The ups and downs of harm reduction in Afghanistan

Frishta Nafeh,[a] Dan Werb,[a,b] and Mohammad Karamouzian[a,b,c,*]

[a]Centre on Drug Policy Evaluation, St. Michael's Hospital, Toronto, ON, Canada
[b]Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada
[c]HIV/STI Surveillance Research Center, and WHO Collaborating Center for HIV Surveillance, Institute for Futures Studies in Health, Kerman University of Medical Sciences, Kerman, Iran

The Lancet Regional Health - Southeast Asia 2023;13: 100186

Published Online 4 April 2023
https://doi.org/10.1016/j.lansea.2023.100186

Afghanistan is the world's leading producer of opium and supplies 80% of the global demand.[1] For decades, Afghanistan, Iran, and Pakistan—known as the Golden Crescent—dominated the global opium market as a major hub for production and trafficking.[2] However, production shifted to Afghanistan in the 1970s after opium was banned in Turkey and other countries in the Golden Crescent.[2] By 1989, opium had become one of Afghanistan's leading exports, supplying a third of the world's opium. Opium cultivation has been a major contributor to political instability in Afghanistan, fueling violence, civil war, and corruption. Indeed, it has led to the growth of a shadow economy that generates substantial income for criminal networks and insurgent groups and enables them to fund their activities and operate with relative impunity. For example, the Taliban, who initially gained control of Afghanistan in the mid-1990s, allowed warlords to continue opium production in exchange for loyalty and a sizeable yearly opium tax revenue.[2] However, in 2000, they briefly banned it, declaring it "un-Islamic" and harshly penalized farmers who continued to grow the crop.[2] Following the Taliban's collapse in 2001, various hands-on (e.g., poppy crop eradication) and hands-off tactics (e.g., alternative crop incentive schemes) were used by the USA, the UK, and the Afghan government in their war on drugs in the country.[2] However, opium production did not shrink; instead, opium cultivation increased from an average of 60,000 ha between 1994 and 2001 to a record high of 330,000 ha in 2017.[1] In 2021, the opiate economy accounted for up to 14% of Afghanistan's gross domestic product (GDP), making opium cultivation and trade a major economic source. Given that Afghanistan's GDP further contracted in the following year, the opiate economy has likely constituted a larger proportion of its total economy in 2022.[1]

Despite the turmoil, political instability, insurgency across the country, as well as American commitment to a War on Drugs model, the post-Taliban era in Afghanistan was marked by successful implementation of harm reduction measures.[3] In 2003, the Afghan government recognized harm reduction as an important intervention for its National Drug Control Strategy with explicit supportive references in national policy documents.[3,4] Later, in 2005, the Ministry of Public Health and the Ministry of Counter Narcotics jointly signed a National Harm Reduction Strategy and approved a wide range of harm reduction and treatment programs.[4] The Afghan government continued to support harm reduction as a key strategy in various national policy efforts, including the National Drug Demand Reduction Policy (2012–2016) and the National AIDS Control Program, despite pushback from conservative groups promoting abstinence-based solutions in accordance with Islamic laws pertaining to intoxicants.[4] Indeed, despite a multitude of implementation challenges, needle and syringe programs (NSP), HIV testing and counseling, and opioid agonist therapy (OAT) gained momentum with the support of civil society and international donors.[3,5] By 2020, 24 NSP and 8 OAT sites were operating across the country.[3] Notably, in 2020, Afghanistan was one of the only countries in the Eastern Europe and Central Asia region with peer naloxone distribution programs, and even managed to maintain the availability of harm reduction services during the COVID-19 pandemic through innovative take-home OAT and harm reduction kits.[3]

In August 2021, the Taliban regained control in Afghanistan, leading to widespread economic and social disruptions. This has resulted in millions of newly displaced individuals, decreased access to critical healthcare services, and a need for humanitarian aid for over half of the population, especially marginalized groups including people who use drugs (PWUD).[6] Following the resurgence of the Taliban, opium cultivation saw an overall rise of 32% (i.e., 56,000 ha), compared to the previous year.[1] However, in April 2022, the Taliban reinstated its pre-2001 policy of criminalizing drug use as a means of enhancing its international credibility. Policies aimed at eradicating opium poppy cultivation have been unsuccessful and repeatedly proven ineffective in various global contexts.[2] The Taliban announced the ban only a few weeks prior to harvest; its timing increased the likelihood that opium farmers, after a long season of investing resources, would refuse to comply.[7] Since the announcement of the opium ban, the price of opium has doubled–from $116/kg in March 2022 to $203/kg in April 2022–and left many of those involved

*Corresponding author. Centre on Drug Policy Evaluation, Li Ka Shing Knowledge Institute, St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8, Canada.
E-mail address: mohammad.karamouzian@unityhealth.to (M. Karamouzian).

in the opium trade impoverished.[1] These policies may also result in a shift of drug production in Afghanistan from opium to methamphetamine, a fact recognized by the Taliban government when it extended its current opium ban to cover ephedra, a flowering plant that is also an amphetamine precursor, and finally all drugs.[7]

