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AFGHANISTAN DRUG INSIGHTS VOLUME 5

HIGH-RISK DRUG USE IN AFGHANISTAN

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ABBREVIATIONS AND ACRONYMS

DfA	De facto Authorities
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
MDMA	3,4-Methylenedioxymethamphetamine
MMT	Methadone maintenance treatment
NSP	Needle and syringe programmes
OAT	Opioid agonist maintenance therapy
PWID	People who inject drugs
SD	Standard deviation
SDS	Severity Dependence Scale
STIs	Sexually transmitted infections
TB	Tuberculosis
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar

CONTENTS

1 EXECUTIVE SUMMARY

1.1 Background

The United Nations Office on Drugs and Crime (UNODC), with funding from the United Nations Development Programme (UNDP), conducted a series of research studies to estimate the prevalence and extent of drug use in Afghanistan. The aim was to provide sub-national estimates on high-risk drug use and an evidence base that stakeholders can use to design and implement evidence-based interventions to prevent and treat drug use disorders. This report presents the results of three interconnected studies:

1. Mapping of Drug Use Hotspots

2. Key Informant Interviews

3. High-Risk Drug Use Survey

The mapping of drug use hotspots assessed drug use behaviours in public places. It also estimated the size of these hotspots and the number of individuals using drugs in those areas by interviewing 3,555 people (2,820 men and 735 women). The key informant interviews provided insights from 1,232 individuals (822 men and 410 women) regarding their perceptions of drug use and drug use disorder treatment services in their communities. The third study examined the characteristics of 6,893 people engaged in high-risk drug use (6,342 men and 551 women), along with their drug use patterns and use of services. High-risk drug use was defined as the non-medical use primarily of opiates or amphetamine-type stimulants within the past 30 days by individuals who had faced problems related to their drug use, such as health issues, legal challenges, or family difficulties.

The first two studies were carried out in 2022 and the third in 2023. For context, the De facto Authorities (DfA) announced the enforcement of the ban against drugs, including production, distribution and use, in April 2022. The ban was more strenuously enforced starting from early 2023, at which point the authorities increasingly restricted drug use in public areas, with the aim of coercing individuals into treatment. Significant changes in drug use patterns are therefore likely to have occurred, as seen in other contexts where drug use is addressed primarily through law enforcement. All three studies were conducted across 34 provinces of Afghanistan to allow for sub-national estimates.

The De Facto Authorities provided their comments to this publication, which are attached herein as Annex 2.

1.2 Key findings

Hotspot Mapping: In 2022, a total of 651 hotspots where people who use drugs congregate in public places were identified across 32 provinces (two provinces, Khost and Pakita, were excluded because of the low precision of data). The highest number of hotspots were identified in Kandahar City and Kabul City, with 64 and 55 hotspots, respectively. However, Nimroz, Zabul, and Nuristan had the highest rate of hotspots per 100,000 inhabitants.

Estimates of high-risk drug use in hotspots: On average nationwide, there were about 41 people per hotspot. The total national number of people engaging in high-risk drug use in the hotspots was estimated to be approximately 27,000 (24,330 men and 2,670 women) – the average of estimates ranging from 22,000 to 32,000. Kabul had the highest number (4,700), followed by Faryab (3,200). The national average rate of people engaging in high-risk drug use was 97 per 100,000 inhabitants. Nimroz had the highest rate at 533, followed by Faryab at 277. Additionally, the total estimated number of people who injected drugs in these hotspots was approximately 2,500, with a range of 1,800 to 3,100. Approximately 9 per cent of people who use drugs in the hotspots were injecting substances.

The total estimated number of women who used drugs in the hotspots was 2,670, with a range from 2,080 to 3,270. Women accounted for 10 per cent of all people who use drugs in these areas. Additionally, the estimated total number of children under 15 years old using drugs in the hotspots was 2,150, ranging from 1,700 to 2,600. Children represented 8 per cent of individuals who used drugs in these areas.

Socio-demographic characteristics of people with high-risk drug use: The median age of the 6,893 interviewed people engaging in high-risk drug use was 35.

Compared to the general population, people engaging in high-risk drug use had a lower socio-economic status. Half of them reported having no formal education, compared to 37 per cent of the adult population. Sixty per cent were married and 8 per cent were divorced or separated. More than one-fifth of hotspot respondents reported experiencing homelessness. Although approximately 70 per cent were employed, three-quarters of them reportedly engaged in irregular work. Families and friends provided financial support in 43 per cent of cases, while a third reported engaging in crime to pay for their drug use.

Drug use patterns: Women and men engaging in high-risk drug use display different drug use patterns in terms of drugs used, their initiation, and harm experienced. Men generally initiated drug use, typically at earlier ages, and with cannabis, while women reported starting with opium. In most cases, drug use began between the ages of 20 and 30. Cannabis use typically began earlier, with a median starting age of 19, while opium use started at a median age of 23, heroin at 25, and methamphetamine at 27.

Among men, the use of opiates (primarily opium and heroin), stimulants (mainly methamphetamine), and cannabis was common among hotspot respondents. Among women, the most used substances were opium, followed by methamphetamine, heroin, and sedatives. Cannabis use was rare among women. Poly-drug use (the use of more than one drug) was common among hotspot respondents with half consuming drugs from two classes and 10 per cent using drugs from three classes simultaneously. The rate of poly-drug use in the past month in the sample was 61 per cent in men and 30 per cent in women. Key informants' estimates of drug use in their area generally aligned with the personal use patterns reported by individuals engaging in high-risk

drug use. Additionally, key informants indicated that cannabis, methamphetamine and heroin were the most commonly used substances among adolescents, while opium was most prevalent among younger children, followed by heroin.

Among men, heroin and methamphetamine were associated with the most harm, such as health, legal, or family problems. In contrast, for women, opium posed the most significant harm, followed by methamphetamine and heroin. However, these differences largely correlate with variations in prevalence between the sexes. The highest monthly expenditures on drugs were for heroin (on average 35 USD) and methamphetamine (on average 28 USD).

Injection drug use: Approximately 8 per cent of hotspot respondents (8.2 per cent of men and 6.6 per cent of women) had a history of injection drug use in their lifetime and 5.3 per cent had injected in the last six months (5.5 per cent of men and 3.7 per cent of women). Individuals who injected drugs tended to be older, had lower levels of education, and a higher rate of unemployment. Many were divorced or separated, were homeless, or lived alone or with friends, and they often relied on financial support from others. Heroin was the most commonly injected drug (70 per cent of hotspot respondents), followed by methamphetamine (31 per cent). Most injections occurred in public places, such as abandoned houses, graveyards, under bridges, sewage drains, streets, parks, gardens, and agricultural lands. Half of those who injected drugs found it easy to access sterile needles and syringes, while the other half faced difficulties in accessing them. More than three-quarters had shared needles and syringes with someone else in the past six months, either by giving or receiving a used needle or syringe.

Arrest: Nearly one in five hotspot respondents had a history of being arrested for drug-related offences (20 per cent of men and 1 per cent of women). The arrest rate was higher among men, individuals with a history of injection drug use, those living in rural areas, those experiencing homelessness, those who were divorced or separated, and those with higher levels of drug dependence (assessed by the Severity Dependence Scale).

Treatment: Half of hotspot respondents had a lifetime history of receiving treatment for a substance use disorder (53 per cent of men and 29 per cent of women). This rate was lower among younger individuals, those with lower levels of dependence, and in rural areas. The percentage of people who use drugs who had received treatment varied significantly by geography, ranging from 7 per cent in Urozgan to 86 per cent in Samangan. Over half of hotspot respondents reported having received treatment only once. More than two-thirds of individuals found it difficult to access treatment for drug use disorders in their local area. Most key informants believed that the available drug treatment services were widely utilized, and they considered them to be acceptable and beneficial. The majority of hotspot respondents had received treatment for opiates, mainly heroin, followed by opium, which was in line with the results of the UNODC survey on facilities for treatment of substance use disorders in Afghanistan.[1] Moreover, a greater percentage reported accessing treatment in the Western region of the country, which also corresponds to the findings of the survey on facilities, which noted a higher coverage for treatment in this region. Financial constraints, fear of stigma and structural factors (such as limited service availability, lack of scientifically-based options, service shortages, and poor food quality at centres) were the primary barriers reported by hotspot respondents who did not receive treatment.

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1 UNODC Afghanistan Drug Insights Vol. 3. Mapping of facilities for treatment of substance disorders: Addressing service provision challenges in a humanitarian crisis. 2024.

Trends over time: In addition to the current hotspot survey, a similar study was conducted in 2009.[2] When comparing the key indicators from the current study to those of the previous one, several significant changes are noted [Figure 1]. In the current study, the literacy rate among participants is higher, and a greater proportion of individuals are homeless and living alone. Moreover, use of cannabis and opium has decreased, while the use of heroin and stimulants has increased significantly. Stimulants, the use of which was barely reported in 2009, were consumed by 55 per cent of the current sample in the 30 days prior to interview. Additionally, there appears to be an increase in injecting drug use between the two surveys.

Figure 1. Main findings from two studies on people with high-risk drug use conducted in Afghanistan in 2009 and 2023
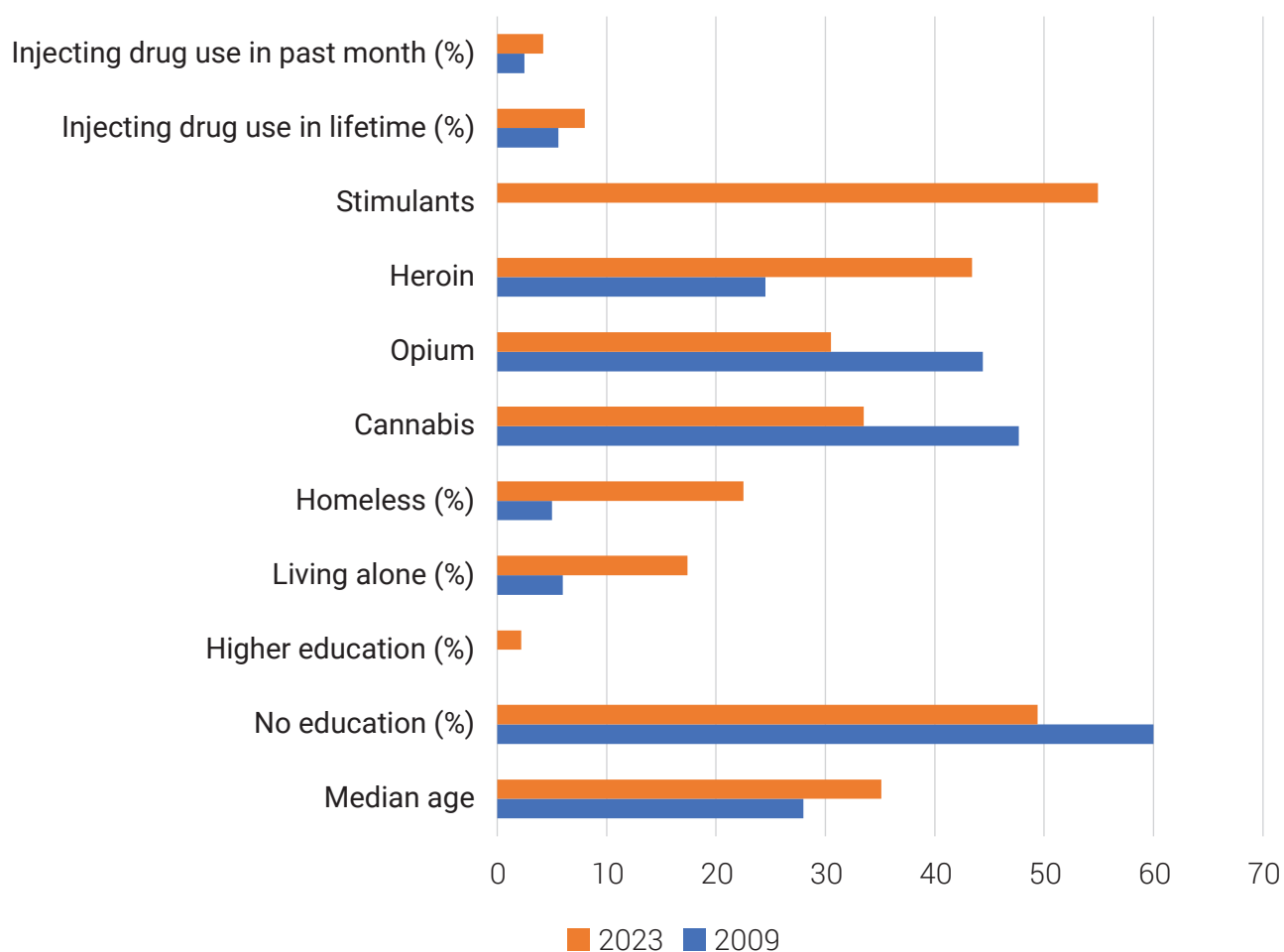
2 UNODC. Drug Use in Afghanistan: 2009 survey. United Nations Office on Drugs and Crime, Ministry of Counter-Narcotics, Ministry of Public Health. 2009.

1.3 Policy recommendations

Based on the trends observed in the three aforementioned studies, the following recommendations are made:

1. Develop drug use prevention programmes customized to the cultural and socio-economic contexts of Afghanistan, addressing children's vulnerabilities and empowering families in protecting children;

2. Enhance and expand drug use disorder treatment services to provide a variety of interventions, including medication-assisted treatment, psychosocial support, and housing assistance, tailored to meet the specific needs and circumstances of individuals who use drugs, particularly the most vulnerable such as children and adolescents;

3. Promote efforts to strengthen reintegration or post-treatment support, such as vocational reintegration and family support programmes, to facilitate long term recovery for those who use drugs;

4. Offer a range of interventions along the continuum of care aimed at minimizing the harms associated with drug use for individuals, their families, and society as a whole, especially for injecting drug use. Presently, a high rate of individuals reporting injection drug use also share injection equipment, posing severe health risks. Efforts should be made to reduce sharing of needles and increasing access to sterile injection equipment;

5. Address the unique needs of women by establishing women-specific treatment centres for drug use disorders, especially in areas with high demand;

6. Implement continuous monitoring mechanisms through a data surveillance system and repeated surveys for the early detection of changes in drug consumption patterns and contributing factors, as well as to evaluate the effectiveness of responses.

2 CONTEXT

2.1 Introduction

Afghanistan has an estimated population of over 42 million people, of which approximately 27 per cent live in urban areas.[3,4] It is considered a low-income country, with an adult literacy rate of 37 per cent, and a life expectancy at birth of 63 years.[5,6,7] The Afghan population has endured five decades of instability, war and poverty, along with limited access to essential health and social services.

2.2 Drug production and supply

Afghanistan has historically played a crucial role in the global illicit production and trade of drugs, particularly opium and cannabis. Between 2018 and 2022, it was estimated that Afghanistan produced between 5,000 and 6,500 tons of opium annually.

The impact of illicit drug cultivation and production on economic, environmental and social development in Afghanistan has been complex. Before illegal opium cultivation drastically decreased in 2023, the gross value of the Afghan opiate economy was significant, accounting for 6 to 11 per cent of the country's gross domestic product in 2020.[8] Drug production has contributed to the emergence of an illicit economy, leading many communities to depend on income from opium poppy cultivation.[9] However, the drug ban implemented by the De facto Authorities (DfA) in April 2022 has led to a significant decrease in opium production since 2023, along with a reduction in opiate-related income.[10,11]

Illicit cannabis cultivation has also characterized Afghanistan over the years. In 2012, it was estimated that the cultivation of cannabis was more profitable per hectare than opium.[12] Afghanistan has also been the second most reported country as a source of cannabis resin worldwide, with 19 per cent of countries identifying it as their primary supplier from 2014 to 2018.[13] There is no updated information available regarding the impact of the drug ban on cannabis production.

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3 World Bank. Data on population estimates and projections. 2024. Available at: https://databank.worldbank.org/source/population-estimates-and-projections.
4 World Bank. Data on urban population. 2024 Available at: https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?end=2023&locations=AF&start=2023.
5 World Bank. Data on population estimates and projections. 2024. Available at: https://databank.worldbank.org/source/population-estimates-and-projections.
6 World Bank. Data on literacy rate. 2024. Available at: https://data.worldbank.org/indicator/SE.ADT.LITR.ZS.
7 World Bank. World Bank Country and Lending Groups: 2025 Definition. 2024. Available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.
8 Afghanistan Ministry of Interior Affairs & UNODC. Afghanistan drug price monitoring monthly report. 2020.
9 Ibid.
10 UNODC. Opium poppy cultivation 2024; Afghanistan Drug Insights, Volume 1. United Nations Office on Drugs and Crime. 2024. Available at: https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V1.pdf.
11 UNODC. Opium production and rural development 2024; Afghanistan Drug Insights, Volume 2. United Nations Office on Drugs and Crime. 2024. Available at: https://www.unodc.org/coafg/uploads/documents/Afghanistan_Drug_Insights_V2.pdf.
12 Afghanistan Ministry of Counter-Narcotics & UNODC. Afghanistan Survey of Commercial Cannabis Cultivation and Production 2012. 2013.
13 UNODC. World drug report 2020. 2020. Vienna, United Nations Office on Drugs and Crime (United Nations publication, Sales No. E.20.XI.6).

Methamphetamine has been manufactured in Afghanistan for at least a decade. Like other drugs, it was banned by the DfA in 2022, but its precursors, ephedrine, pseudoephedrine and ephedra plant, continue to be widely available across the country and its manufacture may have not been disrupted as quickly as opium cultivation.[14] A drastic increase in methamphetamine seizures in Afghanistan and neighbouring countries has been reported in recent years, suggesting that methamphetamine manufacture and trafficking remains unimpeded.[15]

2.3 Drug use

Afghanistan faces a significant challenge with drug use. The 2012-2014 Afghanistan national household drug use survey based on biological samples[16] estimated that approximately 16.1 per cent of men and 19.5 per cent of women in Afghanistan had exposure to some drug, including alcohol. Opioids were found in 10.3 per cent of men and 6.7 per cent of women, and cannabis was found in 6.1 per cent of men and 1.5 per cent of women.

Several studies were conducted on various groups of people who use drugs, revealing that opiates, followed by cannabis, were the primary substances used among individuals with drug use disorders. A large study carried out from 2011 to 2014 surveyed 3,163 people who use drugs across 17 Afghan provinces known for high levels of drug production and use.[17] The findings indicated that most people who used drugs were young, married, and had either no education or a low level of education, and were unemployed. Specifically, the study found that 38 per cent of participants reported using opium in the five years leading up to the survey (35 per cent of men and 54 per cent of women). Heroin use was reported by 30 per cent of participants (37 per cent of men and 12 per cent of women), while 26 per cent reported using cannabis (33 per cent of men and 9 per cent of women). Additionally, 15 per cent stated they used more than one drug in a single day. The first drug used was opium for 44 per cent of participants, cannabis for 36 per cent, and heroin for 16 per cent.

Furthermore, since 2022, the DfA have been actively taking people who use drugs and who are without adequate housing to treatment centres managed by the Ministry of Public Health or the Ministry of Interior.[18] This may be altering the characteristics and prevalence of people who currently use drugs in public hotspots.

2.4 Injecting drug use and the associated harms

The use of opiates has been linked to injecting drug use and its associated harms in Afghanistan. In 2019, a mapping study and population size estimation for people who inject drugs (PWID) was conducted in eight cities, identifying 374 hotspots. The total number of PWID in 31 cities is estimated to be over 25,000, including more than 1,000 women.[19] The estimate was slightly higher than the previous estimate from 2009, which ranged

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14 UNODC. World drug report 2024. 2024. United Nations Office on Drugs and Crime. Available at: https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2024.html.

15 UNODC. Understanding illegal methamphetamine manufacture in Afghanistan. 2023. United Nations Office on Drugs and Crime. Available at: https://www.unodc.org/documents/data-and-analysis/briefs/Methamphetamine_Manufacture_in_Afghanistan.pdf.

16 SGI Global & Colombo Plan. Afghanistan National Drug Use Survey (ANDUS). 2015. Available at: https://colombo-plan.org/wp-content/uploads/2020/03/Afghanistan-National-Drug-Use-Survey-2015-compressed.pdf.

17 UNODC. Impacts of drug use on users and their families in Afghanistan. United Nations Office on Drugs and Crime. 2014.

18 UNODC & UNDP. Mapping of facilities for treatment of substance use disorders in Afghanistan: Addressing Service Provision Challenges in a Humanitarian Crisis; Afghanistan Drug Insights, Volume 3. United Nations Office on Drugs and Crime. 2024.

19 Afghanistan MoPH. Global AIDS monitoring, country progress report, Afghanistan. Afghanistan Ministry of Public Health. 2020.

from 18,000 to 23,000.[20] Additionally, unsafe injection practices among PWID had significantly increased during peak periods of conflict.[21]

A 2012 Integrated Biological and Behavioral Surveillance (IBBS),[22] reported an HIV prevalence range of 0.3 per cent to 13.3 per cent among PWID in Afghanistan. A concentrated epidemic of HIV was identified in Herat, where the prevalence reached 13.3 per cent. Many PWID demonstrated inadequate knowledge about HIV, and risky behaviours such as unsafe sex and sharing injection practices were commonly observed. Furthermore, during the 2010s more than 40 per cent of people identified with HIV in Afghanistan were people who inject drugs.[23] From 2009 to 2019, PWID accounted for 41 per cent of all HIV-related deaths. Moreover, it was believed that HIV prevalence among PWID was increasing at that time.[24]

2.5 Policies and programs

The national health strategy of Afghanistan for 2016-2020 focused on addressing substance use and substance use disorders as a key objective. This included enhancing treatment capacity and improving access to quality preventive, curative and rehabilitative services for individuals who use drugs, with drug use disorders and other vulnerable populations.[25] Since 2010, the country has launched several large-scale campaigns against drug use targeting various populations.[26]

The number and capacity of treatment centres had substantially increased according to the 2015 Afghanistan Drug Report, although the overall treatment capacity remained insufficient.[27] Most of these centres were situated in urban areas and were supported by various donors providing free treatment services. While private drug use disorder treatment centres were also present, there was limited data available regarding their operations. Presently, drug treatment centres offer a variety of services, including inpatient and outreach programmes, harm reduction, community-based services and shelter.

