers. It is thus important for actors beyond Afghanistan to equally sustain commitment to counter narcotics efforts within Afghanistan and the region.
ANNEX: COUNTER NARCOTICS POLICY AND LEGAL FRAMEWORKS

National Drug Control Strategy
The NDCS as a milestone five year plan strategy was first launched in 2003 and revised in 2006 for the period of 2006-2011, the second draft of the strategy for the period of 2012-2016 was drafted in 2012 and is pending final approval with the High Commission on Drugs and Intoxicants.

The overall goal of NDCS is to secure a sustainable decrease in the cultivation, production, consumption and trafficking of illicit drugs with a goal of complete and sustainable elimination. The six overall goals at the national and provincial levels are as follows:

- Reduce poppy cultivation 25% from the 2011 level of 131,000 hectares
- Increase drug treatment capacity nationwide by 30%
- Increase the drug seizure rate by 5-10% in narcotics and precursors
- Increase the number of major drug traffickers convicted
- Expand public awareness down to the village level, reaching all targeted populations
- Increase cooperation with neighboring countries and the international community in balanced, results-based counter-narcotics efforts

In order to achieve the goal, NDCS has specified four strategic areas: Disrupting drug trade, Strengthen and diversify legal rural livelihoods, Reduce Demand for Illicit Drugs, and Cross-cutting Issues.

The strategy under the first strategic area aims to target major drug traffickers and their networks, target the major landowners and government land users and repeated offenders through Governor-led poppy eradication, control the illegal smuggling of precursor chemicals into the country, and establish a Strategic Policy Coordination Center in Kabul.

In the second strategic area, the strategy aims to formulate policy to address the root causes of drug crop cultivation by focusing on subsistence and marginal farmer and laborers, mainstream counter narcotics in the National Priority Programs of the six Ministerial Clusters (Agricultural and Rural Development, Human Resource Development, Economic and Infrastructure Development, Private Sector Development, Governance and Security) over the course of the next decade (2012-2022), assist the farmers, laborers and rural communities, achieve economic development by focusing on the ongoing Ministerial-level National Programs, and Targeted Alternative Livelihood Interventions such as Good Performance Initiative (GPI), Comprehensive Agricultural Rural Development Facility (CARD-F), and Food Zone (FZ).

304 National Drug Control Strategy (2012-2016), Ministry of Counter Narcotics (MCN), p. 6
305 Ibid
306 Ibid, p. 8-9
307 Ibid
In the third strategic area, the strategy aims to deliver a comprehensive cycle of treatment services, provide effective drug demand reduction package, deliver appropriate interventions to reduce the demand for and harm of illicit drugs in Afghanistan, mainstream the DDR into the programs of the MoPH and other line ministries, establish a DDR M&E system, and build the institutional capacity of the drug demand reduction and harm prevention system.\textsuperscript{308}

In the fourth strategic area, the strategy focuses on cross cutting issues which are fundamental to the three other strategic areas. The cross cutting issues are improved governance, institution building, public awareness, regional and international cooperation, and research, policy, and advocacy.\textsuperscript{309}

### Alternative Livelihoods Policy

The national AL policy has 12-year horizon and is reviewed once in every three years. The policy identifies key issues which serve as drivers for poppy cultivation and affect the sustainability of licit livelihoods.\textsuperscript{310}

The overall goal of the national AL policy is strengthening and diversifying legal rural livelihoods by addressing the causes and factors for poppy cultivation, which includes poverty, food insecurity, massive unemployment, inequities in access to natural resources (land and water), indebtedness to narco-entrepreneurs, and inequities in the level of national and international developmental assistance to a distinct geographic area.\textsuperscript{311}

The short and medium term objectives of National AL policy and to be achieved through targeted interventions, such as Good Performance Initiative (GPI), Comprehensive Agriculture Rural Development - Facility (CARD-F), Food Zone and the research project of MCN/UNODC. The long-term objectives will be achieved through mainstreaming of CN into 24 National Priority Programmes (NPPs).\textsuperscript{312}

The objectives of the AL Policy are as follows:\textsuperscript{313}:

- **Assist farmers, laborers and rural communities affected by GoA’s counter narcotics campaigns (Public Awareness, Law Enforcement, Eradication) with a package of comprehensive, locally adapted and practical interventions, which could alleviate poverty, food insecurity and have a lasting impact on livelihoods**
- **Assist farmers, laborers and rural communities who have consciously decided not to engage in the production of narcotics, through direct cultivation or through supply of labor, with a package of comprehensive, practical and sustainable interventions in an equitable manner, regardless of geographic location**
- **Maintain the “poppy-free” status (i.e., prevent the resurgence of poppy cultivation) in communities which have consciously opted not to engage in, or have strived to abandon,**

\textsuperscript{308} Ibid, p. 12-13
\textsuperscript{309} Ibid, p. 14, 15
\textsuperscript{311} Ibid, p. 9
\textsuperscript{312} Ibid, p. 7
\textsuperscript{313} Ibid, p. 9
illicit cultivation and production of narcotics (i.e., through Social Contracts) by addressing the key drivers of opium poppy cultivation

- Keep the pace of further reductions in cultivation of opium poppies and production of narcotics through effecting lasting change on livelihoods of currently subsistence households.
- Prevent the spread of cultivation to areas hitherto unaffected by narcotics by embedding CN measures, realizing the mobility of the narco-entrepreneurs who are ready to exploit vulnerabilities.
- Achieve a steady reduction (25% reduction after 6-years, or 5500 ha/year) of opium poppy cultivation, through alleviation of poverty and food insecurity, coupled with significant improvements in security, good governance and overall economic development, after the start of implementation of the Policy.