The risk of provoking resistance and domestic backlash seems to have persuaded the Taliban to enforce an incomplete and subjective ban on opium production. However, their all-out war on PWUD is unrelenting. The Taliban has withdrawn support for harm reduction and HIV prevention services and cracked down on PWUD by arresting, detaining, and subjecting them to violent treatment.[3,8,9] As of August 2022, there were a limited number of NSP and OAT facilities, with 8 NSP sites and 9 OAT sites in operation, four of which were located within prisons.[3] Moreover, the Taliban has adopted involuntary detoxification as a 'solution' to the growing substance use problem in Afghanistan. Crackdown and human rights abuses on homeless and street-based PWUD have been intensified, forcing them into detox without withdrawal support in overcrowded rehabilitation camps.[8,9] These 45-day detoxification facilities are severely understaffed, inadequately equipped, and currently operating beyond capacity with limited supplies of food and personal hygiene items.[8,9] These centres also lack any form of mental health support, despite the fact that many Afghan PWUD are struggling with mental health disorders and have suffered immense trauma, due to the loss of their homes, family members, and hope in a country torn apart by conflict, deprivation, and oppression in the past few decades. While the Taliban use their interpretation of Islam to justify denial of life-saving harm reduction services and strictly promote abstinence-based models, evidence from other conservative Muslim-majority countries, such as Malaysia and Iran, have shown abstinence-only treatment models to be ineffective and rather counterproductive by contributing to an increase in drug use prevalence, a shift to more harmful drugs including heroin, widespread stigma towards PWUD, and a transition from smoking to injecting.[10–12] These countries, therefore, have successfully adopted a harm reduction model by viewing substance use disorders from a health perspective and recognizing harm reduction as an ethical evidence-based social and public health response, grounded in principles of social justice and human rights.[11,12] The Taliban could learn from the implementation of harm reduction interventions in such Muslim-majority settings which are indeed compatible with the Islamic principles of preserving human life, alleviating suffering, and prioritizing the safety and well-being of individuals.[10]

The recent Taliban takeover in Afghanistan is yet another bitter reminder, after the Russian seizure of Crimea,[13] of the fragility of harm reduction services in the face of political instability. More importantly, the decline of harm reduction efforts in Afghanistan should be viewed as severe regional and global health threats. Criminalizing PWUD coupled with limited access to NSP and OAT, could force them to engage in riskier substance use practices, and transition to injection drug use, exacerbating the spread of infectious diseases, such as HIV and HCV amongst themselves and to the general population.[10,14] Overcrowded and under-resourced rehabilitation camps and prisons also pose a risk of the spread of infectious diseases beyond Afghanistan's physical borders. COVID-19, HIV, and other pandemics have clearly demonstrated that infectious diseases have a tendency to spread across borders and future infectious outbreaks could easily reach other parts of Central Asia, North Africa, Europe, and beyond.[15] Therefore, the inhumane treatment of PWUD in Afghanistan is a human rights emergency and global health concern, requiring urgent international support and humanitarian aid. These human rights violations must be brought to the negotiating table with the Taliban hand in hand with discussions of Afghanistan's long-term development plans. It is also essential to remind the Taliban that they have a unique opportunity to achieve social and financial prosperity by adopting evidence-based drug policies that prioritize compassionate care and tackling social inequities, instead of relying on the ineffectual and unethical practice of compulsory treatment and incarceration of PWUD.

Contributors

Conceptualisation: FN.
Supervision: DW, MK.
Writing – original draft: FN, MK.
Writing– review & editing: FN, DW, MK.

Declaration of interests

We declare no competing interests.

References

1 United Nations Office on Drugs and Crime. *Opium cultivation in Afghanistan – latest findings and emerging threats*. 2022.
2 Coyne CJ, Blanco ARH, Burns S. The war on drugs in Afghanistan: another failed experiment with interdiction. *Indep Rev*. 2016;21:95–119.
3 Harm Reduction International. *The global state of harm reduction 2022*. 2022.
4 Todd CS, Macdonald D, Khoshnood K, Mansoor GF, Eggerman M, Panter-Brick C. Opiate use, treatment, and harm reduction in Afghanistan: recent changes and future directions. *Int J Drug Policy*. 2012;23(5):341–345.
5 Nafeh F, Fusigboye S, Sornpaisarn B. Understanding injecting drug use in Afghanistan: a scoping review. *Subst Abuse Treat Prev Policy*. 2022;17(1):65.
6 United Nations Development Programme. *Afghanistan since August 2021: a socio-economic snapshot*. 2022.
7 Mansfield D. *Will They, Won't They? What do we know about the coming opium poppy season and what both farmers and the Taliban will do?*; 2022. https://www.alcis.org/post/taliban-opium-ban. Accessed January 31, 2023.
8 Berz KL, Sharaf S. *Afghan women, children grappling with opioid addiction live in fear of being imprisoned by the Taliban*. The Globe and Mail; 2022.

9 Noroozi E. *AP photos: despair and poverty fuel drug use in Afghanistan*. Associated Press; 2022.
10 Todd CS, Nassiramanesh B, Stanekzai MR, Kamarulzaman A. Emerging HIV epidemics in Muslim countries: assessment of different cultural responses to harm reduction and implications for HIV control. *Curr HIV AIDS Rep*. 2007;4(4):151–157.
11 Bin Shaikh Mohd Salleh SMS, Kamarulzaman A. Implementation of an Islamic approach to harm reduction among illicit drug users in Malaysia. In: *Islamic perspectives on science and technology: selected conference papers*. Springer; 2016:269–274.
12 Ekhtiari H, Noroozi A, Farhoudian A, et al. The evolution of addiction treatment and harm reduction programs in Iran: a chaotic response or a synergistic diversity? *Addiction*. 2020;115(7):1395–1403.
13 Hurley R. At least 80 people have died in Crimea since Russian law banned opioid substitutes, says UN special envoy. *BMJ*. 2015;350:h390.
14 Todd CS, Stibich MA, Stanekzai MR, et al. A qualitative assessment of injection drug use and harm reduction programmes in Kabul, Afghanistan: 2006-2007. *Int J Drug Policy*. 2009;20(2):111–120.
15 Karamouzian M, Madani N. COVID-19 response in the Middle East and North Africa: challenges and paths forward. *Lancet Glob Health*. 2020;8(7):e886–e887.