The first opioid agonist maintenance treatment (OAMT) programme in Afghanistan was launched in Kabul in 2010. By 2019, over 2,000 PWID were receiving methadone maintenance treatment (MMT), a type of OAMT.[28] A study on the efficacy of drug treatment centres in Afghanistan found that these centres were largely successful in reducing both substance use and its related consequences.[29] In 2022-2024, UNODC,

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20 Afghanistan MoPH. HIV/AIDS country progress report 2014. Afghanistan, Afghanistan Ministry of Public Health. 2014.
21 Todd, C. S., Nasir, A., Stanekzai, M. R., Fiekert, K., Sipsma, H. L., Strathdee, S. A., & Vlahov, D. Impact of conflict and displacement on risk behaviours amongst people who inject drugs in Kabul, Afghanistan. International Journal of Drug Policy 2016, 27: 173-177.
22 Johns Hopkins University & Afghanistan MoPH. Integrated Biological & Behavioral Surveillance (IBBS) in selected cities of Afghanistan: findings of 2012 IBBS survey and comparison to 2009 IBBS survey. Afghanistan Ministry of Public Health and Johns Hopkins University Bloomberg School of Public Health. 2012.
23 Aghaei, A. M., Gholami, J., Sangchooli, A., Rostam-Abadi, Y., Olamazadeh, S., Ardeshir, M., Baheshmat, S., Shadloo, B., Taj, M., Saeed, K.& Rahimi-Movaghar, A. Prevalence of injecting drug use and HIV, hepatitis B, and hepatitis C in people who inject drugs in the Eastern Mediterranean region: a systematic review and meta-analysis. The Lancet Global Health 2023, 11(8): e1225-e1237.
24 Afghanistan MoPH. The National HIV, STIs and Hepatitis Strategic Plan IV (NSP IV) 2021-2025. Afghanistan Ministry of Public Health. 2020.
25 Afghanistan MoPH. National health strategy 2016 2020. Afghanistan Ministry of Public Health. 2016.
26 Afghanistan Ministry of Counter Narcotics & UNODC. Afghanistan drug report 2015. 2015.
27 Ibid.
28 Afghanistan MoPH. The National HIV, STIs and Hepatitis Strategic Plan IV (NSP IV) 2021-2025 (see footnote 24).
29 Shamblen, S. R., Courser, M., Young, L., Schweinhart, A., Shepherd, C., Morales, B., & Redpath, B. The efficacy of drug treatment in Afghanistan: overall results and implications from a new evaluation". International Journal of Mental Health and Addiction 2022, 20(1): 541-552.

with funding from UNDP, conducted a mapping study of facilities for the treatment of substance use disorder.[30] The study identified 82 operational treatment facilities, mainly residential treatment centres, that primarily serve male patients. Although treatment services were available in almost all provinces, there were significant disparities in their distribution and accessibility, which particularly affected women. Opiates were found to be the most common primary substances leading to treatment admissions in Afghanistan, followed by a significant demand for services addressing stimulant use, particularly methamphetamine and amphetamines.

In 2023, a significant reduction in international and public funding resulted in only 10 per cent of drug treatment centres remaining operational with international support. Meanwhile, 44 per cent of the centres were closed, and the rest were operating on limited budgets. Moreover, the number of needle and syringe programmes, as well as MMT sites, has declined.[31]

These changes in both Afghanistan's drug scene and the associated policies and responses highlight the need for new assessments and studies to gain a better understanding of the current situation.
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30   UNODC & UNDP. Mapping of facilities for treatment of substance use disorders in Afghanistan (see footnote 18).
31   Noroozi, A., De Lara, M., & Abouzeid, A. Drug policies and responses in Afghanistan. The Lancet Psychiatry 2024, 11 (2): 90-91.

3 METHODS

This report presents the findings of three interconnected studies:

1. Mapping of Drug Use Hotspots
2. Key Informant Interviews
3. High-Risk Drug Use Survey

The timeline and process for implementing these studies are illustrated in Figure 2.

Figure 2. The process of the three parts of the study

Mapping Drug Use Hotspots	Key Informant Interviews	High-Risk Drug Use Survey
3,555 interviews	*1,232 interviews*	*6,893 interviews*

Nov 2022   *Dec 2022*   *Nov 2023*
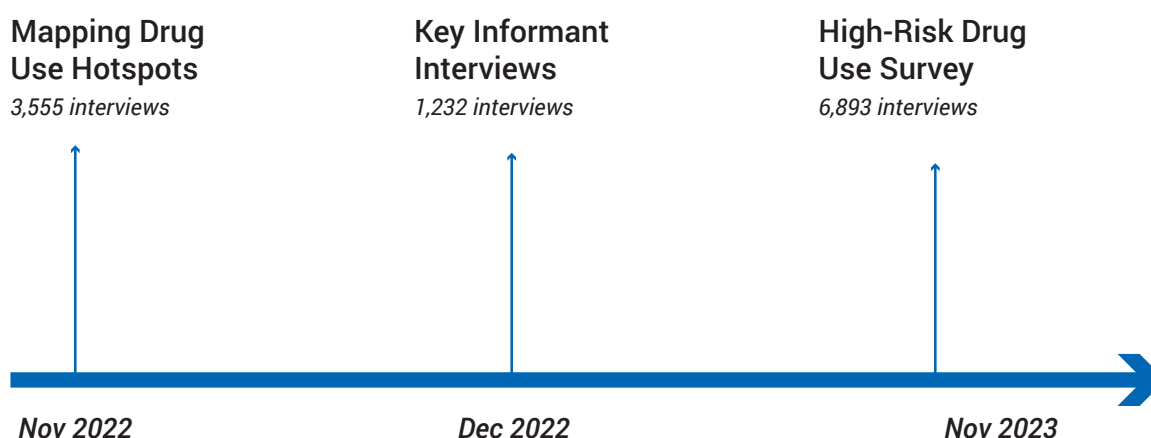
The Mapping of Drug Use Hotspots aimed to identify areas where individuals who use drugs congregate and consume drugs in public places. The study also aimed to estimate the number of hotspots, as well as the number of people who use drugs, including those who inject drugs in these areas. Additionally, the study assisted in identifying key individuals, referred to as "seeds", for the high-risk drug use survey. This study was conducted in each province's capital city and between one to four districts across 34 provinces.

Interviews of key informants were conducted to collect in-depth information about the extent and nature of drug use, as well as their knowledge of the availability of treatment programmes and their opinions of their effectiveness. The study was carried out across each provinces' capital city and two districts surrounding it.

The High-Risk Drug Use Survey was designed to assess the socio-demographic characteristics of respondents, their first drug use experience, patterns of drug use, harms associated with drug use, history of injecting drug use, high-risk behaviours, drug-related offences, and utilization of treatment services, along with the barriers they encountered. People engaging in high-risk drug use were defined as individuals who had regularly used primarily opiates or amphetamine-type stimulants for non-medical purposes in the past 30 days, and who had faced problems related to their drug use, such as health issues, legal challenges or family difficulties. This study was also conducted across all 34 provinces' capital city and two districts.

The questionnaires used for the three studies consisted of both open-ended and closed-ended questions to facilitate the collection of qualitative and quantitative data and guide in-person interviews. The interviewers used an online system to complete forms during the in-person interviews with all males who use drugs and, in certain cases, conducted mobile phone interviews with females who use drugs.

Fieldwork was conducted by teams of male and female interviewers in each province. Significant efforts were made to interview female respondents to accurately assess the situation regarding female individuals who use drugs as well. Eighty-four interviewers with significant education and survey experience conducted the fieldwork. The interviewers received two days of training and conducted a practical interview with a drug user. For the purpose of cognitive testing, questionnaire development and data verification, focus group discussions were conducted in various provinces of the country (Badakhshan, Balkh, Kabul, Kandahar and Nangarhar).

Ethical considerations for the survey included ensuring the safety and security of field workers, obtaining informed consent from respondents, and preserving anonymity and confidentiality.

The main substances were classified as:

- Opiates: opium and heroin
- Pharmaceutical opioids: tramadol, methadone, buprenorphine, and butorphanol
- Cannabis
- Stimulants/hallucinogens:[32] methamphetamine, amphetamine, tablet K, ecstasy (MDMA), ketamine, and other hallucinogens
- Inhalants/solvents
- Sedative/hypnotics: barbiturates, benzodiazepines, and pregabalin

Descriptive statistics [frequency, percentage, range, mean, Standard Deviation (SD), median] were used in the data analysis, depending on the variable type. Bivariate analysis employed chi-square/Fisher's exact tests for categorical variables and independent t-tests for continuous variables to assess associations between groups. P-values <0.05 were considered statistically significant. The population estimates from the Afghanistan National Statistics and Information Authority were utilized to estimate the selected indicators for the general population of Afghanistan and its provinces.[33]

For the mapping of hotspots, respondents were asked to identify hotspots in their local area where people who use drugs gather and consume drugs in public. Some respondents did not identify any hotspots, while others mentioned more than one. Two provinces, Khost and Paktia, were excluded from the analysis due to low precision in defining the hotspots.

For estimating the population size of people who use drugs in the hotspots, the respondents were asked to estimate the overall number of individuals who use drugs, the numbers of children and women using drugs, and the number of people who inject drugs in each identified hotspot. They were instructed to provide both their lower and upper estimates. For each hotspot, the median values of the lower and upper estimates provided by the respondents were calculated separately. Next, for each geographical area – such as a region, city, or district – the median estimates were summed to obtain the overall estimations for that area, separately for the lower and upper bounds of people who use drugs. Then, to calculate the estimations for each province, all the estimates made for the districts or areas within that province were summed, again separately for the lower and upper bounds of people who use drugs. Finally, midpoints were derived by averaging the lower and upper bounds for each group.

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32   Stimulants and hallucinogens are grouped together because some stimulants can produce hallucinogenic effects, while certain hallucinogens may have stimulating effects. For instance, ecstasy (MDMA) exhibits both types of effects nearly equally. Furthermore, in this study, differentiating between drugs in this category may not be entirely precise.
33   Afghanistan National Statistics and Information Authority (NISA). Statistical Yearbook 2022-23.

It is important to note that the estimates for each province are based solely on the districts or cities where the study was conducted and do not account for all areas within a province. Caution should be exercised when comparing data between provinces, as in this study different types of area were covered in each province. In areas where a larger number of respondents have identified a hotspot, the estimates can be considered more reliable.

The number and characteristics of participants in the three parts of the study are presented in Table 1.

Table 1. Number and characteristics of participants in the three parts of the study

	Number of persons interviewed	Percentage of women interviewed	Percentage of persons interviewed in rural areas
Mapping drug use hotspots	3,555	20.7%	Not recorded
Key informant interviews	1,232	33.3%	30.3%
High-risk drug use survey	6,893	8.0%	13.3%

4 RESULTS

4.1 Profile of drug users

Data on the socio-demographic characteristics of people engaging in high-risk drug use is shown in Table 2. The age of respondents ranged from 14 to 80, with an average of 35.1 (SD=9.9) and a median of 35. Approximately 90 per cent of the participants were between the ages of 20 and 50 [Figure 3]. There was no significant difference in mean age between men and women. The average age was 35.6 (SD= 12.7) in women and 35.1 (SD= 9.7) in men and the median was 35 in both sexes.

Figure 3. Age distribution (in percentage) of people with high-risk drug use according to the general population (a) and by sex (b), Afghanistan, 2023 (N=6,893).
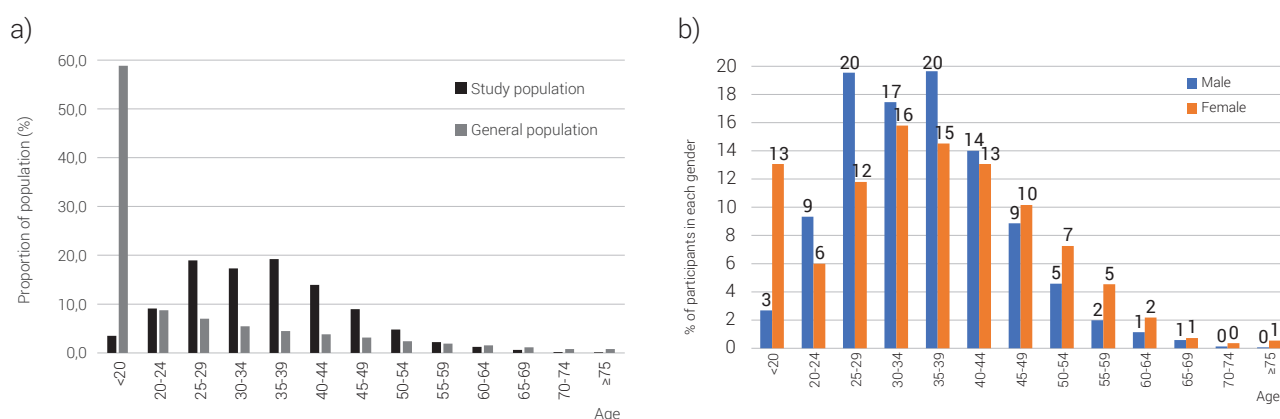
Nearly 50 per cent of the respondents had no formal education, while 2 per cent had received higher education. Among women, approximately three-quarters had no education, and the level of secondary school education was lower compared to men. For respondents from rural areas, the rate of illiteracy was lower, and the level of education was higher than those from urban areas. Regarding marital status, approximately 60 per cent of the participants were married, while 8.3 per cent were previously married. Among women, the percentage of singles was lower, and the percentage of widowed or divorced individuals was higher compared to men.

Answering the question on the place they had mainly lived in during six months before the interview, the majority (76.8 per cent) reported living in a house. However, a significant portion of the respondents lived in public places, such as streets (21.4 per cent). Other places included hotels or camps. Among those who did not specify the type of place they lived in (N=30), most (n=20) reported being in Iran during that period. Among women, the prevalence of living in public places and shelters was much lower than for men. Nearly three-quarters of participants had resided with their family or relatives for the past six months. Most were living with their spouses and children, followed by parents. Others lived alone or with friends. Living with family or relatives was significantly more common among women and in rural areas than among men and in urban areas.

Most of the respondents self-reported as being employed (about 70 per cent). However, the main type of work was casual. About a third were either unemployed or homemakers. The second most common source of support was family and friends (43.1 per cent). However, a significant proportion of respondents (31.9 per cent)

admitted to supporting themselves through committing various crimes. In the case of women, the primary source of support was their families (65 per cent).

Table 2. Socio-demographic characteristics of people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

Variables (N)	Total (%)	Sex		Living area	
		Men (%)	Women (%)	Urban (%)	Rural (%)
Age (6893)					
≤20 (353)	5.1	4.3	15.1	4.9	5.5
21-30 (2240)	32.5	33.3	23.2	31.8	33.9
31-40 (2511)	36.4	37.1	28.9	36.1	37.1
41-50 (1338)	19.4	19.2	22.1	20.2	17.9
51-60 (365)	5.3	5.0	8.2	5.5	4.8
>60 (86)	1.2	1.1	2.5	1.5	0.7
Education (6892)					
No education (3403)	49.4	47.2	74.0	51.0	46.2
Primary (1441)	20.9	21.4	15.6	20.4	21.9
Secondary (1804)	26.2	27.7	8.3	25.1	28.4
Higher education (153)	2.2	2.2	2.0	2.3	2.1
Madrasa (91)	1.3	1.4	0.0	1.3	1.4
Marital Status (6892)					
Never married (2246)	32.6	33.6	20.9	33.0	31.8
Married (4074)	59.1	59.3	56.4	57.9	61.5
Previously married (572) [a]	8.3	7.0	22.7	9.1	6.7
Place of residence in past 6 months (6863)					
House (5270)	76.8	75.1	96.4	71.2	87.9
Homeless (1547)	22.5	24.2	3.6	28.2	11.3

Prison (24)	0.3	0.4	0.0	0.2	0.7
Others (22)	0.3	0.3	0.0	0.4	0.1
Living with in past 6 months (6887)					
Family/ close relatives (5010)	72.7	70.8	95.3	67.3	83.7
Friends (679)	9.9	10.7	0.7	12.8	4.0
Alone (1198)	17.4	18.6	4.0	19.9	12.3
Source of financial support (6883) [b]					
Work (5037)	73.2	75.7	44.3	71.5	76.6
Received from others (2969)	43.1	40.8	70.1	36.8	55.8
Crime perpetuation (2199)	31.9	32.7	23.4	32.1	31.5
Occupation (6888)					
Full-time work (1044)	15.2	15.9	6.5	16.9	11.7
Part-time work (686)	10.0	10.3	6.0	10.1	9.7
Casual work (3072)	44.6	45.6	33.5	44.1	45.5
Unemployed/homeworker (2034)	29.5	27.5	53.3	28.4	31.7
Student (39)	0.6	0.6	0.5	0.3	1.2
Others (13)	0.2	0.2	0.2	0.2	0.3

[a] Previously married includes divorced, separated, and widowed.

[b] The total percentage exceeds 100% as respondents could choose multiple options.

Note: numbers in parentheses show the total respondents to each question. There were significant differences between men and women, as well as between urban and rural areas, in terms of age, education, marital status, place of residence, people living with, and occupation. Regarding the source of financial support, the only significant difference observed was between men and women.

4.2 Drug initiation

Among respondents, cannabis was reported as the substance first used by more than half of the individuals engaging in high-risk drug use. Opium was the next most commonly reported substance of initiation, and heroin was the third. Figure 4 shows the substance first used by the participants. In the sample, a very high percentage (95.1 per cent) reported continuing to use the substance after initiation. Among men, cannabis (57 per cent) and opium (25 per cent) were the most commonly reported substances first used [Figure 5], while among women, opium (60 per cent) followed by heroin (20 per cent) were the most common reported substances first used [Figure 6].

Figure 4. Proportion of first substances used reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

First used substance	% of participants
Cannabis	52,4
Opium	28,1
Heroin	10,9
Methamphetamine/Amphetamine	4,9
Tablet K	2,0
Sedatives	0,8
Pharmaceutical opioids	0,6
Codeinated cough syrup	0,2
Inhalants	0,1
Cocaine	0,04
Ecstasy/MDMA	0,04
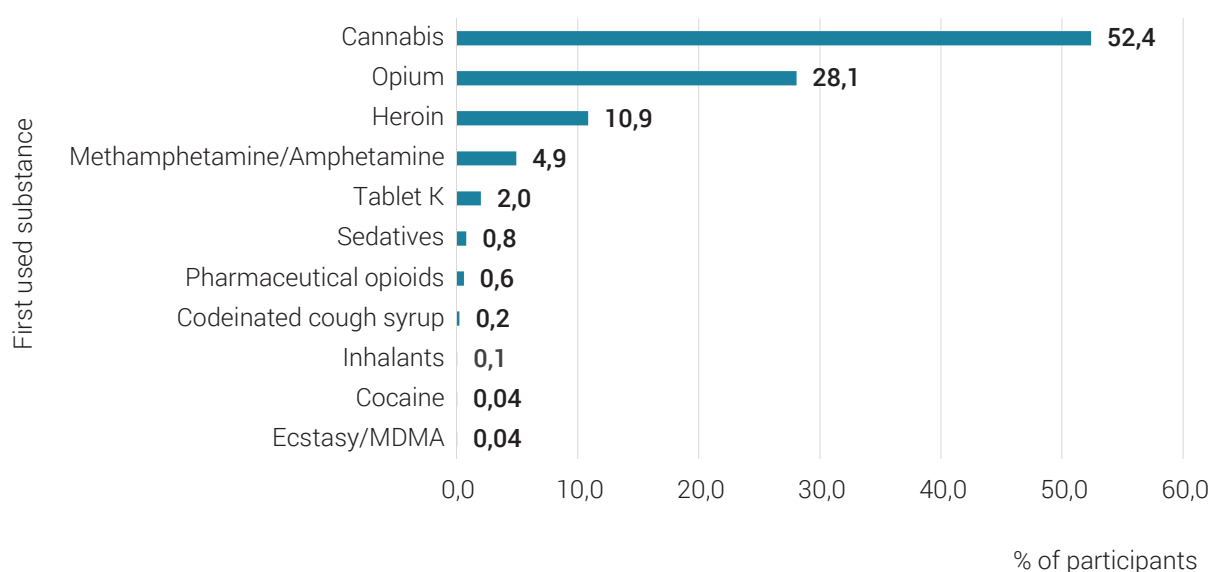
Figure 5. Proportion of drug of initiation used among male individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,342).

First used substance	% of male participants
Cannabis	56,7
Opium	25,3
Heroin	10,1
Methamphetamine/Amphetamine	4,3
Tablet K	2,1
Pharmaceutical opioids	0,6
Sedatives	0,5
Codeinated cough syrup	0,3
Inhalants	0,1
Cocaine	0,05
Ecstasy/MDMA	0,05
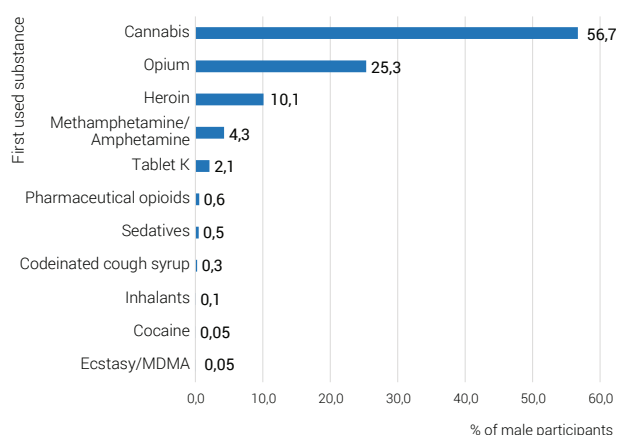
Figure 6. Proportion of drug of initiation used among female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=551).