Drug Demand Reduction Policy

Prior to the drafting and enactment of the National Drug Demand Reduction Policy, the Ministry of Counter Narcotics (MCN) and other relevant governmental and non-governmental organizations used the National Drug Control Strategy to coordinate drug demand reduction activities. Due to the increasing rate of drug use and addiction in the country, there was need for a comprehensive drug demand reduction policy in Afghanistan. In this regard, based on the Afghan Counter Narcotics and Intoxicant Law and the National Drug Control Strategy, MCN in close cooperation with the Ministry of Public Health (MoPH) and the Ministry of Labor and Social Affairs, Martyrs and Disabled (MoLSAMD) formulated the National Drug Demand Reduction Policy in June 2012.  

This policy recommends the establishment of drug treatment complexes in regional centers, expanding of the harm reduction services and increasing the drug prevention and treatment capacity by up to 40% in five years. Under this policy MCN and MoPH are committed to work together to include drug treatment in MoPH’s strategies as an integral part of public health services secure regular funding in the government budget.  

This policy consists of five chapters covering the following key areas: Prevention of drug use through preventive programs, increase the coverage of drug treatment services with continuous care and enhancing the quality of the existing services, reduce the unfortunate health, social and economic consequences of drug use and include the drug users in relevant programs; emergency response and provision of services during emergencies and crisis, and other miscellaneous activities such as monitoring, capacity building, and research and survey. 

The following are the objectives of the policy:

- Decrease vulnerable groups not to become narcotic users
- Prevent children, adolescents, and other vulnerable groups from misuse of narcotics
- Decrease drugs’ socio-health impact in affected communities and provide high quality therapeutic and rehabilitation services along with improved access to these services for all drug users

315 Ibid, p.5
316 Ibid p. 10, 11
317 Ibid, p. 15
• Establishing a system to standardize therapeutic services and regulate license for service providers and therapeutic centers in order to improve the quality of demand reduction services
• Establishing epidemiological center to collect, analyse and disseminate the data related to demand reduction activities including data collection about the treatment, conducting surveys and researches
• Establishing a national coordination system to standardize all demand reduction related activities and evaluate the implementation of these programs

**Counter Narcotics and Intoxicants Law**

The Ministry of Counter Narcotics (MCN) in coordination with relevant line ministries drafted the first Afghan Counter Narcotics and Intoxicant Law based on the article 7 of the Afghan Constitution to prevent the cultivation of opium poppy, cannabis plants, and coca bush, and the trafficking of narcotic drugs, and to control psychotropic substances, chemical precursors, and equipment used in manufacturing, producing, or processing of narcotic drugs and psychotropic substances.\(^\text{318}\)

The law consisted of fifty eight articles under eight chapters: general provisions, classification and regulation of drugs, licensing provisions, drug trafficking offenses and penalties, adjudication of drug-related offenses, techniques of search, seizure, and investigation, ministerial duties and responsibilities, and final provisions.\(^\text{319}\)

In June 2010, the Afghan Counter Narcotics and Intoxicant Law was amended into five chapters consisting of sixty seven articles, and based on the act (158) the Afghan National Assembly enacted it. The amended law is titled as the “Law against Intoxicating Drinks and Drugs as well as controlling them” and focuses on the following objectives\(^\text{320}\):

- To prevent the cultivation of opium poppy, cannabis plants, and coca and other narcotics plants
- To prevent the production, preparation, processing, purchase, sale, distribution, commissioning, import and export, transportation, supply, demand, storage, and concealment of any substances or compounds, which includes one of the substances set forth in the Table 1, 2, and 3 of CN law
- To regulate and control narcotic drugs, psychotropic substances, chemical precursors, and substances and equipment used in the manufacture, production, or processing of narcotic drugs and psychotropic substances in order to prevent their use for illicit purposes and to ensure their use for medical, scientific, research and industrial purposes in accordance with the provisions of the law
- To prescribe the penalties for the convicts of drug and intoxicant related crime\(^\text{321}\)

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\(^{319}\) Ibid

\(^{320}\) Official Gazette, Law Against Intoxicating Drinks and Drugs as well as controlling them, Issue No: 1025, June 2012, (Dari), available online at:

\(^{321}\) The term drug trafficking in the Law against Intoxicating Drinks and Drugs as well as controlling them is specified as cultivation of seeds of drug producing plants or production, preparation, process, purchase, sell, keep, distribution, commissioning, import and export, transport, supply, demand, storage, and conceal of any substances or compounds, which includes one of the substances set forth in the Table 1, 2, and 3 of CN law.
• To establish coordination among the government and non-government organizations in the area of counter narcotics and intoxicants, and monitor and evaluate the implementation of National Drug Control Strategy
• To encourage farmers to cultivate licit crops instead of opium poppy, coca bush, and cannabis plants
• To attract the cooperation and assistance of national and international organizations in the task of combating cultivation, trafficking and use of narcotic drugs, psychotropic substances, and the chemical precursors used in their production, manufacturing, and processing

Anti-drug Trafficking Policy
The Ministry of Counter Narcotics (MCN), with the assistance of law enforcement and criminal justice agencies, drafted the Anti-Drug Trafficking Policy in order provide an enhanced framework and guidance to curtail drug trafficking, improve border controls and eliminate poppy cultivation. In May 2012, the policy was formally signed and enacted by the Ministry of Counter Narcotics (MCN), the Ministry of Interior (MOI), the Ministry of Defense (MoD), the Ministry of Finance (MoF), the Criminal Justice Task Force (CJTF), the Counter Narcotics Special Court (CNSC) and the National Directorate of Security (NDS).

The policy identifies measures to respond to key challenges related to counter narcotics including targeting high value drug traffickers and destroying their networks, confiscation of drug traffickers’ assets and property, revising the poppy eradication program, establishing a gallantry trust fund for law enforcement agencies, improving the situation of those incarcerated for drug-related crimes, enhancing the capacities of counter narcotics law enforcement agencies, controlling the borders, identifying and countering money laundering activities, prosecuting major land-owners who use personal or government owned land for poppy cultivation, enhancing regional cooperation, and coordination among counter narcotics institutions.322

More specifically, the following targets have been set in the policy for a five year period (2012-2017)

• To reduce drug trafficking by 30% in the first three years of the policy’s implementation
• To increase the drug seizure rate from 0.5 - 1.5 % in 2012 to 12% - 25% in 2017323
• To target high value drug traffickers and to increase the arrest level from 1,300 small traffickers to 2,000 low, mid and high value traffickers annually324
• To increase the seizure rate of precursors to 30-50% up to 2017
• To improve the poppy eradication process
• To implement bilateral and multilateral agreements currently in place with countries in the region

323 At time of publication, according to the MCN Law Enforcement Working Group the seizure rate is 14% (624 tons of opium, heroin, morphine) of total production of opium (3700 tons)
324 The policy makes a clear distinction between low value, mid value and high value traffickers as follows. Low- value traffickers are those who traffic due to lack of social opportunities, unemployment and poverty, and normally traffic small amount of drug and sell it in exchange of for a small amount of money. Mid-value traffickers have a considerable role in the trafficking process, and they traffic narcotics for their personal profit and do not establish ties to terrorist groups. High-value traffickers are those who lead and control major and series narcotics trafficking activities and are members of organized drug trafficking groups, these people have a direct connection with serious international criminal groups.
To increase coordination for improving security and better border control
To improve the conditions of drug prisoners
To make trials of major traffickers public in order to discourage other drug trafficking networks

The Counter Narcotics Monitoring and Evaluation Mechanism

The Counter Narcotics Monitoring and Evaluation Mechanism was introduced as part of the requirements falling out from the Kabul Conference (2010) and the declaration of the Tokyo Conference (2012) and ensures the genuine mainstreaming of CN in all of the National Priority Programs (NPPs). The mainstreaming of CN is not just a critical review of the NPPs; CN issues should be mainstreamed in all phases of the NPPs, including in the monitoring and evaluation of programs - to see for example their effect on licit crops.

The Monitoring and Evaluation Mechanism was endorsed on 26 July 2012 by the Joint Coordination Monitoring Board (JCMB) as a strategy for further development. It is presented at the Standing committee meetings by the MCN, and the mechanism is overseen through a secretariat and a monitoring and evaluation committee.

The CN Monitoring and Evaluation Mechanism Secretariat is comprised of technical personnel from the MCN and UNODC. It is responsible for the identification of activities (or specific interventions) related to the CN in the NPPs and what defining what major impact these activities are intended to have on drug cultivation. The secretariat also identifies possible priorities areas in the NPPs for improving the current CN efforts (or specific interventions) to achieve these desired goals.

The CN Monitoring and Evaluation Mechanism Committee consists of MCN, the UNODC and relevant ministries, namely, the Ministry of Finance (MoF), the Ministry of Energy and Water (MeW), the Ministry of Economy (MoEc), the MAIL and the MRRD; additionally, other clusters interested in CN are part of the committee. The committee is responsible for incorporating CN goals in the NDCS and CN laws and policies. On making decisions, it directs the secretariat accordingly. The Deputy Minister for Policy and Coordination of the MCN oversees the monitoring, evaluation and reporting of the CN developments and activities in the NPPs.

Please see figures below for the external and internal organization of the CN Monitoring and Evaluation Mechanism.

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325 Ibid, p. 14
Internal and External Consultation Mechanism

Source: MCN, 2013

Internal Government Mechanism
REFERENCES


MoJ (2010), Law against Intoxicating Drinks and Drugs as well as controlling them, Official Gazette, Dari version, issue No. 1025.


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