First used substance	% of female participants
Opium	59,5
Heroin	19,8
Methamphetamine/Amphetamine	12,5
Sedatives	3,8
Cannabis	2,7
Tablet K	1,3
Pharmaceutical opioids	0,4
Codeinated cough syrup	0,0
Inhalants	0,0
Cocaine	0,0
Ecstasy/MDMA	0,0
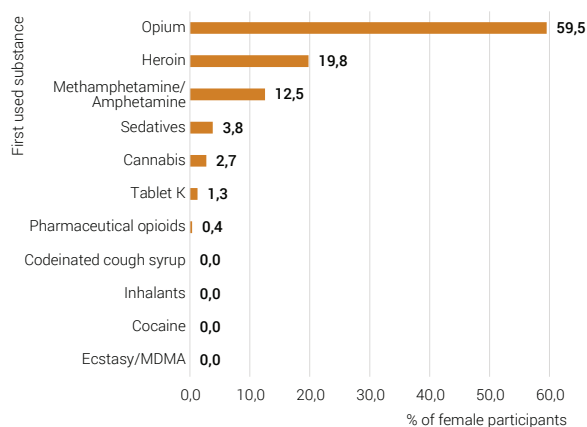
Both in urban and rural areas, more than half of the respondents reported using cannabis as their first substance. However, starting with heroin and methamphetamine was more common, while starting with opium was less common in rural areas compared to urban areas. Overall, the differences in first drug use patterns were significant both between men and women and between urban and rural areas. Cannabis was the most commonly reported first substance in 21 provinces, while opium was the most common in 11 provinces. In two provinces, Urozgan and Kapisa, heroin was reported as the most used first substance.

Figure 7 depicts the age at first use for various substances.[34] Cannabis had the lowest average age of initiation, at 19.9 (SD=5.0), with a median age of 19. Opium followed, with an average age of initiation at 23.7 (SD=6.5) and a median age of 23.

Figure 7. Mean and median age at first use for each substance reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
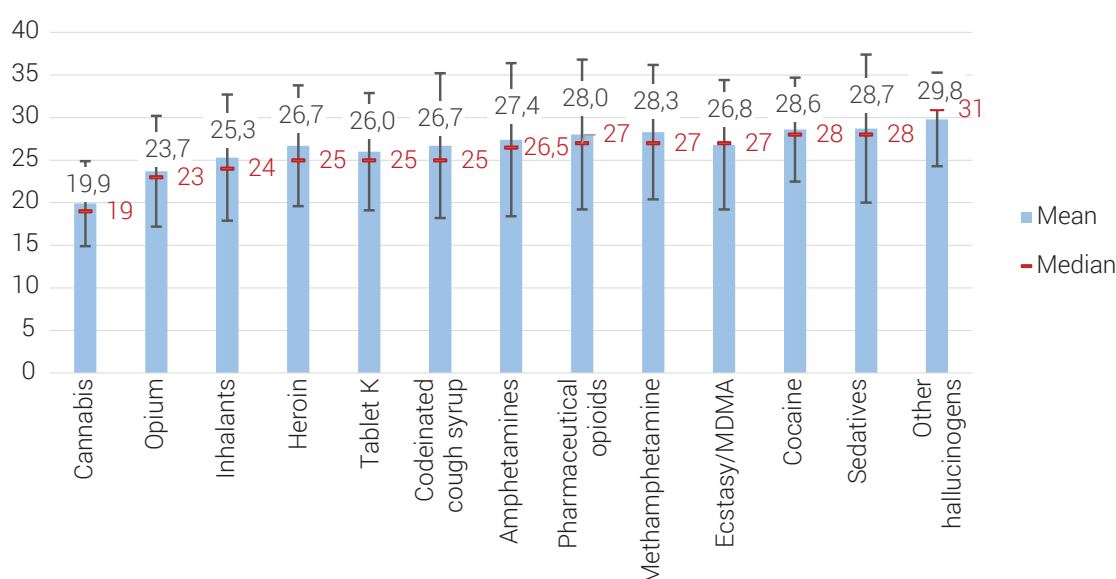
Note: red numbers indicate median and black numbers indicate mean. The whiskers show the 95% confidence intervals.

Among **key informants** interviewed, the median estimated age of initiation obtained for most substances was 25 for both men and women. The median age of the estimations was lower for cannabis and opium than for other drugs, in both sexes. For individuals 20-25 years old, the median age of initiation for most substances was estimated to be 20, with a lower age for cannabis (18). For adolescents between 10 and 19 years old, the median estimated age of initiation was 16 or 17. For children under 10 years old, the median age of 8 was estimated for initiating most substances, with an age of 5 for opium and codeine-based cough syrup.

4.3 Patterns of drug use

The most commonly used substances by reported by respondents were opiates, followed by stimulants/hallucinogens and cannabis, both in the past month, the past year and throughout their lifetime. From 6,893 respondents, 78.5 per cent reported lifetime use of opiates, 71.9 per cent reported use in the past 12 months and 62.2 per cent reported use in past 30 days. The prevalence of lifetime use of stimulants or hallucinogens was 70.6 per cent, past 12-month use was 66 per cent and use in the past 30 days was 54.9 per cent. People

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34   See also Table 1 of the Annex 1. Statistical information.

reporting lifetime opiate or stimulant/hallucinogen use are more likely to report use during the past 30 days (79.2 per cent and 77.8 per cent) than those who have tried cannabis (51.9 per cent).

A large group of participants were using more than one substance at a time [Figure 8]. Among 5,675 participants who used opiates, stimulants/hallucinogens, or cannabis in the past 30 days, 41.3 per cent used only one type of drug, 49.2 per cent used two, and 9.5 per cent used all three. While 61 per cent of men with polydrug use (use of more than one drug type in the past 30 days), in women the rate is 29.6 per cent.

Figure 8. Proportion (%) of people engaging in high-risk drug use who reported using three main drug classes (cannabis, opiates and stimulants) in the past 30 days and their overlaps, Afghanistan, 2023 (N=5,675).
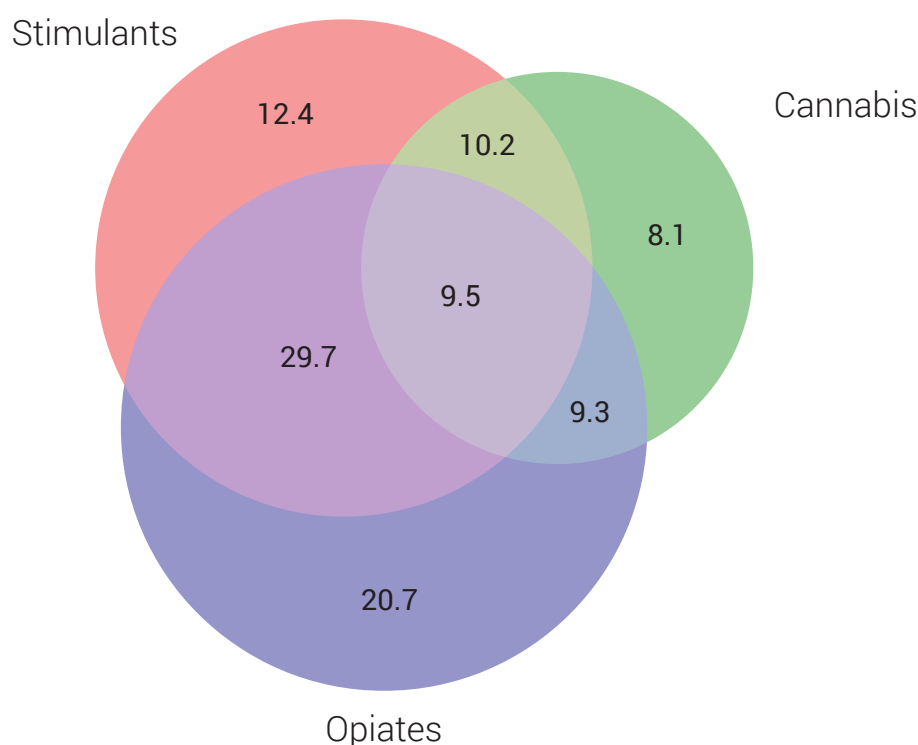
When disaggregating opiates and stimulants [Figure 9], the drugs most commonly used in the past 12 months among all participants are methamphetamine and/or amphetamine, heroin, cannabis and opium.[35] The drugs most commonly used in the past 30 days are methamphetamine and/or amphetamine, heroin, cannabis and opium.

Among men [Figure 10], the drugs most commonly used in the past 12 months are methamphetamine and/or amphetamine, heroin, and cannabis. Again, the drugs most commonly used in the past 30 days are methamphetamine and/or amphetamine, heroin and cannabis.

Among women [Figure 11], opium, and methamphetamine and/or amphetamine are the most commonly used drugs in the past 12 months. Opium, and methamphetamine and/or amphetamine are the most commonly used drugs in the past 30 days.

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35   See also Table 2 of Annex 1. Statistical Information

Figure 9. Prevalence of use of the seven most commonly used substances by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

Cannabis — 64,2 / 45,1 / 33,3
Opium — 61,6 / 41,5 / 30,5
Methamphetamine/Amphetamine — 61,0 / 57,8 / 48,0
Heroin — 56,6 / 50,4 / 43,4
Tablet K — 23,1 / 15,9 / 9,0
Sedatives — 19,2 / 13,0 / 7,5
Pharmaceutical opioids — 10,5 / 6,4 / 3,1

% of participants

■ Lifetime use   ■ Last 12-month use   ■ Last 30 days use
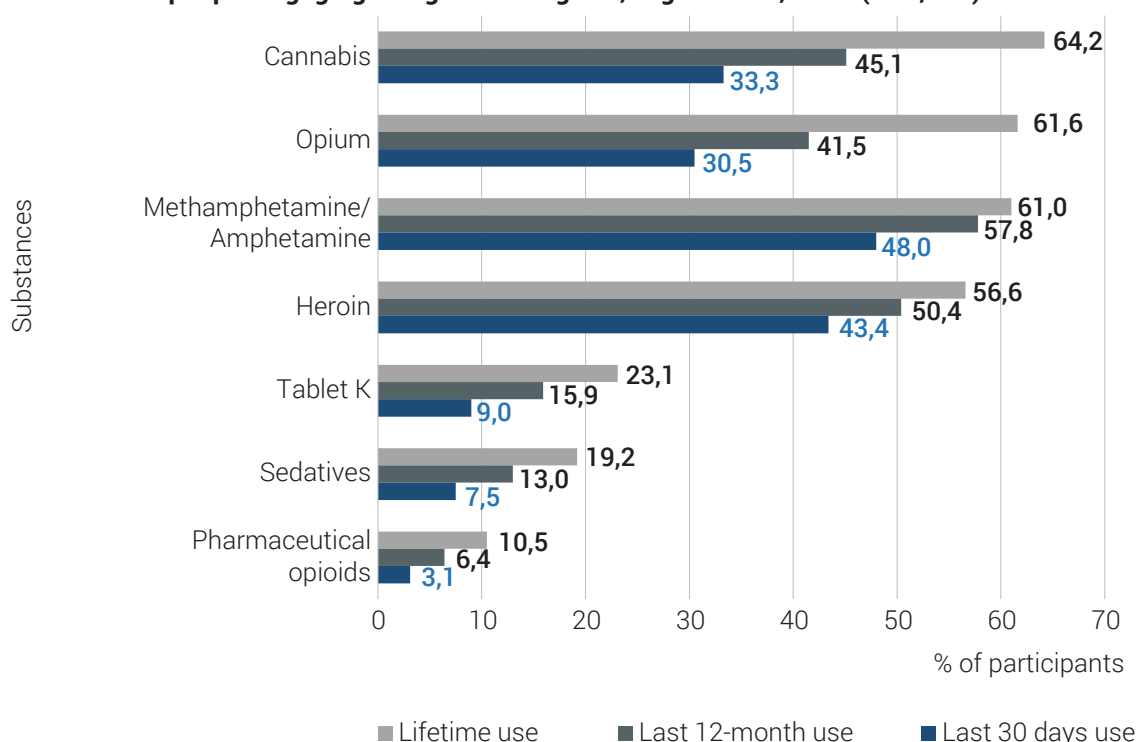
Figure 10. Prevalence of use of the most commonly used substances among male individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,342).

Cannabis — 69,2 / 48,8 / 36,2
Methamphetamine/Amphetamine — 62,2 / 58,9 / 49,0
Opium — 61,6 / 40,9 / 29,6
Heroin — 58,1 / 51,8 / 45,1
Tablet K — 24,3 / 16,8 / 9,5
Sedatives — 18,3 / 11,8 / 6,3
Pharmaceutical opioids — 10,9 / 6,5 / 3,1

% of male participants

■ Lifetime use   ■ Last 12-month use   ■ Last 30 days use
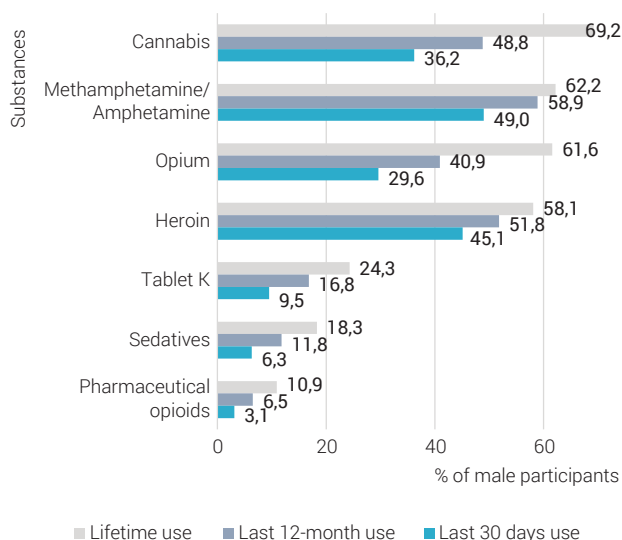
Figure 11. Prevalence of use of the most commonly used substances among female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=551).

Opium — 62,1 / 48,6 / 40,1
Methamphetamine/Amphetamine — 47,0 / 44,5 / 36,4
Heroin — 39,0 / 34,4 / 23,7
Sedatives — 29,8 / 27,0 / 21,5
Tablet K — 8,9 / 6,2 / 3,4
Cannabis — 6,5 / 3,1 / 1,8
Pharmaceutical opioids — 6,0 / 4,7 / 3,6

% of female participants

■ Lifetime use   ■ Last 12-month use   ■ Last 30 days use
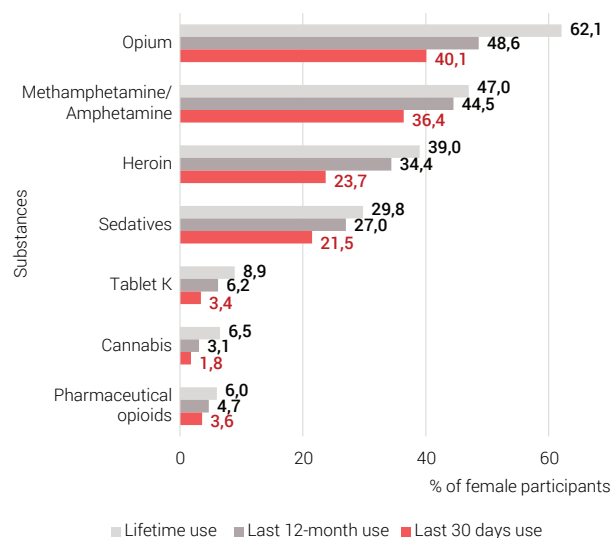
The provincial distribution of the four most commonly used drugs in the past 30 days among the general sample, namely opium, heroin, cannabis, and methamphetamine and/or amphetamine, is shown in Maps 1-4. Opium use is most prevalent in Badakhshan and Bamyan, while heroin use is highest in Urozgan and Baghlan. Cannabis use is most common in Panjshir and Kunar, mainly in the East and Southeast of the country. Methamphetamine and/or amphetamine use is predominantly found in Takhar and Kunduz, primarily in the North and Northwest of the country.

Map 1. Provincial distribution of opium use in the past 30 days as reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
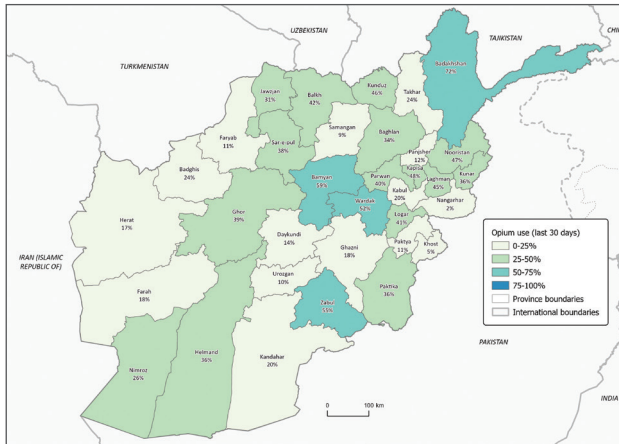
Map 2. Provincial distribution of heroin use in the past 30 days as reported by people engaging in high-risk drug use Afghanistan, 2023 (N=6,893).
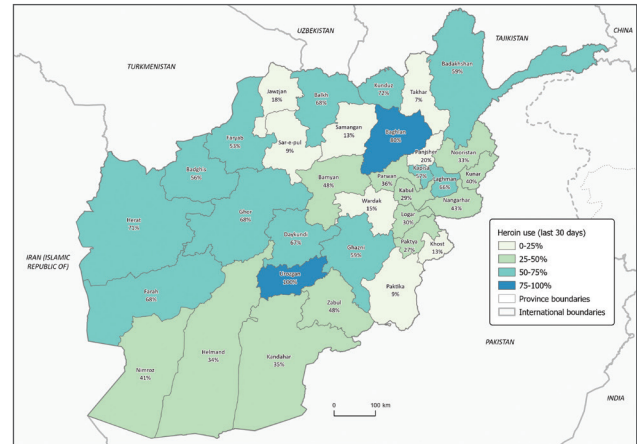
Map 3. Provincial distribution of cannabis use in the past 30 days as reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
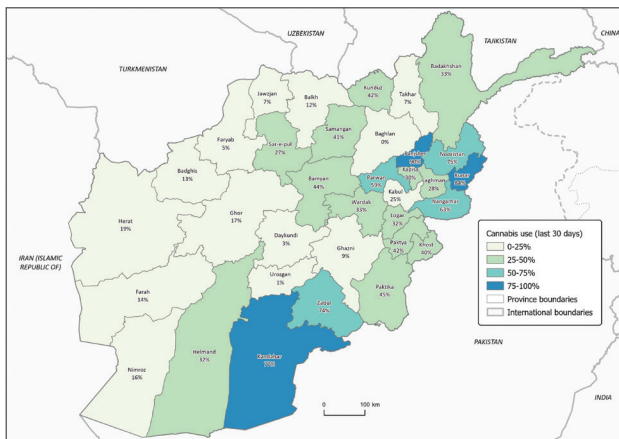
Map 4. Provincial distribution of methamphetamine and/or amphetamine use in the past 30 days as reported by people engaging in high-risk drug use, 2023 (N=6,893).
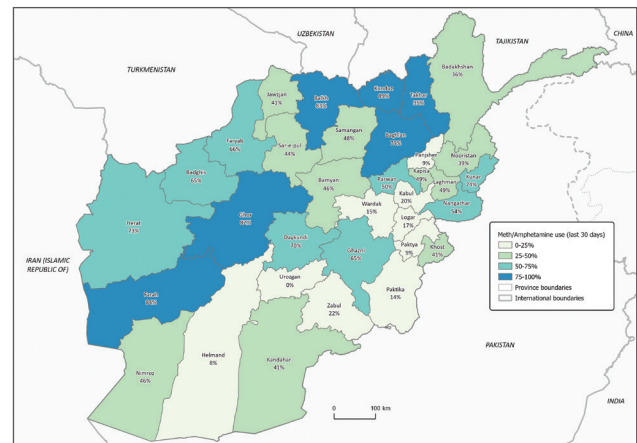
When assessing the number of days of use within the past 30-day period, heroin, methamphetamine and cocaine were associated with a higher frequency of use than other substances [Figure 12].[36]

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36 See also Table 2 of Annex 1. Statistical information

Figure 12. Number of days of substance use over the past 30 days among people engaging in high-risk drug use, Afghanistan, 2023.
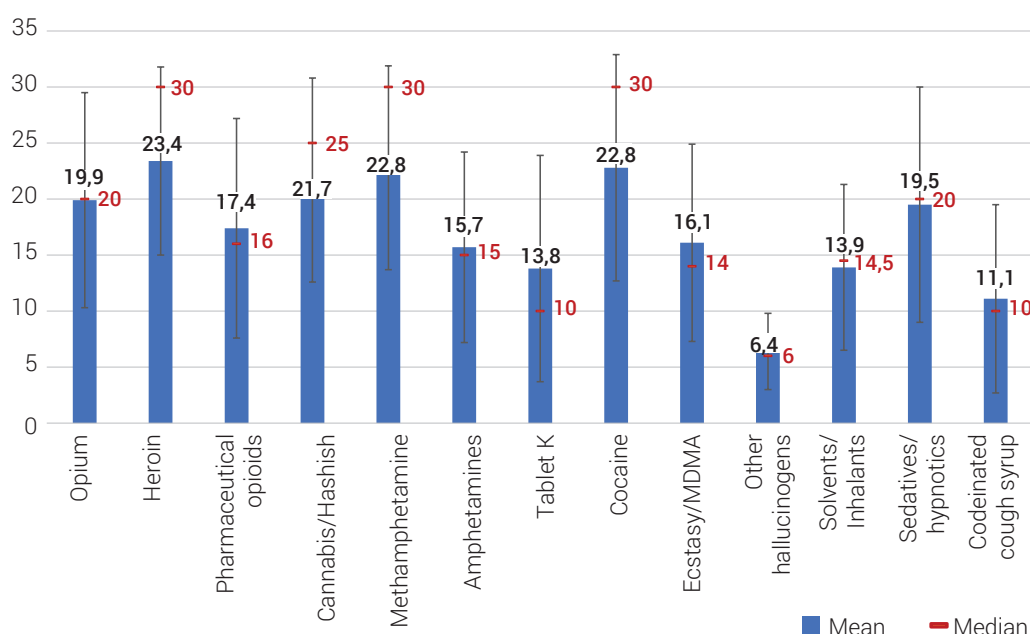
Note: red numbers indicate median and black numbers indicate mean. The whiskers indicate the 95% confidence intervals.

Moreover, ecstasy, cannabis, methamphetamine, heroin, and hallucinogens were more frequently used during a typical day than other substances [Figure 13].[37]

Figure 13. Times used in a typical day over the past 30 days among people engaging in high-risk drug use, Afghanistan, 2023.
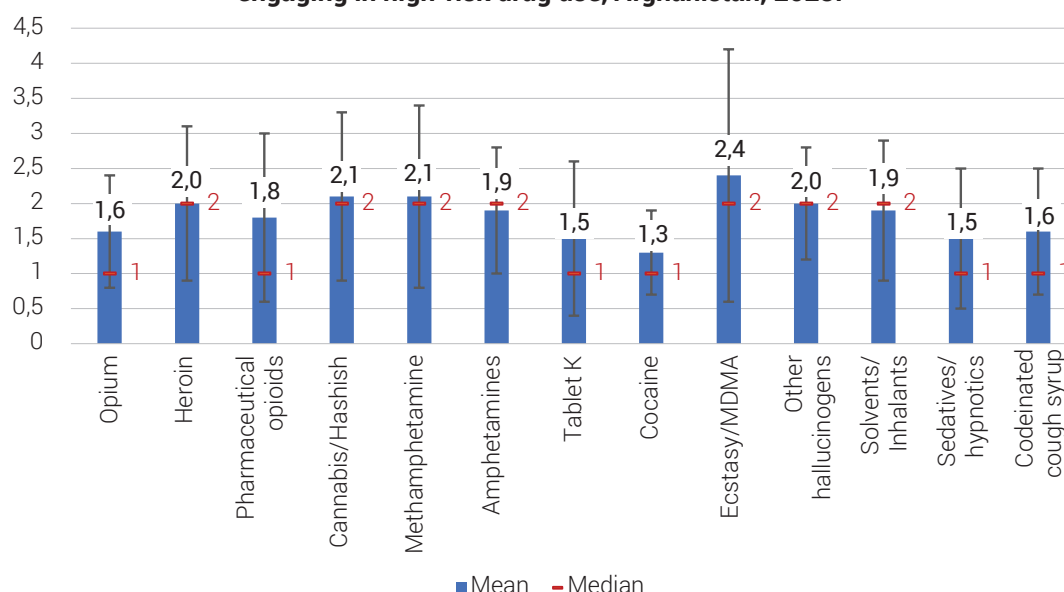
Note: red numbers indicate median and black numbers indicate mean. The whiskers indicate the 95% confidence intervals.

The median cost of heroin for 30 days was 2,500 Afghanis (equivalent to 35.2 USD)[38] with an average cost of about 3,000 Afghanis (41.4 USD), making it the costliest substance, followed by methamphetamine and cocaine [Figure 14].[39]

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37   Ibid.
38   1 USD = 71 Afghani.
39   See also Table 3 of Annex 1. Statistical information

Figure 14. Money spent over the past 30 days on substances (USD) among people engaging in high-risk drug use, Afghanistan, 2023.
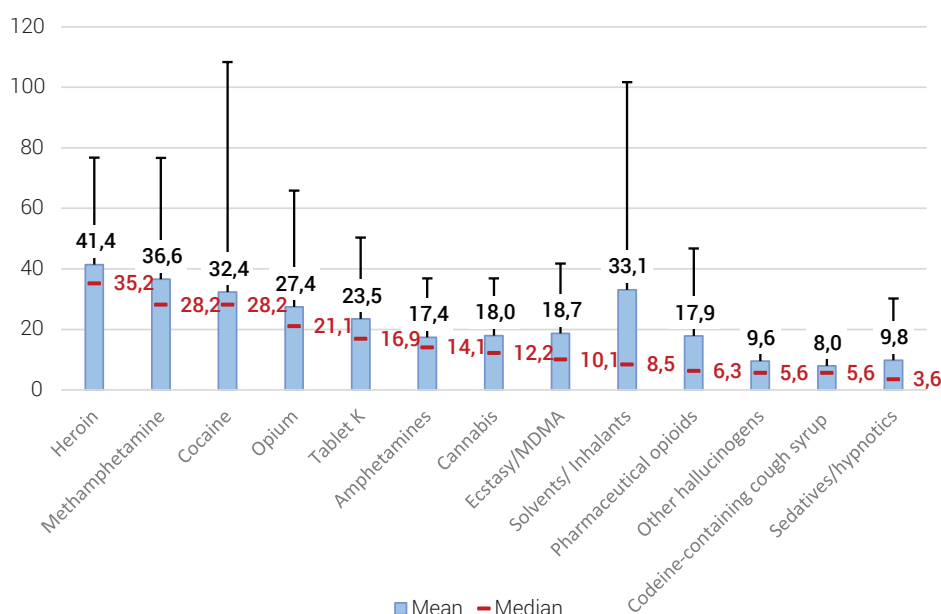
Note: red numbers indicate median and black numbers indicate mean. The whiskers indicate the 95% confidence intervals.

Key informants reported cannabis as the most commonly used substance in their area, followed by heroin and opium [Figure 15].[40] Opium, heroin, pharmaceutical opioids and amphetamine were reported more frequently in urban areas than in rural areas, while cannabis and methamphetamine were reported more often in rural areas than in urban areas. Among women, opium and heroin were reported by key informants more frequently than other substances. Among adolescents aged 10–19, cannabis, methamphetamine, and heroin were reported most frequently, while among children under 10, opium was reported most often, followed by heroin.

Figure 15. Key informants' beliefs about substance use in their area, Afghanistan, 2022 (N=1,232).

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40   See also Table 4 of Annex 1.
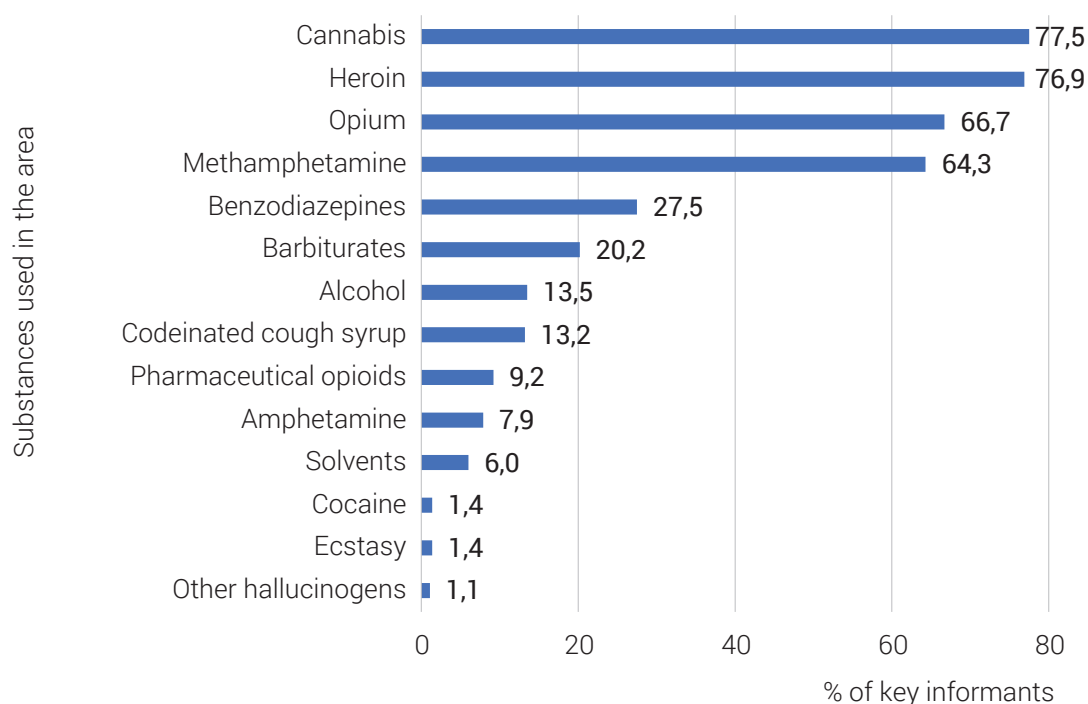
Key informants were asked if they personally knew individuals who used different types of substances. People who used cannabis were the most commonly known, followed by individuals who used heroin and opium. No respondents reported knowing anyone who used ecstasy (MDMA), and only a few knew individuals using cocaine (3 people) and hallucinogens (1 person) [Figure 16].[41]

Key informants reported knowing more women who used opium and heroin, followed by benzodiazepines, than other substances.[42]

Figure 16. Distribution of key informants reporting personally knowing someone who uses substances, Afghanistan, 2022 (N=1,232).

Substance	Value
Cannabis	38,4
Heroin	35,6
Opium	29,3
Methamphetamine	20,4
Benzodiazepines	11,2
Barbiturates	8,2
Alcohol	4,6
Codeinated cough syrup	4,5
Pharmaceutical opioids	1,9
Amphetamine	1,5
Solvents	0,9
Cocaine	0,2
Other hallucinogens	0,1
Ecstasy	0,0
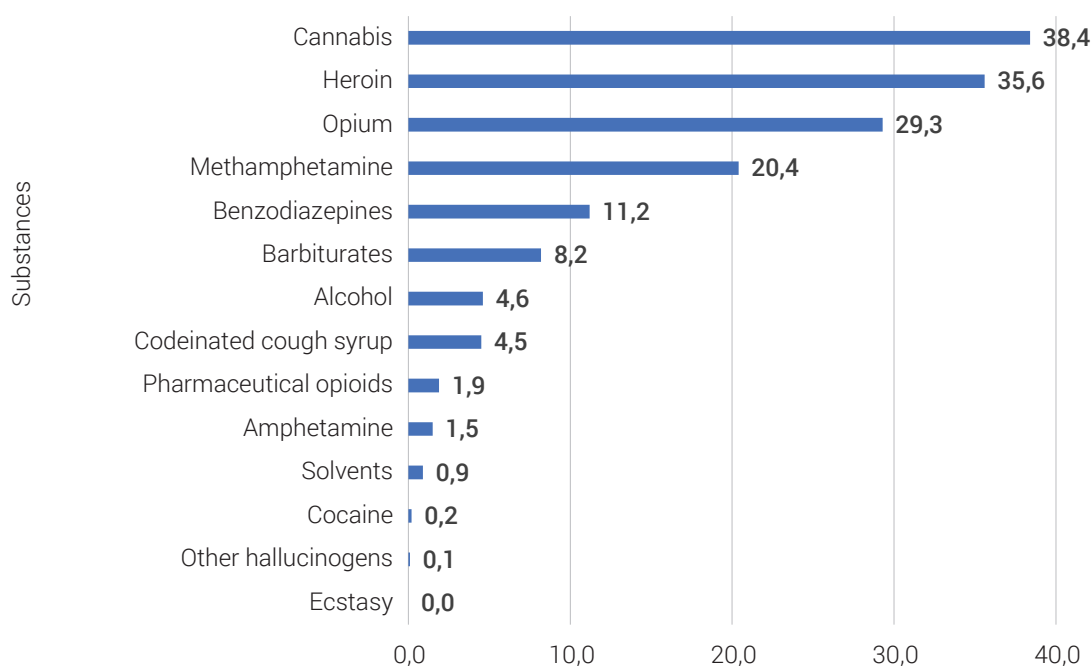
4.4 Harms of drugs

Respondents were assessed using the Severity Dependence Scale (SDS) and 96 per cent of them scored 5 or higher, indicating drug dependency. All participants were asked to identify the substance that caused the most harm (health, legal, or family problems) in the past six months. The most frequently reported substance was heroin, followed by methamphetamine and/or amphetamine [Figure 17].

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41   See also Table 5 of Annex 1. Statistical information
42   Ibid.

Figure 17. Distribution (in percentage) of substances perceived as the most harmful over the past six months among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
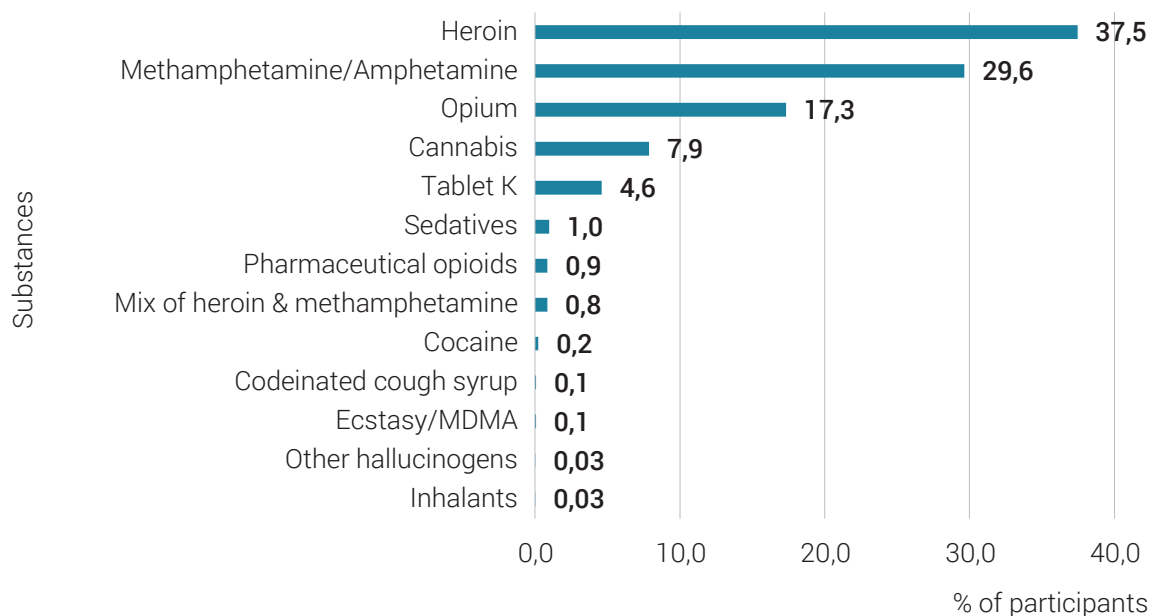
Figure 18. Distributions of substances perceived as the most harmful over the past six months among male individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,342).
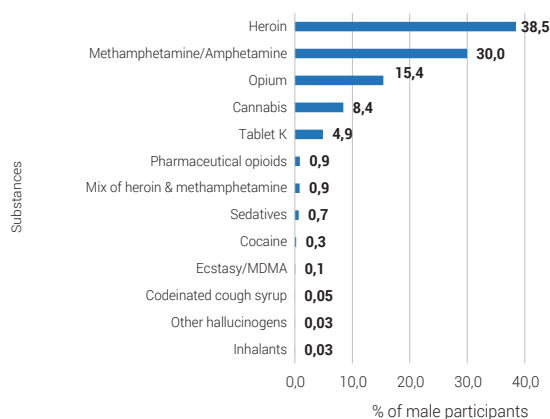
Figure 19. Distribution of substances perceived as the most harmful over the past six months among female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=551).
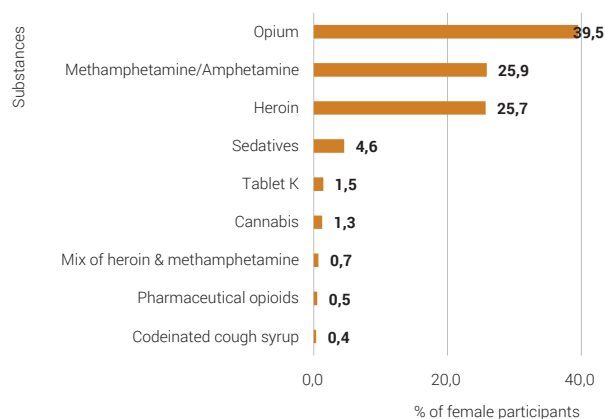
Among men, heroin and methamphetamine and/or amphetamine were reported as the substance associated with the most harms [Figure 18]. Among women, opium was reported most frequently, followed by methamphetamine and/or amphetamine and heroin [Figure 19]. The differences in responses between women and men were found to be significant. In both urban and rural areas, heroin and methamphetamine and/or amphetamine were reported to have greater harm, but in urban areas, the share of harm is greater for these two substances groups.

Map 5 depicts the most harmful substances as perceived by respondents in each province. Heroin was most commonly reported as the most harmful substance in 18 provinces, while methamphetamine and/or amphetamine were in 11 provinces. Opium was the most commonly reported harmful substance in three provinces, while cannabis was in two.

Map 5. Provincial distribution of the most harmful substances reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
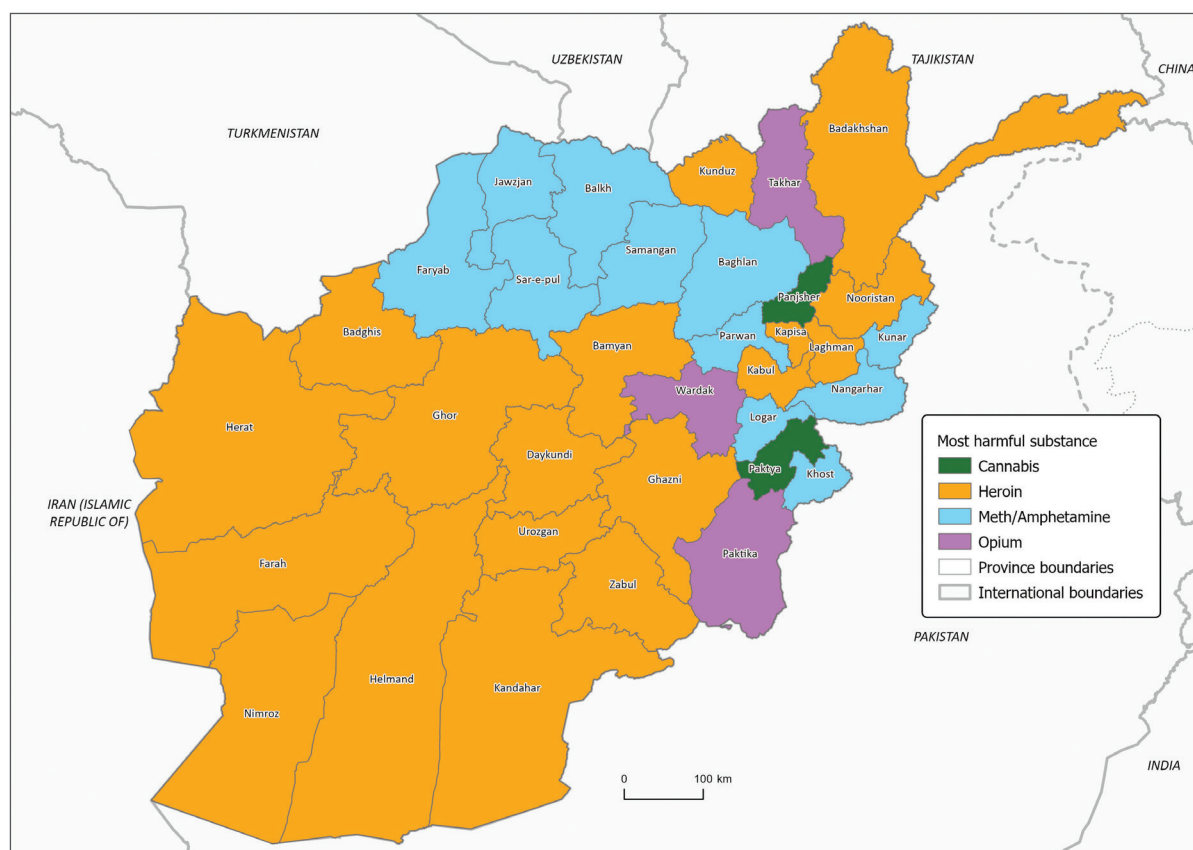
Participants reported a wide range of negative effects from their most harmful substance, including health issues, financial strain, family problems, difficulties in work or education, behavioural issues, and legal challenges [Figure 20].[43] Women reported lower rates of harm to parents and friends, difficulties in work and education, and violence compared with men. Moreover, respondents residing in rural areas reported higher rates of negative effects related to health, family, education, and violence and a lower rate of legal trouble.

Figure 20. Distribution (in percentage) of perceived harmful consequences of the substances reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

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43   See also Table 6 of the Annex.
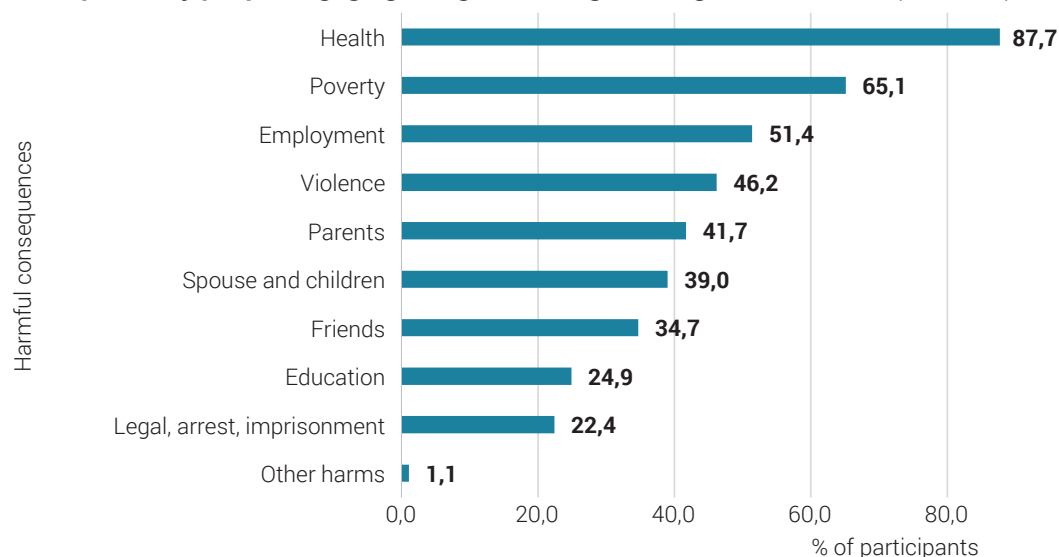
Figure 21. Distributions of perceived harmful consequences of the substances among male individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,342).
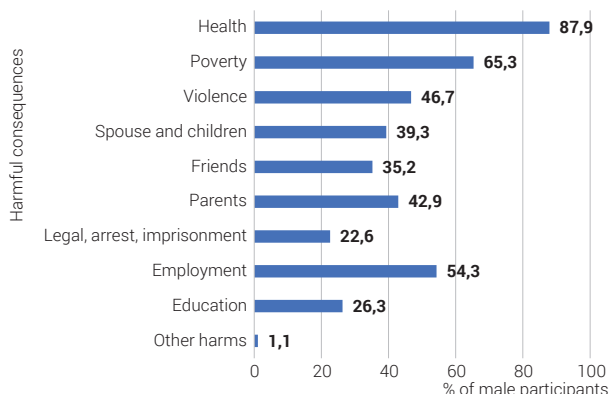
Figure 22. Distributions of perceived harmful consequences of the substances among female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=551).
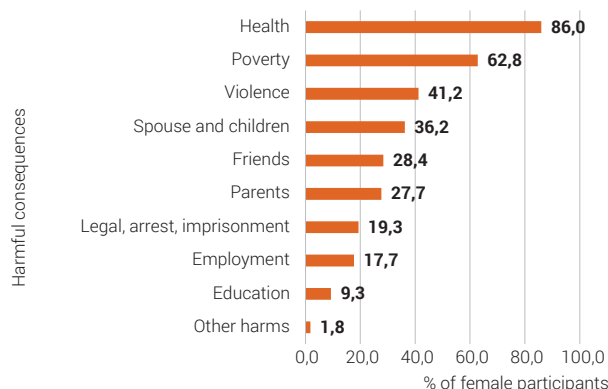
Fewer than 5 per cent of participants reported engaging in sex work or having sex with a sex worker over the past six months.[44]

A history of blood donation was reported by 13.2 per cent and blood sales by 1.7 per cent of respondents. Women reported significantly lower rates of both, at 3.8 per cent and 0.7 per cent, respectively. Location (urban vs. rural) had no significant impact. Individuals with a history of injecting drugs reported higher rate of blood sales (6.2 per cent) compared to those without such a history (1.3 per cent).[45]

Out of 6,305 respondents who reported never injecting drugs, 6,087 answered questions about histories of being infected by infectious diseases. Among those, 11.8 per cent had been infected with at least one of the following five diseases: HIV, hepatitis C virus (HCV), hepatitis B virus (HBV), tuberculosis (TB), or sexually transmitted infections (STIs) in their lifetime. Specific infection rates were 0.8 per cent for HIV, 1.8 per cent for HCV, 2.1 per cent for HBV, 5.7 per cent for TB, and 3.7 per cent for STIs. Infection rates did not significantly differ between men and women. HIV prevalence was higher in rural areas (1.3 per cent) compared to urban areas (0.6 per cent), and TB prevalence was also higher in rural areas (7.5 per cent) compared to urban areas (4.7 per cent).

4.5 Injecting drug use

Respondents were asked about their history of injecting drug use over their lifetime, past six months, and past 30 days [Figure 23].[46] The difference between men and women was only significant for injection in the past 30 days (4.4 per cent vs. 2.4 per cent). The difference between those residing in urban and rural areas was only significant for the lifetime history of injection (8.6 per cent vs. 6.9 per cent) [Figure 23, Figure 24]. Bamyan, Balkh, and Paktika were the provinces with the highest percentage of current injecting use [Map 6]. PWID were asked about the number of injections on a typical use day. Of these, 77 per cent reported injecting once a day, 22.6 per cent reported injecting two to four times a day, and 0.6 per cent reported injecting more than four times a day.

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44   See Table 7 of Annex 1. Statistical Information
45   See Table 8 of Annex 1. Statistical Information
46   See also Table 9 of Annex 1. Statistical Information

Figure 23. History of injecting drug use among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
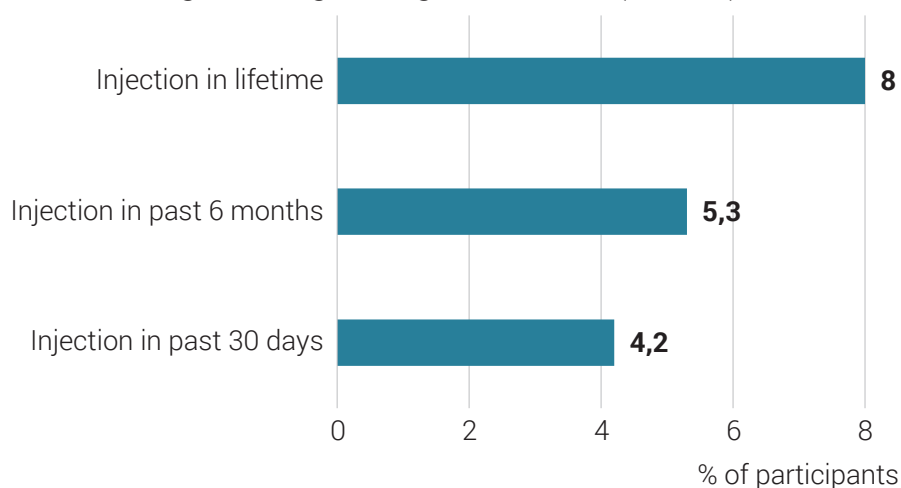
Figure 24. Prevalence of injecting drug use among male and female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
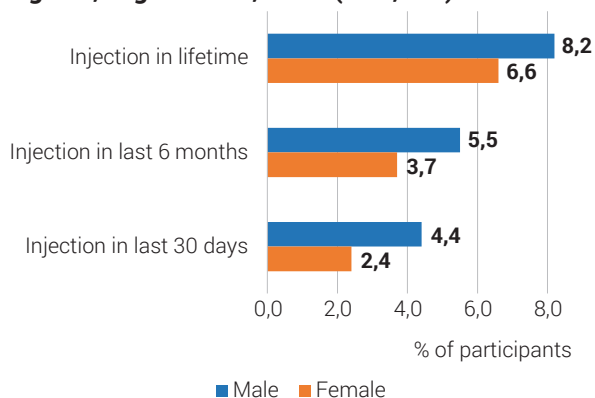
Figure 25. Prevalence of injecting drug use in urban and rural areas among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
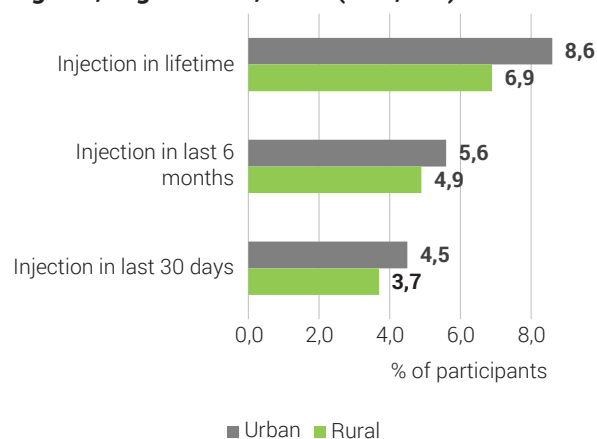
Map 6. Provincial distribution of the prevalence of injecting drug use over the past six months among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).
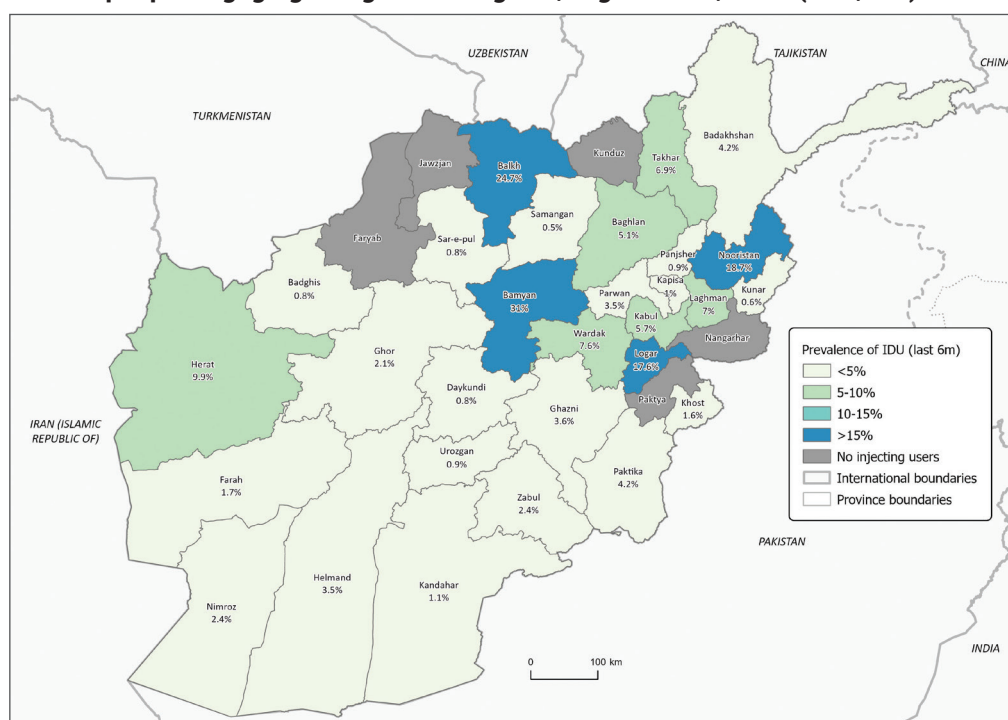
Characteristics of the PWID in the past six months were compared with people who had not injected (non-PWID).[47] The mean age of PWID (37.7) was significantly higher than that of non-PWID (34.9). Among PWID compared to non-PWID, the level of education was significantly lower. Additionally, a higher proportion of PWID were previously married, homeless, living alone or with friends, received financial support from others, and were unemployed.

Those who did not report injection (N=6,305) were asked about their reasons for not injecting.[48] The most common reasons included fears of becoming too addicted (48.7 per cent), not wanting to become like those who inject (47.4 per cent), and concerns about physical health (41.2 per cent). Other common reasons included the cost of injection, lack of knowledge about how to inject, not having friends or partners who inject, difficulty in accessing syringes, and fear of the pain associated with injection. Not seeing the need for injection, not liking injection, and using non-injectable drugs were cited as less common reasons for not practicing substance injection.

Those with a history of injecting who had not used any substances by injection in the past six months (N=172) were asked about their reasons for not continuing injection. The most common reason was the cost of injection, followed by the unavailability of syringes.[49] Heroin was the most prevalent injected drug (70.2 per cent) over the past six months, followed by methamphetamine and/or amphetamine (30.6 per cent). While there were no differences between the sexes in terms of drug types injected, rural areas showed a higher share of heroin and pharmaceutical opioids, and a lower share of stimulants for injection [Figure 26][50] compared to urban areas.

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47   See Table 10 of Annex 1. Statistical information
48   See Table 11 of Annex 1. Statistical information
49   See Table 12 of Annex 1. Statistical information
50   See also Table 13 of Annex 1. Statistical information

Figure 26. Distribution of substances (in percentage) injected in the past six months reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=365).
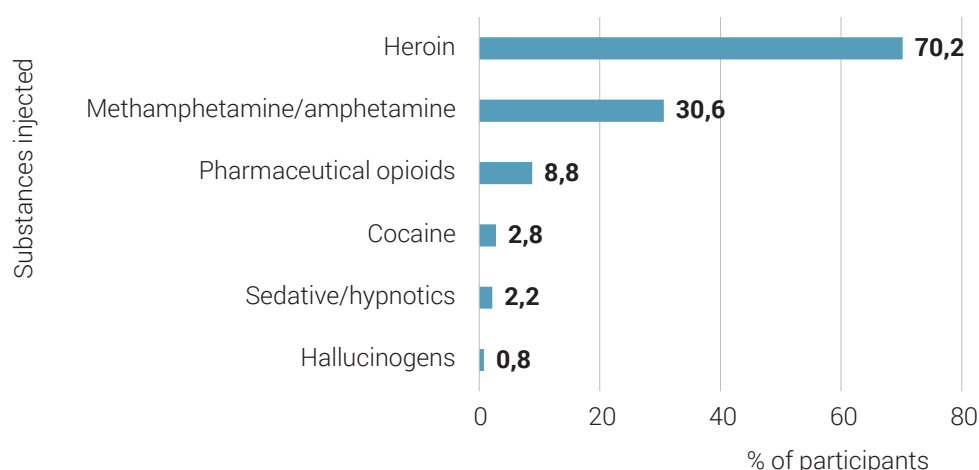
A greater number of **key informants** reported knowing individuals who injected heroin compared to those who injected other substances [Figure 27].

Figure 27. Distribution of key informants' knowledge about individuals using substances through injection by substance, Afghanistan, 2022 (N=1,232).
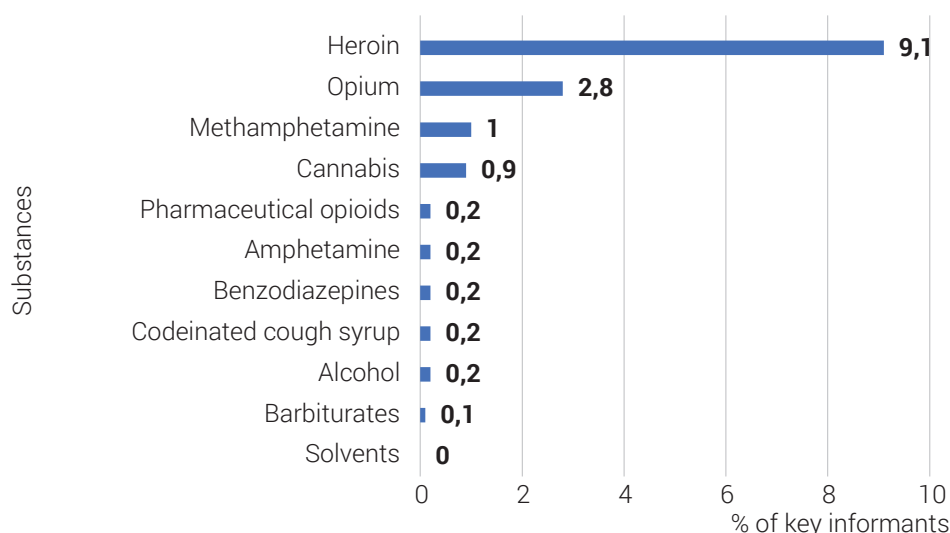
Among respondents, the majority of PWID (84.1 per cent) reported injecting alone in the past six months.[51] The majority of PWID (86.6 per cent) reported injecting in public places over the past six months. Common locations included abandoned houses, graveyards, under bridges and sewage drains, streets and parks, gardens, and agricultural lands. The second most frequent injection site was the individual's residence.[52] Women were more likely to report their home as an injection site.

Regarding access to new sterile needles in the past six months, half of PWID found it easy, while approximately the other half found it difficult. About 44.4 per cent cited health facilities as their primary sources of new needles and syringes over the past six months, most of which were received from pharmacies (36.4 per cent). Other individuals reported that their main sources were drop-in centres (7.8 per cent) and outreach workers (0.3 per cent).

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51   See Table 14 of Annex 1. Statistical information
52   See Table 15 of Annex 1. Statistical information

In response to the question "In the past 6 months, once you started a brand-new needle, how many times did you use it?", only 20.7 per cent said that they used it once. The other responses ranged from twice to 100 times, with an average of 4.7 (SD=7.7), and a median of 3.

Among individuals who had injected in the past six months, 13.2 per cent reported always or often injecting with needles and syringes used by someone else, and 14.5 per cent reported that someone else always or often injects with their used needle and syringe. Only 23.4 per cent of respondents stated that over the past six months they had never shared their needle and syringe with anyone else, either by giving or receiving a used one.[53] Those who had shared injections with others (giving or receiving needle and syringe) (N=277) were asked about the reasons for sharing. The unavailability of more needles and the urgent need to take drugs were the most reported reasons.[54] The individuals who had injected with a needle that was used before by someone else (N=265) were asked about their cleaning practices. The most common methods involved rinsing with running water, normal saline, or distilled water, and wiping with a cloth. Bleach, alcohol, or boiling water were rarely used.[55]

4.6 History of drug-related offences

Among participants, 18.4 per cent reported having been arrested for drug-related offences in their lifetime. Such a history was reported among 19.9 per cent of men and 1.1 per cent of women. The rate was 17.7 per cent in urban areas and 20.0 per cent in rural areas. Arrests for drug-related offences were reported in 40.1 per cent and 16.4 per cent of those with and without a lifetime history of drug injection, respectively [Figure 28]. The average age of first arrest among 1,261 individuals with such a history was 30.6 (8.6) and the median age was 30. The average number of arrests was 1.8 (2.1) and the median was 1.

Participants with a history of arrest for drug-related offences in their lifetime differed from those without such history in several ways.[56] The former group had a higher proportion of men, residing more often in rural areas, were older, were more likely to have previously been married and be homeless, and had a larger proportion with high dependence scores. They also were more likely to use drugs by injection and to have history of treatment for a drug problem.

53   See Table 16 of Annex 1. Statistical information
54   See Table 17 of Annex 1. Statistical information
55   See Table 18 of Annex 1. Statistical information
56   See Table 19 of Annex 1. Statistical information

Figure 28. Percentage of people engaging in high-risk drug use arrested for drug-related offences during lifetime, Afghanistan, 2023 (N=6,893).
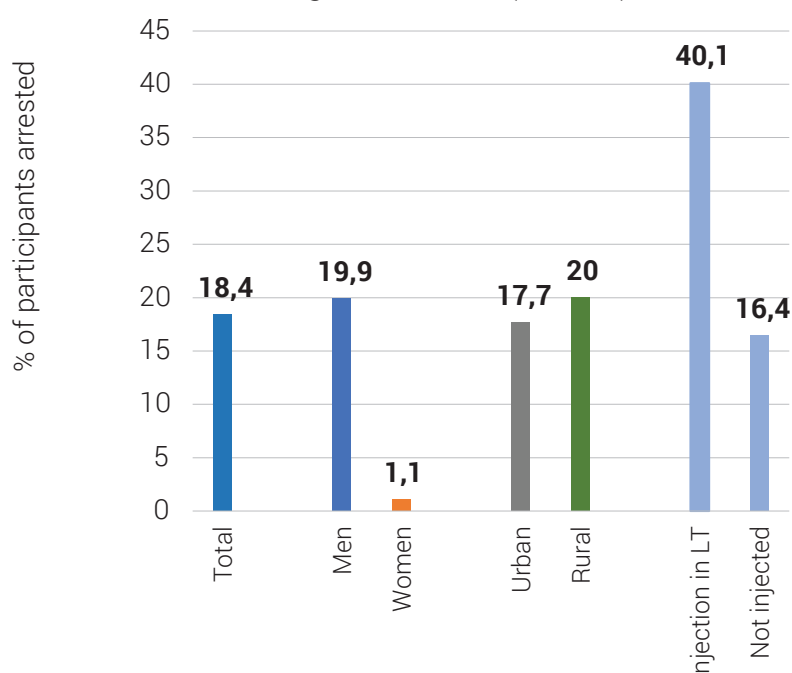
4.7 Hotspots and estimating the number of individuals engaging in high-risk drug use

During the mapping exercise, 651 hotspots were identified, which corresponds to 2.6 hotspots per 100,000 inhabitants. The highest number of hotspots was identified in Kandahar City, which had 64 hotspots (though with a smaller number of people who use drugs per hotspot), followed by Kabul City with 55 hotspots, Faryab with 43, Badakhshan with 39, Nangarhar with 39, and Balkh with 38 [Map 7].[57] However, Nimroz (7.9), Zabul (5.5), and Nuristan (5.3) had the highest number of hotspots per 100,000 inhabitants.

The total number of people engaging in high-risk drug use in the hotspots of the studied areas was estimated to be 26,739, with a lower estimate of 21,601 and an upper estimate of 31,877. The highest estimates were for Kabul (4,662) and Faryab (3,182). Other notable areas included Kunduz (1,640) and Balkh (1,588) [Map 8].[58] The national average rate of individuals with high-risk drug use was 97 per 100,000 population (157 men and 13 women per 100,000 population). Nimroz had the highest rate at 533, followed by Faryab at 277. The average number of people who use drugs in each hotspot was estimated to be 41. The highest estimated numbers of people who use drugs per hotspot were for Farah (105), Daykundi (86), Kabul (85), Faryab (74), and Kunduz (71). The total estimated number of people who inject drugs in the identified hotspots of the studied areas was 2,474, with a lower estimate of 1,840 and an upper estimate of 3,107. Overall, it was estimated that 9.3 per cent of people who use drugs in these hotspots were injecting substances. The highest estimated number of people who inject drugs were found in several provinces in the Eastern part of country, namely Kabul (474), Kunduz (460), and Nangarhar (291). Parwan (30 per cent) and Kunduz (28 per cent) had the highest proportion of people who inject drugs [Map 9].[59]

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57   See also Table 20 of Annex 1. Statistical information
58   Ibid.
59   Ibid.

The total estimated number of women who use drugs in the hotspots of the studied areas was 2,673, with a lower estimate of 2,078 and an upper estimate of 3,268. Women were estimated to make up 10 per cent of all people who use drugs in these hotspots. The areas with the highest estimated numbers of women who use drugs were Faryab (940), Kunduz (304), and Balkh (295). The northern provinces were estimated to have a higher proportion of women among people engaging in high-risk drug use [Map 9].[60]

The estimated total number of children under 15 using drugs in hotspots within the studied areas was 2,151, with a lower estimate of 1,698 and an upper estimate of 2,604. It was estimated that 8 per cent of individuals who use drugs in these hotspots were children. The highest estimated numbers of children using drugs were in Kunduz (537), Badakhshan (298) and Nangarhar (263) provinces. The provinces in the North-East were estimated to have a higher proportion of children among those engaging in high-risk drug use [Map 10].

Map 7. Provincial distribution of the number of hotspots identified, Afghanistan, 2022 (N=3,555).
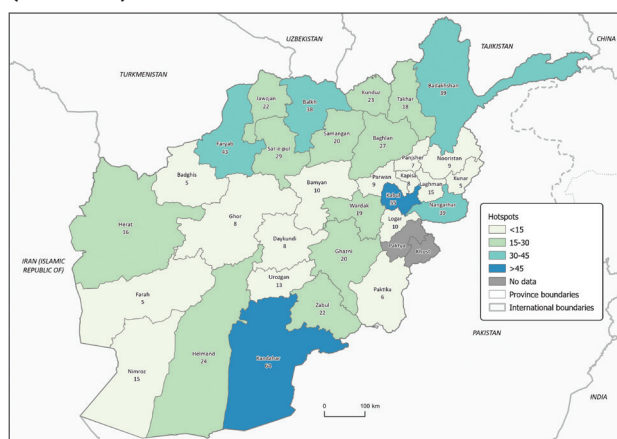
Map 8. Provincial distribution of the number of estimated people engaging in high-risk drug use in the identified hotspots, Afghanistan, 2022 (N=3,555).
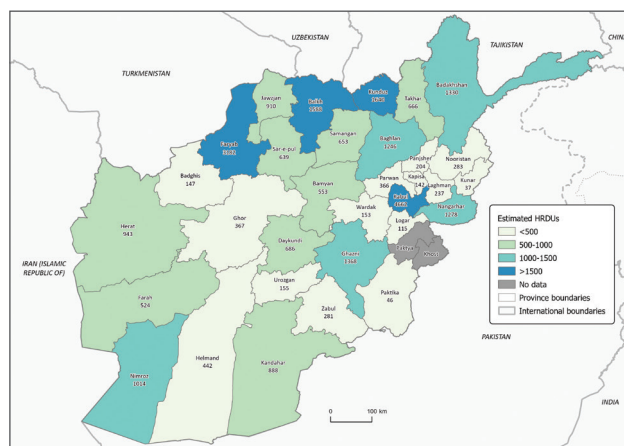
Map 9. Provincial distribution of the proportion of people engaging in high-risk drug use who injected drugs in the hotspots, Afghanistan, 2022 (N=3,555).
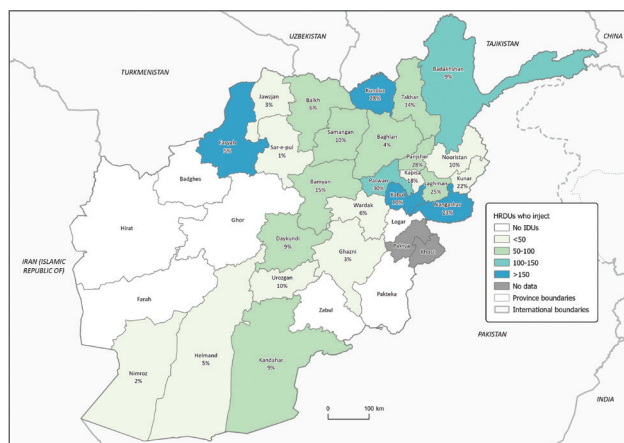
Map 10. Provincial distribution of the proportion of women among people engaging in high-risk drug use in the idenfitied hotspots, Afghanistan, 2022 (N=3,555).

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60   Ibid.
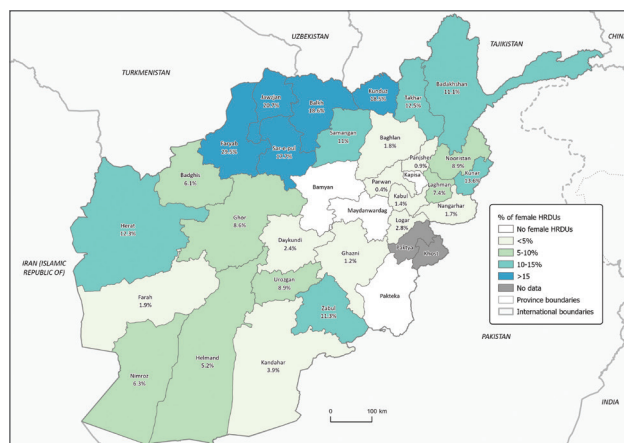
Map 11. Provincial distribution of the proportion of children among people engaging in high-risk drug use in the identified hotspots, Afghanistan, 2022 (N=3,555).
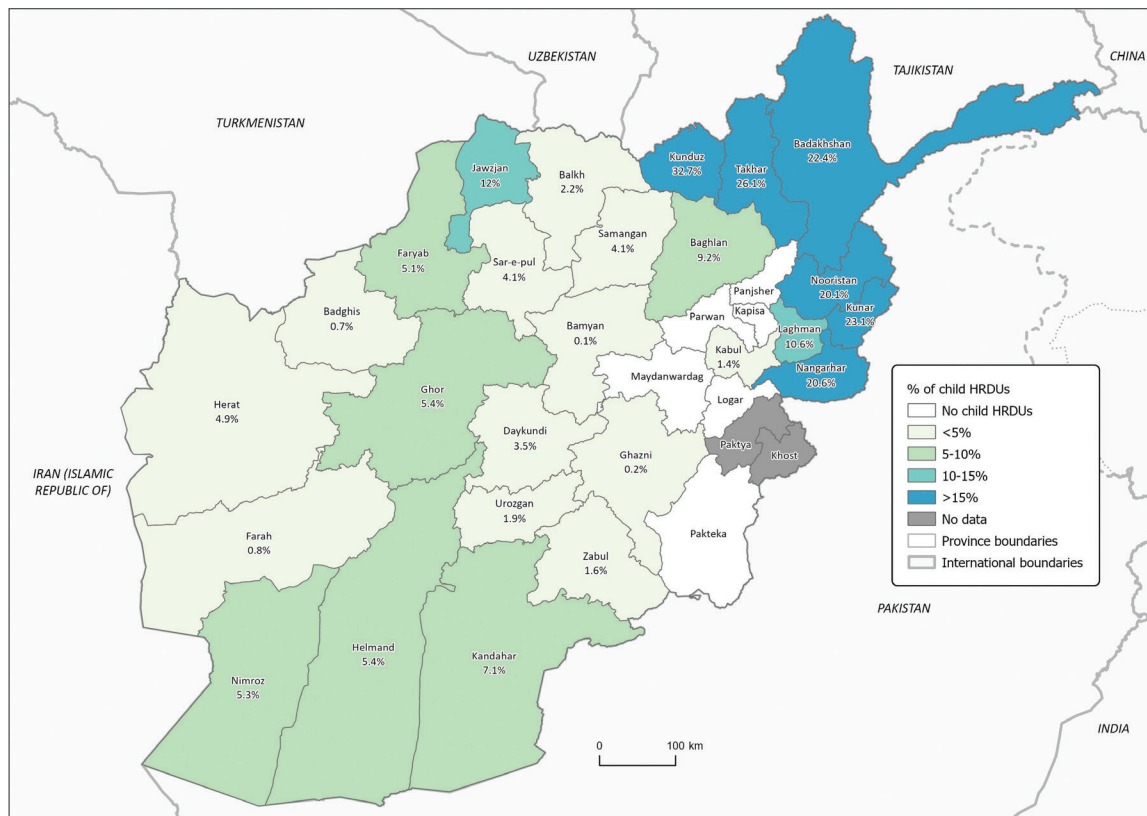
4.8 Treatment history

Among the 6,876 people with high-risk drug use who responded to questions regarding their treatment history, over half reported a history of receiving treatment for a drug problem in their lifetime. This rate was significantly higher among men than women and in urban areas compared to rural areas [Figure 29]. A history of treatment was reported from as low as 6.8 per cent of high-risk drug users in Urozgan to 86.4 per cent in Samangan [Map 13]. Individuals from the western and central provinces had a higher rate of having received treatment in the past.

Figure 29. Proportion of participants who reported receiving treatment for a drug problem at least once in the lifetime, Afghanistan, 2023 (N=6,876).
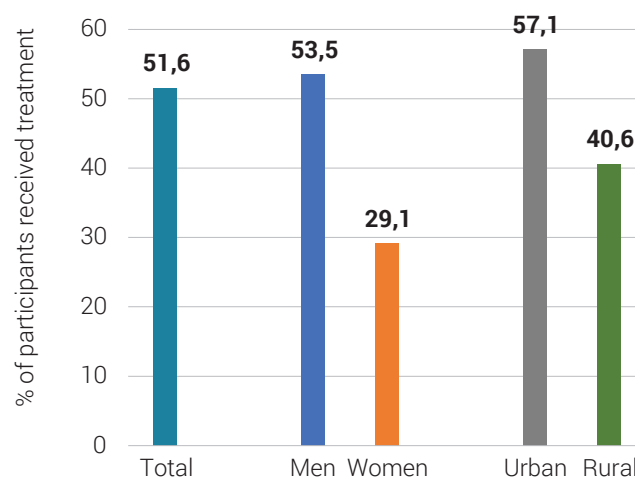
Map 12. Provincial distribution of the proportion of participants who reported receiving treatment for a drug problem at least once in their lifetime, 2023 (N=6,876).
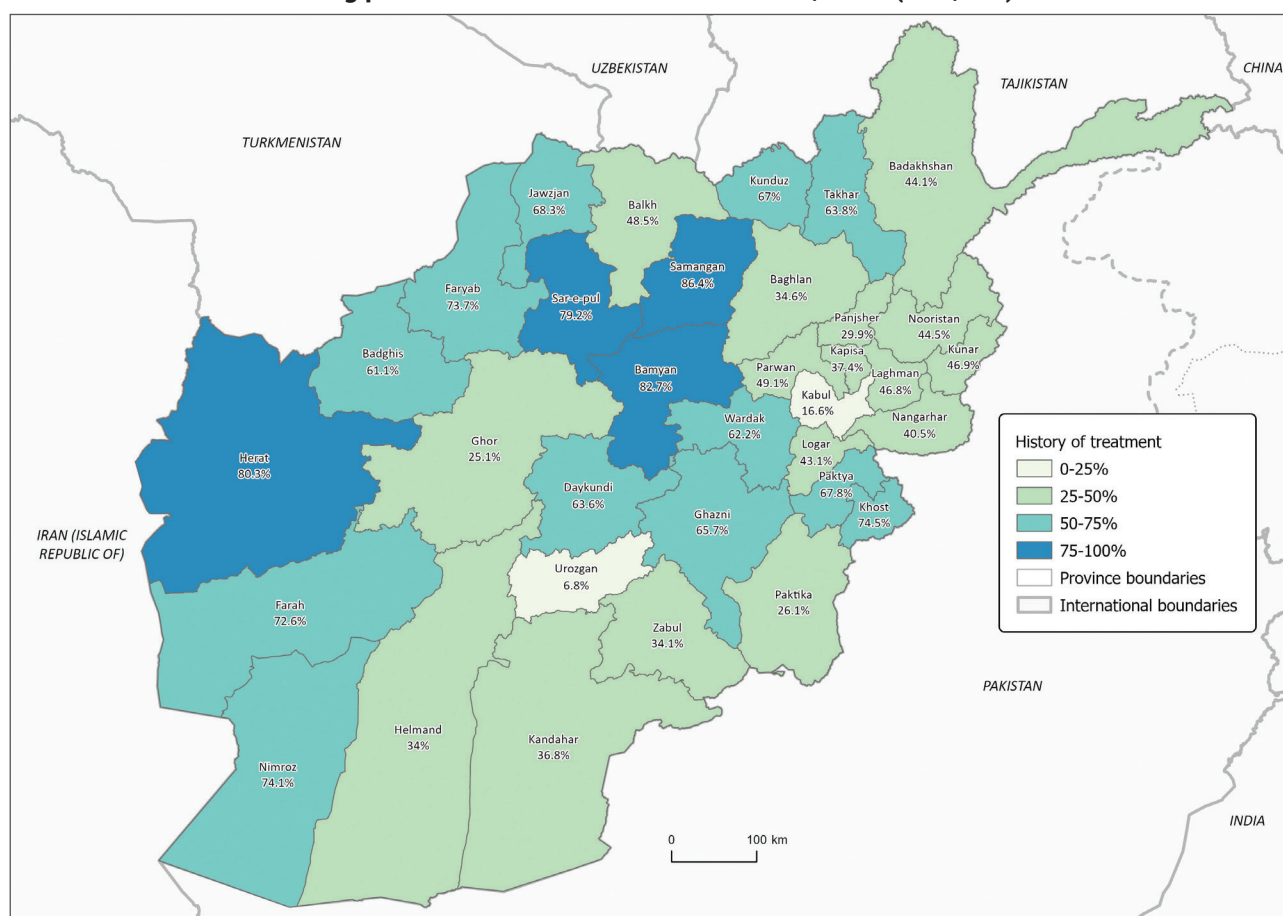
Respondents with no history of drug treatment differed from those with such history in several ways.[61] The former group had a higher proportion of women, resided more often in rural areas, were younger and more educated, were more likely to be single, lived in their own homes or with family, and had a lower proportion with high Severity Dependence Scale scores. They also were less likely to use drugs by injection and fewer had drug-related arrests.

Regarding the provinces where the treatment takes place, Kabul (12.3 per cent) and Herat (6.6 per cent) were the provinces where most respondents were treated in their latest treatment episode. Among women, Herat was the primary province with 30.6 per cent, followed by Kabul (14.4 per cent). In nearly all provinces, the majority of residents reported being treated within their province, with the next most common treatment location being Kabul. However, the treatment rate was low for people with drug use disorders recruited from Kabul itself (16.6 per cent).

A total of 3,544 individuals with treatment history responded to the question about the number of drug use disorder treatment episodes in their lifetime. Over half (52 per cent) reported receiving treatment only once [Figure 30]. The average length of stay in a treatment facility during the latest treatment episode was 47.6 days (SD= 23.7), with a median and mode of 45 days.

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61   See Table 21 of Annex 1. Statistical information

Figure 30. Proportion of people engaging in high-risk drug use who received treatment during lifetime by number of treatment episodes, Afghanistan, 2023 (N=3,544).
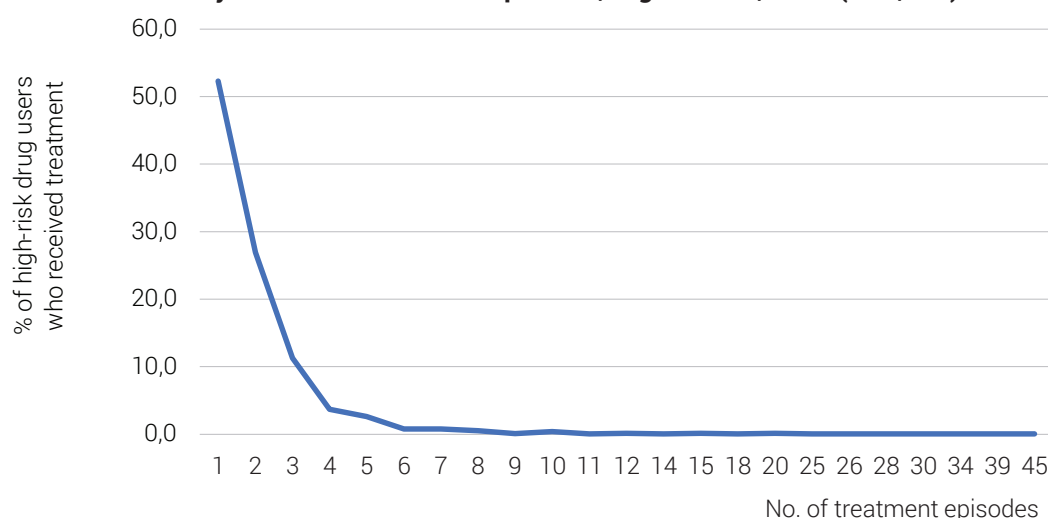
Among those with treatment history in their lifetime, most (62.4 per cent) had received treatment because of a problem with heroin, followed by opium (40 per cent) and methamphetamine (36.5 per cent). Among 160 women with a treatment history in their lifetime, the primary drugs responsible for their needing treatment were opium (49.4 per cent), heroin (43.1 per cent), and methamphetamine (28.7 per cent).[62]

A total of 3,523 individuals provided their age of first treatment for a drug problem. The average age was 31.3 (SD= 8.9) and the median and mode were 30 [Figure 31]. Among men, the average age was 31.2 (SD= 8.7), with a median and mode of 30. Among women, the average age was 32.5 (SD= 11.1), with a median of 32 and a mode of 33.

The average time between the first treatment for a drug problem and the interview was 4.7 years (SD= 5.2), and the median was 3 [Figure 32]. This means that about half of those with treatment history had received treatment within the three years before the interview. Among men, the average was 4.7 years (SD= 5.2), and the median was 3. Among women, the average was 4.3 (SD= 5.9), and the median was 2.

Figure 31. Distribution of people engaging in high-risk drug use by age of first treatment for a drug problem, Afghanistan, 2023 (N=3,523).
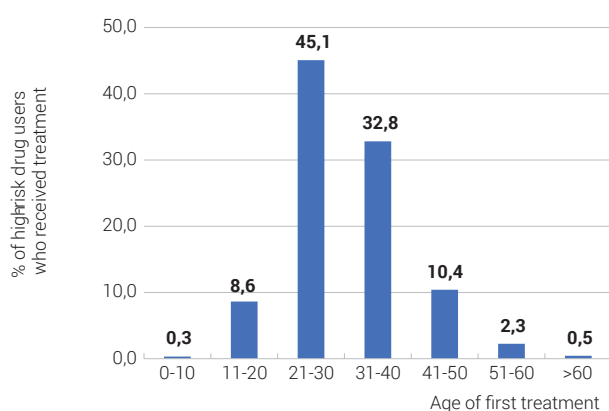
Figure 32. Proportion of participants by time between treatment and interview, Afghanistan, 2023 (N=3,523).

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62   See Table 22 of Annex 1.
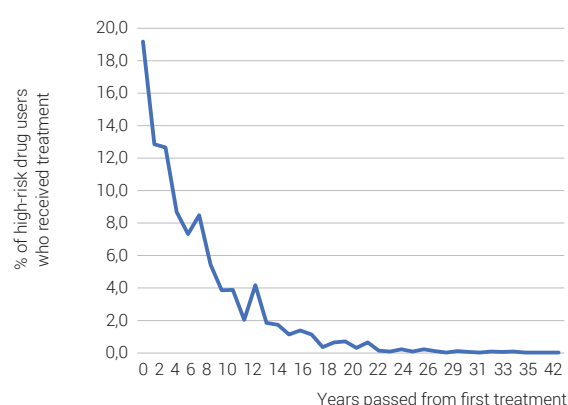
Participants were asked if they had ever wanted to seek treatment for their drug problem but were unable to do so. Out of 6,768 respondents, 44.6 per cent answered positively. Among those who had never received treatment (N=3,217), approximately 60 per cent reported that they had never wanted to seek treatment. Regarding the ease of getting treatment for drug problems in the area where the participants were living, two-thirds found it difficult, while only 18.4 per cent thought it was easy [Figure 33, Figure 35]. Women and residents of rural areas found accessing treatment significantly more challenging compared to men and those living in urban areas.

Figure 33. Difficulty levels in accessing treatment in the area, as reported by people engaging in high-risk drug use, Afghanistan, 2023 (N=6,884).
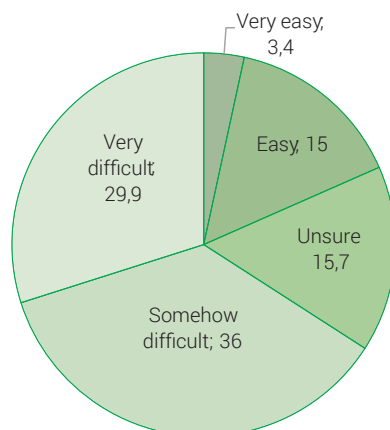
Figure 34. Difficulty levels in accessing treatment in the area, as reported by male individuals engaging in high-risk drug use, Afghanistan, 2023 (N=6,335).
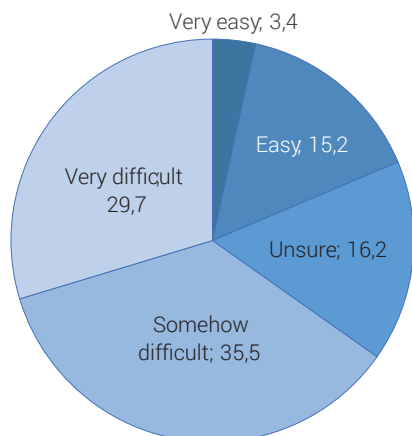
Figure 35. Difficulty levels in accessing treatment in the area, as reported by female individuals engaging in high-risk drug use, Afghanistan, 2023 (N=549).
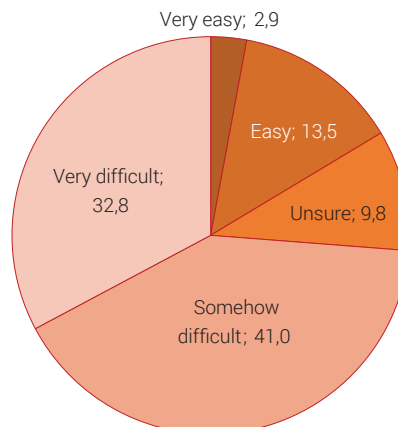
Barriers for getting treatment were also assessed.[63] Financial constraints/opportunity cost (57.4 per cent) and fear of stigma (42.7 per cent) were the primary barriers reported by those who did not receive treatment. Structural factors, including limited service availability, lack of scientifically based options, service shortages, and poor food quality at centres, were cited by about half of participants. Other obstacles included the absence of a guarantor, being the head of the household, and childcare responsibilities. Many respondents also highlighted the lack of women-specific treatment facilities in their communities as a main barrier.

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63   See Table 23 of Annex 1. Statistical information

Key informants were asked about availability of treatment facilities in their areas. A higher number of key informants reported the availability of hospital-based drug treatment services (53 per cent) and primary health care (50.6 per cent) in their areas, while specialized social rehabilitation services were mentioned by fewer key informants (18.4 per cent) [Figure 36]. A greater number of key informants in rural areas reported primary healthcare, therapeutic communities, and low-threshold services as being available in their areas [Figure 37]. Most key informants found drug use services widely utilized and largely acceptable and useful.[64] On the other hand, most key informants reported that drug treatment services were difficult to access, particularly for women, although the perceived need was highest for men.[65]

Figure 36. Key informants' awareness of the availability of drug treatment services in their area, Afghanistan, 2022 (N=1,232).
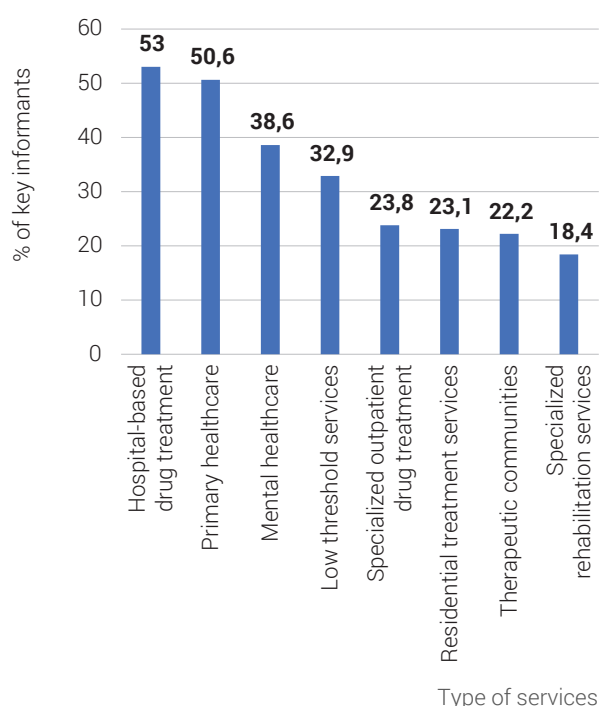
Figure 37. Availability of services in the area, as reported by key informants by urban and rural area, Afghanistan, 2022 (N=1,232).

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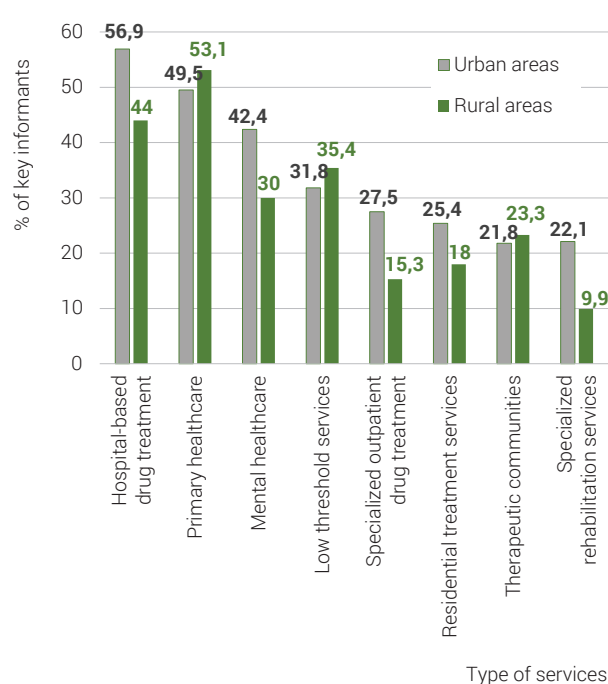
64   See Table 24 & Table 25 of Annex 1. Statistical information
65   See Table 26 & Table 27 of Annex 1. Statistical information

5 POLICY RECOMMENDATIONS

The three studies revealed a spectrum of drug use, ranging from low-risk individuals using a single substance, such as opium or cannabis, without injecting, and maintaining stable home and employment situations, to high-risk individuals engaging in poly-drug use, exhibiting severe dependence, injection, public drug use, homelessness, unemployment, and often criminal activity to support their use. Individuals may shift in this spectrum due to changing circumstances, access to treatment, and substance availability. The degree of drug use intensity depends not only on usage patterns but also on individual vulnerabilities and support systems. Interventions should thus be multi-faceted, address different levels of vulnerability, and be tailored to each person's unique needs.

5.1 The need for drug use prevention programmes

The findings suggest that many children are introduced to opium and codeine-containing cough syrups at ages under 10. This highlights the significant role of the family environment on drug use by children. Exposure within the family unit is a primary factor contributing to early substance abuse. This necessitates a comprehensive approach to intervention and prevention. Therefore, public health strategies must prioritize educating families. These educational campaigns should specifically address the risks associated with both opium and codeine-containing cough syrups, emphasizing the long-term physical and psychological harm these drugs can inflict on developing children. Moreover, a focus on empowering families to protect their children from early exposure, including strengthening family attachment and parenting, is crucial in combating this problem.

Cannabis and opium use often begin at an earlier age when compared to other drugs. Initiation early in life is linked to a greater likelihood of progressing to substance use disorder, often with more harmful substances, such as heroin or methamphetamine. Factors like ease of access and positive or neutral attitudes toward cannabis and opium, along with their dependence potential, contribute to this trend, highlighting the need for universal prevention measures.

All drug use prevention activities should adhere to evidence-based guidelines to ensure their effectiveness. Using scientifically proven programmes enables the application of strategies that have shown success, such as "Strong Families", a UNODC evidence-based programme originally developed in Afghanistan. Moreover, in Afghanistan, drug use prevention programmes must be tailored to align with the unique cultural and socio-economic contexts and the level of availability of drugs. Understanding local customs and beliefs is essential for ensuring programme utilization and effectiveness. Taking the socio-economic conditions, such as poverty and low education, into account is critical in designing interventions and developing the content of programmes. By adopting a culturally and contextually relevant approach, programmes can more effectively mitigate drug use and promote healthier communities.

5.2 Enhancing and expanding drug treatment to address current needs

The three studies revealed the treatment gap, which includes relatively low service utilization, inadequate evidence-based and cost-effective services, and a variety of barriers.

The changes in drug use patterns over the decade and the current dominance of heroin and methamphetamine as the most harmful substances corroborate the need for adjustments in service provision. For those dependent on heroin, the preferred treatment is maintenance therapy using opioid agonists. For methamphetamine dependence, cognitive behaviour therapy or family therapy for adolescents is essential, with some adaptation to meet the needs of patients with lower levels of education. However, a significant challenge lies in the integration of these distinct treatment approaches within existing service frameworks. Many facilities lack the resources or expertise to provide opioid agonist therapy and specialized psychosocial therapy concurrently. Furthermore, the co-occurrence of opiate and methamphetamine use is increasingly common, requiring the development of integrated treatment programmes capable of addressing both substance use disorders simultaneously. These programmes must be flexible enough to accommodate the diverse needs and levels of engagement observed within this population.

The study indicated that residential and hospital-based treatment programmes make up a significant portion of the available services. However, these services can be expensive and do not offer opportunities for in-community experiences. Therefore, there should be greater emphasis on expanding affordable and outpatient treatment options. Additionally, since continuous relapse prevention plans are essential for long-term recovery, all services should include regular follow-up and ongoing support.

Finally, addressing the social determinants of health, like poverty, homelessness, and lack of access to healthcare, is crucial for improving long-term recovery and preventing relapse, which, in the context of Afghanistan, is both necessary and challenging. Such an approach requires collaboration between healthcare providers, social workers, and community groups to develop innovative social services. This is particularly important in the case of children (individuals under 18) with drug use disorders, as initiation at an early age is usually due to clusters of severe vulnerabilities that would have been compounded by their use and progression to drug use disorders. These children would need dedicated services able to build their personal, social and vocational skills.

Significant differences in drug use patterns and harms exist across provinces. Therefore, services should be tailored to meet local situations and needs. This necessitates a flexible and decentralized approach to service planning and delivery. A single uniform strategy is likely to overlook the diverse range of drug use patterns and related factors in different regions of the country. Continuous monitoring and adaptation of services are essential to ensure relevance and effectiveness in response to evolving drug use patterns and emerging harms.

The study showed that stigma from drug use is a significant barrier to seeking help. To overcome this, public awareness campaigns that promote understanding and compassion, alongside easily accessible, non-judgmental support services, are crucial.

Overall, the services should offer a range of interventions, including medication-assisted treatment, psychosocial interventions, and housing support, tailored to the individual's specific needs and circumstances. Addressing underlying mental health issues, often co-occurring with drug dependence, is also crucial. Special attention should be paid to the specific needs of women and children.

5.3 Provision of a wide range of harm reduction interventions

In Afghanistan, the harm associated with drug use appears to be significant, including health, familial, social, and economic burdens. A variety of evidence-based interventions can reduce these risks. Such interventions include opioid agonist treatment for heroin dependence and, the provision of sterile needles and syringes for individuals who inject drugs. It is strongly recommended to widely implement preventive measures, screening, identification, treatment, and care for tuberculosis and blood-borne and sexually transmitted infections, such as HIV/AIDS and hepatitis B and C. These actions are essential to mitigate the substantial health risks faced by people who use drugs, their families, and society as a whole.

Most individuals who use drugs showed limited educational backgrounds. To better meet their needs, services can be tailored to enhance health literacy. The inclusion of well-trained peer groups can further strengthen the effectiveness of treatment and harm reduction efforts.

5.4 Addressing the needs of women

The studies successfully recruited 551 female individuals who use drugs along with a significant number of female key informants. The findings indicated that female individuals who use drugs tend to be less educated, with most being married or previously married, and living with their families. They primarily receive financial support from their families. The main drugs consumed by these women are opium, followed by heroin and methamphetamine. The use of sedatives is also prevalent, while cannabis use is rare. Therefore, they exhibit a relatively different profile from men.

The studies also indicated that women face more challenges in accessing treatment, resulting in considerably lower rates of service utilization. In Afghanistan, it is crucial to establish women-specific treatment centres for drug use disorders, particularly in areas with a high number of women in need of treatment. These centres should create a supportive environment (and wherever possible financial support) that encourages them to seek treatment and facilitate receiving treatment and care over a long period.

5.5 Establishing continuous monitoring mechanisms

Comparing the current findings with studies from a decade ago indicates changes in the pattern of drug use in Afghanistan. The use of opiates has shifted from opium to heroin, with a significant increase in the proportion of heroin use. Additionally, methamphetamine use, which was uncommon a decade ago, is now widespread among people engaging in high-risk drug use. Although the overall prevalence of injecting drug use remains

relatively stable, unsafe injection practices, which were common among individuals who inject drugs, continue to be highly prevalent. Over three-quarters of those individuals had shared needles and syringes with others in the past six months.

These findings, along with changes in drug policies and drug supply, emphasize the need for continuously monitoring the situation. Therefore, a continuous monitoring mechanism should be established. This can be achieved through a robust ongoing data surveillance system that includes contributions from the healthcare system, law enforcement, and the judiciary. Additionally, conducting repeated surveys among people engaging in high-risk drug use can help identify groups that may not be captured by routine data collection methods, and assess their conditions and needs. Such monitoring mechanisms provide the opportunity for early detection of changes and the possibility to investigate the coverage and effectiveness of the national response to drug problems and identify the areas of weakness. A general population survey was conducted by UNODC in 2024, and the results should help enhance the understanding of other aspects of drug use in Afghanistan and its related health and social issues.

In future, greater efforts will be needed to assess the impacts on high-risk populations that use drugs of the ban on drugs that was put into effect in 2022 and 2023. It is possible that strong efforts to crack down on drug production, distribution and use, including public drug use, could have affected the high-risk drug using populations. Some individuals may have experienced greater involuntary treatment or have sought to hide their drug use.

ANNEX 1. STATISTICAL INFORMATION

Table 1. Age distribution of first use for each substance among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

Substances (N)	Age of first use			
	Mean SD	Median	Mode	Range
Opium (4,243)	23.7 6.5	23	20	1-64
Heroin (3,892)	26.7 7.1	25	25	2-60
Pharmaceutical opioids (724)	28.0 8.8	27	30	1-64
Cannabis (4,418)	19.9 5.0	19	20	5-55
Methamphetamine (4,162)	28.3 7.9	27	25	5-65
Amphetamines (186)	27.4 9.0	26.5	28	12-56
Tablet K (1,581)	26.0 6.9	25	25	2-57
Cocaine (238)	28.6 6.1	28	27, 30	16-54
Ecstasy/MDMA (126)	26.8 7.6	27	31	15-61
Other hallucinogens (28)	29.8 5.5	31	35	17-38
Solvents/ Inhalants (141)	25.3 7.4	24	18	12-62
Sedatives/hypnotics (1,303)	28.7 8.7	28	30	3-70
Codeine-containing cough syrup (572)	26.7 8.5	25	20	1-62

Note: numbers in parentheses show the total respondents according to each substance.

Table 2. Patterns of drug use among people engaging in high-risk drug use by substance type, Afghanistan, 2023 (N=6,893).

Substances	% use in LT	% use in L12M	% use in L30D	Days used in L30D[a]					Times used in a typical day in L30D				Usual method of use in L30D		
				% used >20 Days	Mean SD	Median	Mode	Range	Mean SD	Median	Mode	Range	% smoke/ sniff/ inhale	% eat/ drink	% inject
Opium	66.1 (6,892)	41.5 (6,880)	30.5 (6,712)	47.4	19.9 9.6	20 (2,044)	30	1-30	1.6 0.8	1 (2,045)	1	1-10	64.9	35.1 (2,045)	0.05
Heroin	56.6 (6,891)	50.4 (6,878)	43.4 (6,742)	64.4	23.4 8.4	30 (1,884)	1	1-30	2.0 1.1	2 (2,914)	1	1-10	96.5	0.0 (2,918)	3.5
Pharmaceutical opioids	10.5 (6,873)	6.4 (6,870)	3.1 (6,608)	36.2	17.4 9.8	16 (213)	30	1-30	1.8 1.2	1 (211)	1	1-10	9.9	86.3 (212)	3.8
Cannabis	64.2 (6,890)	45.1 (6,881)	33.3 (6,664)	55.6	21.7 9.1	25 (2,217)	30	1-30	2.1 1.2	2 (2,203)	1	1-10	99.5	0.5 (2,218)	0.1
Methamphet-amine	60.6 (6,891)	57.4 (6,883)	47.6 (6,737)	63.2	22.8 9.1	30 (3,208)	30	1-30	2.1 1.3	2 (3,167)	1	1-10	96.8	0.3 (3,208)	2.9
Amphetamines	2.7 (6,866)	1.7 (6,864)	0.8 (6,851)	24.1	15.7 8.5	15 (54)	30	2-30	1.9 0.9	2 (52)	1	1-3	22.6	71.7 (53)	5.7

Substance	%	(N)	%	(N)	%	(N)	%	mean/median	value	(N)		range	mean/median	value	(N)		range	%	%	(N)	%
Tablet K	23.1	(6,876)	15.9	(6,872)	9.0	(6,714)	26.1	13.8 / 10.1	10	(602)	30	1-30	1.5 / 1.1	1	(574)	1	1-10	2.5	97.5	(601)	0.0
Cocaine	3.5	(6,875)	1.7	(6,874)	1.2	(6,864)	69.4	22.8 / 10.1	30	(85)	30	1-30	1.3 / 0.6	1	(82)	1	1-3	80.0	15.3	(85)	4.7
Ecstasy/MDMA	1.8	(6,843)	1.2	(6,838)	0.4	(6,818)	34.5	16.1 / 8.8	14	(29)	30	5-30	2.41 / 1.8	2	(29)	3	1-10	10.3	89.7	(29)	0
Other hallucinogens	0.4	(6,868)	0.2	(6,866)	0.1	(6,862)	0.0	6.4 / 3.4	6	(5)	-	2-11	2 / 0.8	2	(4)	2	1-3	0.0	60.0	(5)	40.0
Solvents/ Inhalants	2.1	(6,849)	1.0	(6,849)	0.4	(6,837)	14.3	13.9 / 7.4	14.5	(28)	15	1-30	1.9 / 1.0	2	(28)	1	1-5	96.4	3.6	(28)	0
Sedatives/hypnotics	19.2	(6,806)	13.0	(6,794)	7.5	(6,668)	48.4	19.5 / 10.5	20	(502)	30	1-30	1.5 / 1.0	1	(496)	1	1-10	1.8	97.6	(501)	0.6
Codeine-containing cough syrup	8.4	(6,858)	5.8	(6,854)	3.2	(6,760)	13.2	11.1 / 8.4	10	(212)	10	1-30	1.6 / 0.9	1	(213)	1	1-8	0.0	100	(211)	0.0

a From those who have used the mentioned substance over the last 30 days.

Note: numbers in parentheses show the total respondents according to each substance.

Table 3. Money spent on each drug over the past 30 days among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

Substances	Money spent in L30D In Afghani			Money spent in L30D In USD[a]		
	Mean SD	Median	Mode	Mean SD	Median	Range
Opium (2,040)	1,948 2,725	1500	50-90000	27.4 38.4	21.1	0.7-1267.6
Heroin (2,912)	2,942 2,510	2500	50-30000	41.4 35.4	35.2	0.7-422.5
Pharmaceutical opioids (204)	1,268 2,050	450	50-15000	17.9 28.9	6.3	0.7-211.3
Cannabis (2,212)	1,276 1,344	865	50-15002	18.0 18.9	12.2	0.7-211.3
Methamphetamine (3,190)	2,596 2,850	2000	50-66000	36.6 40.1	28.2	0.7-929.6
Amphetamines (41)	1,236 1,379	1000	130-8000	17.4 19.4	14.1	1.8-112.7
Tablet K (596)	1,669 1,905	1200	50-15000	23.5 26.8	16.9	0.7-211.3
Cocaine (83)	2,300 5,393	2000	50-50000	32.4 76.0	28.2	0.7-704.2
Ecstasy/MDMA (28)	1,325 1,638	715	90-8000	18.7 23.1	10.1	1.3-112.7
Other hallucinogens (5)	680 800	400	200-2100	9.6 11.3	5.6	2.8-29.6
Solvents/ Inhalants (27)	2,352 4,868	600	35-25000	33.1 68.6	8.5	0.5-352.1
Sedatives/hypnotics (480)	696 1,447	253.5	20-17000	9.8 20.4	3.6	0.3-239.4
Codeine-containing cough syrup (202)	565 736	400	20-5000	8.0 10.4	5.6	0.3-70.4

Note: numbers in parentheses show the total respondents according to each substance.

Table 4. Distribution of key informants' beliefs about substance use across different age and sex groups in their area (in percentage), Afghanistan, 2022 (N=1,232).

Substances	Total	Men	Women	Young people (20-25)	Adolescents (10-19)	Children (<10)
Opium	66.7	65.1	41.8	57.1	37.3	8.8
Heroin	76.9	75.1	41.4	67.3	39.6	3.6
Pharmaceutical opioids	9.2	7.9	4.2	6.7	3.2	0.3
Cannabis	77.5	76.7	21.2	73.6	54.0	1.2
Methamphetamine	64.3	60.6	32.6	59.7	40.3	1.5
Amphetamine	7.9	6.9	4.1	5.9	1.7	0.3
Cocaine	1.4	1.4	0.3	0.5	0.2	0
Ecstasy	1.4	1.3	0.6	1.0	0.5	0.1
Other hallucinogens	1.1	1.0	0.5	0.6	0.3	0.1
Benzodiazepines	27.5	25.5	23.9	19.6	6.4	1.0
Barbiturates	20.2	17.9	16.0	14.5	5.0	0.2
Solvents	6.0	4.8	0.6	4.1	2.8	0.4
Cough Syrup	13.2	10.4	7.6	9.4	5.0	1.7
Alcohol	13.5	13.1	5.1	11.5	5.2	0

Table 5. Proportion of key informants who personally knew people who use drugs within each sex group and the number of individuals who use drugs they knew, Afghanistan, 2022 (N=1,232).

Substances	Know anyone using the substance (%)	Know men using the substance (%)	Number of men using the substance			Know women using the substance (%)	Number of women using the substance		
			Mean SD	Median	Range		Mean SD	Median	Range
Opium	29.3	28.5	10.1 16.8	5 (351)	1-200	11.5	6.6 11.5	3 (142)	1-80
Heroin	35.6	34.5	13.2 30.8	5 (425)	1-300	11.0	7.2 11.1	2 (136)	1-56
Pharmaceutical opioids	1.9	1.9	15.4 22.8	8 (23)	1-100	0.6	3.9 3.2	3 (7)	1-10
Cannabis	38.4	37.9	14.2 21.7	10 (467)	1-250	6.0	4.6 4.8	3 (74)	1-25
Methamphetamine	20.4	18.3	8.5 9.9	5 (226)	1-60	6.2	8.3 13.4	2 (76)	1-56
Amphetamine	1.5	1.4	8.9 12.1	5 (17)	1-50	0.4	9.6 9.1	6 (5)	2-25
Benzodiazepines	11.2	10.7	15.3 14.5	10 (132)	1-80	7.8	13.8 14.7	4 (96)	1-60

Barbiturates	8.2	7.3	15.9 / 16.2	10	(90)	1-100	6.0	14.9 / 15.5	5	(74)	1-52
Solvents	0.9	0.8	7.8 / 12.9	4	(10)	1-44	0.08	-	-	(1)	-
Codeine-containing cough syrup	4.5	4.1	13.9 / 13.1	10	(51)	1-60	2.3	12.4 / 11.1	8	(28)	1-35
Alcohol	4.6	4.4	9.7 / 10.6	6	(54)	1-50	1.0	7.5 / 7.4	4.5	(12)	1-25

Note: Numbers in parentheses show the total respondents according to each substance. The information for substances in each group was excluded if the number of key informants who responded was less than 5.

Table 6. Perceived harmful consequences of substance use among people engaging in high-risk drug use, Afghanistan, 2023 (N=6,893).

Harms	n	%
Health	6040	87.7
Poverty	4480	65.1
Family	4392	63.8
Parents	2870	41.7
Spouse and Children	2688	39.0
Work/Education	4123	59.9
Work	3536	51.4
Education	1717	24.9
Friends	2386	34.7
Violence	3183	46.2
Legal, arrest, imprisonment	1540	22.4
Other harms	79	1.1

Table 7. Engagement in sex work and sexual activity with a sex worker over the past six months among people engaging in high-risk drug use (in percentage), Afghanistan, 2023 (N=6,893).

Variables	Total	Sex			Living area		
		Men	Women	P-value	Urban	Rural	P-value
Sex work in the past 6 months							
Receiving drugs to have sex (6,659)	2.9	3.0	2.2	0.3	2.9	2.9	0.96
Receiving money to have sex (6,666)	1.0	1.0	1.7	0.1	0.8	1.4	0.03
Having sex with a sex worker in the past 6 months							
Giving drugs to have sex (6,707)	3.4	3.7	0	<0.001	3.8	2.7	0.02
Giving money to have sex (6,657)	3.5	3.8	0	<0.001	3.8	3.0	0.1

Note: numbers in parentheses show the total respondents to each question. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 8. History of blood donation and/or sale during lifetime among people engaging in high-risk drug use (in percentage), Afghanistan, 2023 (N=6,724).

Variables	Total	Sex			Injection in lifetime		
		Men (N=6,177)	Women (N=547)	P-value	Yes (N=535)	No (N=6,169)	P-value
Blood donation	13.2	14.1	3.8	<0.001	12.9	13.2	<0.001
Blood sale	1.7	1.8	0.7		6.2	1.3	

Note: P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 9. Prevalence of injecting drug use by sex and living area among people engaging in high-risk drug use (in percentage), Afghanistan, 2023 (N=6,893).

Variables	N	Total	Sex			Living area		
			Men	Women	P-value	Urban	Rural	P-value
Injection in lifetime	6,856	8.0	8.2	6.6	0.184	8.6	6.9	**0.018**
Injection in last 6 months	6,843	5.3	5.5	3.7	0.069	5.6	4.9	0.245
Injection in last 30 days	6,831	4.2	4.4	2.4	**0.024**	4.5	3.7	0.149

Note: P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 10. Socio-demographic characteristics of people engaging in high-risk drug use by injection practice in the past six months (in percentage), Afghanistan, 2023 (N=6,843).

Variables	Total	Injection in the past 6 months		P-value
		PWID [a] (365)	Non-PWID (6478)	
Age (6843)				**<0.001**
≤20 (351)	5.1	3.8	5.2	
21-30 (2229)	32.6	23.8	33.1	
31-40 (2495)	36.5	32.9	36.7	
41-50 (1322)	19.3	30.1	18.7	
51-60 (360)	5.3	8.5	5.1	
>60 (86)	1.3	0.8	1.3	
Education (6842)				**0.001**
No education (3374)	49.3	56.6	48.9	
Primary (1434)	21.0	23.6	20.8	
Secondary (1792)	26.2	18.1	26.6	
Higher education (153)	2.2	1.1	2.3	
Madrasa (89)	1.3	0.5	1.3	
Marital Status (6842)				**<0.001**
Never married (2237)	32.7	27.4	33.0	
Married (4038)	59.0	45.2	59.8	
Previously married (567)	8.3	27.4	7.2	
Living in past 6 months (6814)				**<0.001**
House (5230)	76.8	44.9	78.6	
Homeless (1538)	22.6	54.8	20.7	

Prison (24)	0.4	0.0	0.4	
Others (22)	0.3	0.3	0.3	
Living with in past 6 months (6837)				**<0.001**
Family/ close relatives (4972)	72.7	43.6	74.4	
Friends (678)	9.9	19.7	9.4	
Alone (1187)	17.4	36.7	16.3	
Source of financial support (6834) [b]				
All types of work (5001)	73.2	73.4	73.2	0.913
Received from others (2950)	43.2	35.3	43.6	**0.002**
All types of crimes (2172)	31.8	60.8	30.1	**<0.001**
Occupation (6839)				**<0.001**
Full-time work (1043)	15.3	4.4	15.9	
Part-time work (682)	10.0	3.6	10.3	
Casual work (3057)	44.7	48.5	44.5	
Unemployed (2005)	29.3	43.6	28.5	
Student (39)	0.6	0.0	0.6	
Others (13)	0.2	0.0	0.2	

a People Who Inject Drugs

b The total number of responses is greater than the total number of respondents since respondents could select more than one option.

Note: numbers in parentheses show the total respondents to each question. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 11. Reasons for not yet practicing injection among non-injecting respondents engaging in high-risk drug use, Afghanistan, 2023 (N=6,305)

Reasons for not having used drugs by injection	%
Fears of becoming too addicted	48.7
Do not want to be like those who inject	47.4
Concerns about physical health	41.2
To avoid HIV	24.6
To avoid hepatitis	15.3
Fear of injection	19.4
Injection being dangerous/results in death	3.2
Injection being costly	22.0
Not knowing how to inject	15.2
Friends/partners do not inject	13.1
Syringes not easily available	15.0
Injection is painful	13.4
Other reasons	4.5

Note: the total percentage exceeds 100% as respondents could choose multiple substances.

Table 12. Reasons for not injecting in the past six months among people engaging in high-risk drug use with a history of injection practice, Afghanistan, 2023 (N=172)

Reasons for not using drugs by injection	%
Injection being costly	43.0
Syringes not easily available	34.9
For lower levels of use	25.0
To avoid HIV	23.8
All veins were hard and no place for an injection	14
Friends/partners quit injection	15.7
Friends/partners do not injection	8.1
Skin diseases and infections	8.7
Already Infected with HIV and for protecting others	3.5
Already Infected with HCV and for protecting others	1.2
Other reasons	9.9

Note: the total percentage exceeds 100% as respondents could choose multiple substances.

Table 13. Substances reported injected by participants in the past six months, by substance (in percentage), Afghanistan, 2023 (N=363).

Substances injected in the past 6 months	Total	Sex			Living area		
		Men (N=343)	Women (N=20)	P-value	Urban (N=253)	Rural (N=110)	P-value
Heroin	70.2	70.6	65.0	0.597	66.0	80.0	**0.007**
Pharmaceutical opioids	8.8	8.5	15.0	0.403	5.5	16.4	**0.001**
Methamphetamine/amphetamine	30.6	30.3	35.0	0.659	39.5	10.0	**<0.001**
Cocaine	2.8	2.9	0.0	1.000	3.2	1.8	0.730
Hallucinogens	0.8	0.9	0.0	1.000	1.2	0.0	0.556
Sedative/hypnotics	2.2	2.0	5.0	0.367	1.2	4.5	0.058

Note: the total percentage exceeds 100% as respondents could choose multiple substances. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 14. Individuals with whom people engaging in high-risk drug use injected in the past six months (in percentage), Afghanistan, 2023 (N=365).

People with whom injected in the past 6 months	Total	Sex			Living area		
		Men (N=345)	Women (N=20)	P-value	Urban (N=254)	Rural (N=111)	P-value
Alone	84.1	84.3	80.0	0.538	85.0	82.0	0.462
Friends	56.4	59.1	10.0	**<0.001**	51.6	67.6	**0.005**
Spouse	1.1	0.9	5.0	0.203	1.6	0.0	0.319
Family/relatives	1.6	1.2	10.0	**0.038**	1.6	1.8	1.000
Strangers	11.8	12.5	0.0	0.148	9.4	17.1	**0.037**

Note: the total percentage exceeds 100% as respondents could choose multiple substances. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 15. Injection locations reported in the past six months among people engaging in high-risk drug use (in percentage), Afghanistan, 2023 (N=365).

Locations	Total	Sex			Living area		
		Men (N=345)	Women (N=20)	P-value	Urban (N=254)	Rural (N=111)	P-value
Public places	86.6	90.4	20.0	**<0.001**	84.6	91.0	0.102
Place where the person lived	42.7	41.2	70.0	**0.011**	44.1	39.6	0.429
Dealer's home	10.1	10.1	10.0	1.000	10.2	9.9	0.924
Other people's home	9.3	8.7	20.0	0.104	10.2	7.2	0.360
Prison	1.4	1.4	0.0	1.000	1.2	1.8	0.642

Note: the total percentage exceeds 100% as respondents could choose multiple substances.

P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 16. Frequency of injecting behaviours in the past six months among people engaging in high-risk drug use who inject (in percentage), Afghanistan, 2023.

Frequency	Injecting drugs with others (N=363)	Using needles and syringes used by someone else (N=365)	Someone else injected with the person's needles and syringes (N=358)
Never	10.7	27.7	25.4
Rarely	30.0	37.5	35.8
Sometimes	31.4	21.6	24.3
Often	22.6	11.0	14.2
Always	5.2	2.2	0.3

Table 17. Reasons for sharing injection with others among people engaging in high-risk drug use who inject, Afghanistan, 2023 (N=277).

Reasons	%
More needles and syringes not available	68.2
Need to take drugs was urgent	41.9
Needle was cleaned before use	29.2
Needed help in injecting	29.6
Someone else needed help in injecting	21.3
Needle clogged	22.7
Needle got broken or blunt	14.8
People would be upset if I did not use their needle & syringe	10.1
Trusted the person	7.6

Table 18. Frequency of cleaning methods of needles and syringes used before by others in the past six months, among people engaging in high-risk drug use who inject (in percentage), Afghanistan, 2023.

Frequency	Running water (N=258)	Bleach (N=255)	Alcohol/ spirits (N=253)	Boiling water (N=255)	Saline/ distilled water (N=259)	Paper/ tissue /cloth (N=259)	Other methods (N=200)
Never	17.4	87.1	85.4	62.0	25.1	14.7	8.5
Rarely	31.8	10.2	12.6	23.9	29.7	54.1	76.5
Sometimes	24.8	2.4	1.6	9.8	26.3	19.3	13.5
Often	12.4	0	0.4	3.9	10.8	9.3	1.0
Always	13.6	0.4	0	0.4	8.1	2.7	0.5

Table 19. Characteristics of participants by a history of drug-related offenses during lifetime among people engaging in high-risk drug use (in percentage), Afghanistan, 2023 (N=6,868).

Variables	Total	Drug-related offences in lifetime		P-value
		Yes (N=1266)	No (N=5602)	
Sex				**<0.001**
Men (6322)	92.1	99.5	90.4	
Women (546)	7.9	0.5	9.6	
Living area				**0.020**
Urban (4580)	66.7	63.9	67.3	
Rural (2288)	33.3	36.1	32.7	
Age (6868)				**0.002**
≤20 (352)	5.1	3.7	5.4	
21-30 (2231)	32.5	30.7	32.9	
31-40 (2503)	36.4	35.9	36.6	
41-50 (1332)	19.4	22.8	18.6	
51-60 (364)	5.3	5.2	5.3	
>60 (86)	1.3	1.7	1.2	
Education (6867)				**0.385**
No education (3386)	49.3	51.7	48.8	
Primary (1437)	20.9	19.8	21.2	
Secondary (1802)	26.2	25.5	26.4	
Higher education (152)	2.2	1.9	2.3	
Madrasa (90)	1.3	1.1	1.4	

Marital Status (6867)				0.021
Never married (2244)	32.7	31.8	32.9	
Married (4056)	59.1	58.1	59.3	
Previously married (567)	8.3	10.2	7.8	
Living in past 6 months (6839)				<0.001
House (5250)	76.8	66.4	79.1	
Homeless (1543)	22.6	31.8	20.5	
Prison (24)	0.4	1.2	0.2	
Others (22)	0.3	0.6	0.3	
Living with in past 6 months (6862)				<0.001
Family/ close relatives (4989)	72.7	61.3	75.3	
Friends (677)	9.9	13.5	9.0	
Alone (1196)	17.4	25.2	15.7	
Source of financial support (6858) [b]				
All types of work (5016)	73.1	70.2	73.8	0.009
Received from others (2955)	43.1	37.3	44.4	<0.001
All types of crimes (2192)	32.0	47.0	28.6	<0.001
Severity Dependence Scale (SDS) (6868)				<0.001
SDS < 5 (281)	4.1	1.8	4.6	
SDS ≥ 5 (6587)	95.9	98.2	95.4	
Injection in last 6 months (6828)				<0.001
Yes (363)	5.3	10.5	4.2	
No (6465)	94.7	89.5	95.8	

Treatment for drug problem in life-time (6859)				**<0.001**
Yes (3542)	51.6	72.8	46.9	
No (3317)	48.4	27.2	53.1	

b Respondents could select more than one option.

Note: numbers in parentheses show the total respondents to each question. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 20. Estimated number of hotspots and number of people who use drugs in the hotspots, Afghanistan, 2022 (N=3,555).

Province [a]	Region	Number of hotspots	Mid-estimation for the number of high-risk drug users				
			Per hotspot	All ages & Sexes	Chil-dren	Women	Inject-ing drug users
Badakhshan	Fayzabad District	39	34	1330	298	148	123
Badghis	Qala-e-Naw City	5	29	147	1	9	0
Baghlan	Pul-e-Khumri District	27	46	1246	115	23	52
Balkh	Balkh, Dehdadi & Nahri-Shahi Districts	38	42	1588	36	295	90
Bamyan	Bamyan City	10	55	553	1	0	81
Daykundi	Nili City	8	86	686	24	17	64
Farah	Farah City	5	105	524	4	10	0
Faryab	Maymana & Pashtun-Kot Districts	43	74	3182	163	940	171
Ghazni	Ghazni, Khawaja-Umari & Deh-Yak Districts	20	68	1368	2	16	40
Ghor	Firuzkoh City	8	46	367	20	32	0
Helmand	Lashkargah district	24	18	442	24	23	20
Herat	Herat, Guzara, Enjil & Ghory-an Districts	16	59	943	46	116	0
Jawzjan	Sheberghan District	22	41	910	109	189	25

Kabul	Kabul District	55	85	4662	68	65	474
Kandahar	Kandahar City	64	14	888	63	35	76
Kapisa	Mahmud Raqi District	8	18	142	0	0	26
Kunar	Asadabad City	5	7	37	9	5	8
Kunduz	Kunduz District	23	71	1640	537	304	460
Laghman	Mihtarlam & Qarghayee Districts	15	16	237	25	18	60
Logar	Pul-e-Alam District	10	12	115	0	3	0
Nangarhar	Jalal-Abad, Behsud, Surkh-Rod & Bati-Cot Districts	39	33	1278	263	22	291
Nimroz	Zaranj District	15	68	1014	53	64	25
Nuristan	Parun District	9	31	283	57	25	28
Paktika	Yousef-Khel & Sharana Districts	6	8	46	0	0	0
Panjshir	Bazarak & Rukha Districts	7	29	204	0	2	57
Parwan	Charikar City	9	41	366	0	2	109
Samangan	Abyak & Hazrat-Sultan Districts	20	33	653	27	72	67
Sar-e Pul	Sar-e Pul & Sayyad Districts	29	22	639	26	113	10
Takhar	Taloqan District	18	37	666	174	84	96
Urozgan	Tarinkot District	13	12	155	3	14	15
Wardak	Maidan Shahr & Nirkh Districts	19	8	153	0	0	9
Zabul	Qalat District	22	13	281	5	32	0
Total	Selected Areas	651	41	26,739	2,151	2,673	2,473

a Khost and Paktia were excluded.

Table 21. Characteristics of people engaging in high-risk drug use by a history of treatment for a drug problem (in percentage), Afghanistan, 2023 (N=6,876).

Variables	Total	Treatment in lifetime		P-value
		Yes (N=3,548)	No (N=3,328)	
Sex				**<0.001**
Men (6327)	92.0	95.5	88.3	
Women (549)	8.0	4.5	11.7	
Living area				**<0.001**
Urban (4584)	66.7	73.8	59.1	
Rural (2292)	33.3	26.2	40.9	
Age (6876)				**<0.001**
≤20 (351)	5.1	4.2	6.1	
21-30 (2236)	32.5	30.0	35.2	
31-40 (2505)	36.4	36.9	36.0	
41-50 (1334)	19.4	22.0	16.7	
51-60 (364)	5.3	5.6	4.9	
>60 (86)	1.3	1.4	1.1	
Education (6875)				**<0.001**
No education (3393)	49.4	51.8	46.7	
Primary (1438)	20.9	21.9	19.9	
Secondary (1800)	26.2	22.5	30.1	
Higher education (153)	2.2	2.2	2.2	
Madrasa (91)	1.3	1.6	1.1	

Marital Status (6875)				**<0.001**
Never married (2243)	32.6	29.8	35.6	
Married (4061)	59.1	60.3	57.8	
Previously married (571)	8.3	9.9	6.6	
Living in past 6 months (6848)				**<0.001**
House (5258)	76.8	69.9	84.0	
Homeless (1546)	22.6	29.2	15.5	
Prison (24)	0.4	0.4	0.3	
Others (22)	0.3	0.5	0.2	
Living with in past 6 months (6871)				**<0.001**
Family/ close relatives (4996)	72.7	65.8	80.1	
Friends (678)	9.9	12.6	6.9	
Alone (1197)	17.4	21.6	13.0	
Source of financial support (6866) [a]				
All types of work (5025)	73.2	72.8	73.6	**0.422**
Received from others (2959)	43.1	35.9	50.8	**<0.001**
All types of crimes (2196)	32.0	34.3	29.5	**<0.001**
Severity Dependence Scale (SDS) (6875)				**<0.001**
SDS < 5 (281)	4.1	2.9	5.3	
SDS ≥ 5 (6594)	95.9	97.1	94.7	
Injection in last 6 months (6834)				**<0.001**
Yes (365)	5.3	7.0	3.6	
No (6469)	94.7	93.0	96.4	

Drug-related offences in lifetime (6859)				**<0.001**
Yes (1265)	18.4	26.0	10.4	
No (5594)	81.6	74.0	89.6	

a Respondents could select more than one option.

Note: numbers in parentheses show the total respondents to each question. P-values in "bold" indicate statistically significant differences between the two groups at the 95% confidence level.

Table 22. Treatment received during lifetime by drug type among people engaging in high-risk drug use (in percentage), Afghanistan, 2023.

Treatment history for drug problem	Among those who received treatment (N=3,548)	Among total respondents (N=6,893)
Opium	40.6	20.9
Heroin	62.4	32.1
Pharmaceutical opioids	1.8	0.9
Cannabis	25.5	13.1
Methamphetamine	36.5	18.8
Table K	5.7	3.0
Cocaine	1.5	0.8
Ecstasy/MDMA	0.1	0.04
Other hallucinogens	0	0
Solvents/inhalants	0.3	0.1
Sedative/hypnotics	2.2	1.1
Codeinated cough syrup	0.9	0.5

Note: Treatment might have been received for more than one drug.

Table 23. Reasons for unmet need among people engaging in high-risk drug use without a history of treatment, Afghanistan, 2023 (N=3,873).

Reasons for unmet need	(%)
Structural barriers	49.6
No centre or space in the centre available	10.9
Dislike treatment regime	12.0
Dislike treatment facility staff	6.9
Non-scientific approaches in the centres	31.7
Unavailability of specialized inpatient services	7.3
Financial problems	57.4
Fear of stigma	42.7
Fear of registration	30.8
Fear of arrest	28.3
Fear of death or punishment	18.9
No trust to Governmental facilities	18.4
Don't have information on local services	8.7
Other reasons	7.5

Table 24. Key informants' perception of the extent of service utilization by people who use drugs in areas where such services exist, Afghanistan, 2022 (N=1,232).

Type of services	Commonly (%)	To some extent (%)	Seldom used (%)
Primary healthcare	61.2	26.1	12.7
Mental healthcare	59.2	26.1	14.7
Specialized outpatient drug treatment	55.9	31.9	12.2
Hospital-based drug treatment	59.7	26.1	14.2
Residential treatment services	45.0	27.1	27.9
Therapeutic communities	69.4	20.1	10.4
Specialized rehabilitation services	54.8	30.0	15.2
Low threshold services	57.1	23.4	19.5

Table 25. Key informants' perception of the usefulness of services in areas where such services exist, in terms of acceptability and services provided, Afghanistan, 2022 (N=1,232).

Type of services	Very useful (%)	Somewhat useful (%)	Least useful (%)
Primary healthcare	56.5	29.7	13.7
Mental healthcare	59.4	26.2	14.4
Specialized outpatient drug treatment	46.6	30.7	22.6
Hospital-based drug treatment	66.8	23.7	9.5
Residential treatment services	45.4	33.8	20.8
Therapeutic communities	67.0	19.9	13.1
Specialized rehabilitation services	51.9	30.8	17.3
Low threshold services	43.3	31.1	25.6

Table 26. Key informants' perception of the ease of access to drug treatment in their area for different groups of drug users, Afghanistan, 2022 (N=1,232).

Groups of drug users	Difficult (%)	Neither easy/ Nor difficult (%)	Easy (%)
Men	60.9	13.3	25.8
Women	79.5	7.1	13.4
Young people (20-25)	66.2	11.4	22.3
Adolescents (10-19)	69.9	11.0	19.0
Children (<10)	75.1	9.6	15.3

Table 27. Key informants' perception of the need for drug treatment services in their area for different groups of people who use drugs, Afghanistan, 2022 (N=1,232).

Groups of drug users	Needed (%)	Somewhat needed (%)	Not needed (%)
Men	90.2	1.8	8.0
Women	80.2	11.6	8.2
Young people (20-25)	88.1	2.8	9.0
Adolescents (10-19)	85.0	5.0	10.1
Children (<10)	70.3	7.4	22.3

ANNEX 2: COMMENTS FROM THE DE FACTO AUTHORITIES

Technical comments of the Directorate of Survey and Analysis of Narcotic Drugs and Demand Reduction regarding the fifth report of the UNODC office

As You are already aware, the mentioned survey on drug user was conducted by the UNODC office in 2022. Considering the passage of time, the following points are important in this regard and may affect the results of the report:

- The mentioned survey was conducted before the historic initiative of the Islamic Emirate of Afghanistan regarding the collection of drug addicts. Publishing its results under the current circumstances may lead to public confusion regarding the efforts and achievements of the Islamic Emirate of Afghanistan in the fight against drugs and the treatment of drug addicts.

- The mentioned report refers to major or large gathering spots of drug addicts in the provinces of the country, and among them, it cites 55 such locations in Kabul province. However, according to documented evidence available with the Counter Narcotics Deputy Ministry and the respected Ministry of Public Health, this number is actually 28 locations — and the same applies to other provinces as well.

- After the implementation of the mentioned survey, the Islamic Emirate of Afghanistan, through tireless efforts and with limited resources, established dozens of camps and collected thousands of drug addicts across the country and they continue their efforts in providing treatment for them till now.

- The mentioned report refers to the presence of substances such as ephedrine, pseudoephedrine, and the ephedra plant in the country, as well as the excessive availability of methamphetamine. However, the Counter Narcotics Deputy Ministry has previously shared its technical and professional explanations on this matter with the UNODC office. This issue has already been repeatedly mentioned in previous reports of the respected office, and therefore, it should not be reiterated in the publication of this report

- The mentioned report refers to Afghanistan's economic dependence on illicit products; however, this matter is currently considered no longer applicable.

- The mentioned report states that 31.9% of respondents indicated obtaining their financial resources through criminal activities. However, this issue was not originally part of the scope of the report and should have required coordination with the country's criminal investigation departments.

- Another section of the report refers to sexual relationships among drug users, which, due to the lack of evidence, is a serious concern and considered contrary to Islamic principles. Moreover, such claims could harm the identity of the Muslim population of the country at the international level.

- Another section of the report mentions the distribution of condoms among drug users, which, in turn, legitimizes sexual relations among drug addicts and creates an environment conducive to moral and Islamic deviations.

Therefore, considering the above points, the publication of the report, at a time when the situation regarding drug addiction has undergone significant and unprecedented changes since 2022, may cause confusion among the citizens of the country and Furthermore, the publication of such figures, numbers which have lost their relevance over time, does not contribute to improving the situation and may instead lead to further problems.

With respect,