GLOBAL INITIATIVE
AGAINST TRANSNATIONAL ORGANIZED CRIME

HUMAN RIGHTS ABUSES IN THE TALIBAN'S DRUG CONTROL REGIME

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SUMMARY

This report presents the initial findings of a significant field research initiative conducted by the Global Initiative Against Transnational Organized Crime in collaboration with Coact, a community-led support agency working for the rights of people who use drugs (PWUD). The fieldwork was conducted between 2022 and 2025 to explore the conditions at drug treatment centres in Afghanistan, the broader situation of PWUD in the country, the behaviour of staff and authorities, community dynamics, and the evolving approach of the Taliban government with regard to rehabilitation programmes. The results reveal damning evidence of human rights abuses, in a context of restrictive social policies and the Taliban's mixed scorecard on suppressing drug-related criminality.

When our researchers visited the facilities, they formed the impression that the treatment centres operated more like prisons than hospitals. People were primarily admitted with the aim of separating them from drugs, rather than providing them with care. There were no structured treatment plans, no therapy sessions or real rehabilitation frameworks in place. In many cases, individuals were lying on thin mattresses in crowded, unhygienic and poorly ventilated rooms. Medical care was almost absent, and we did not observe any systematic treatment for withdrawal or any structured psychological support being offered. When patients complained of pain or other health issues, staff often dismissed them; authorities assumed they were either pretending or seeking stronger medication. As a result, people's medical needs went untreated and their health concerns were not taken seriously. The system appears to be based on containment: keeping people away from drugs for a period of time rather than preparing them for long-term recovery.

Alongside the structural shortcomings, the research team observed issues with staff behaviour and their interactions with patients. While we did not witness any physical beatings first-hand, harassment and disrespect were commonplace. Staff mocked patients, ignored their calls for help and dismissed their complaints. Patients were rarely listened to. Several of the people we interviewed said that this treatment made them less willing to try giving up drugs. They described feeling humiliated and pushed around. Instead of encouraging recovery, the disrespectful behaviour of staff increased patients' feelings of resentment and hopelessness, making the situation worse.

The fieldworkers' observations show that female drug users are almost entirely neglected. We met women who were struggling with drug dependence while also caring for children. Several women described extremely difficult experiences. Some spoke of harassment and even rape, both inside and outside treatment facilities. Due to stigma and fear of retaliation, many asked us not to share their stories publicly. What is clear, however, is that women and children are among the most vulnerable

groups in this crisis. Yet their needs are largely ignored, leaving them exposed to abuse, neglect and the risk of intergenerational drug dependence.

The researchers also noted that some individuals were highly skilled at presenting their stories. In some cases, experiences were exaggerated or dramatized – for example, claims of beatings were said to be more severe than the evidence suggested. This may have been an attempt to gain sympathy or secure release. Others changed their accounts from one interview to another. This forced our team to exercise caution in our roles as interviewers. We therefore often asked the same question in different ways or returned to a topic later to verify the consistency of responses. Such tactics indicate how desperate some people are to improve their situation, but they also reveal the need for patience and careful listening in this context.

The health and human rights abuses of PWUD in Afghanistan's drug treatment facilities, as revealed by this report, reflect broader challenges in the country's approach to drug control under the Taliban. Despite a large-scale anti-drugs campaign – including the destruction of methamphetamine laboratories and opium poppy plantations – drug trafficking continues across the country. The focus on eradication risks overlooking those most affected by the drug trade, as the fieldwork findings make clear. The systematic dehumanization of PWUD, at both international and local levels, has enabled a situation that facilitates grave human rights abuses in conditions tantamount to prolonged torture. Interviews paint a picture of people being warehoused en masse and exposed to harsh conditions while receiving minimal care. Although accounts from PWUD and staff differ in some cases, the uniformity of PWUD accounts and the enabling conditions highlighted by staff point to a serious human rights risk that must be investigated and rectified. The accounts speak for themselves.

A billboard in Kabul cautions residents against drug use. Since retaking power, the Taliban have pursued a large-scale anti-drugs campaign in Afghanistan. *© Shah Marai/ AFP via Getty Images*

BACKGROUND

When the Taliban regained control of Afghanistan in 2021, they quickly enacted an anti-narcotics campaign to reduce rates of drug production and use. While smuggling of existing stockpiles has continued,[1] opium production had reportedly fallen drastically by 2023.[2]

Coinciding with the loss of international aid during this time, which amounted to a significant portion of the country's GDP,[3] Afghans also lost approximately 14%–28% of their per capita income in 2021.[4] Previously, the opium harvest alone supported about half a million part-time workers each year across a third of Afghan villages – equivalent to about 100 000 full-time jobs – and in 2023, farmers lost the equivalent of approximately 8% of GDP because of the ban on opium cultivation.[5] In the absence of sustainable, profitable alternatives and a stagnating economy, farmers are likely to return to poppy cultivation in the face of economic hardship, with evidence of the ban being flouted beginning to emerge.[6]

Opium is often used to alleviate the effects of poverty, especially those relating to health issues, in the absence of robust, affordable healthcare, particularly in rural areas.[7] This may include the suppression of appetite in the face of food insecurity and low incomes. Given its analgesic effects, opium is also used to manage pain linked to repetitive activities such as weaving and other forms of manual labour. Opium use in rural areas is 2.5 times higher than in urban areas, and 71.5% of Afghans live in rural communities.

One of the consequences of war has been the displacement of people from rural to urban areas, where heroin and pharmaceutical opiates are more readily available. In cities, exposure to blood-borne infections due to drug injection, and criminalization, which drives higher-risk drug use, are more prevalent. At the same time, access to harm-reduction services is likely to be greater in urban areas.[8]

In 2011, the Islamic Republic of Afghanistan and UNAIDS reported to the UN General Assembly Special Session (UNGASS) on HIV and AIDS in Afghanistan. The report described Afghanistan as 'entering into a concentrated epidemic'.[9] Despite HIV and AIDS being of low prevalence among the general population, the growing at-risk populations, particularly people who inject drugs (estimated at 19 000–25 000 at the time), and bridging risk groups (including prisoners and truck drivers) led to the possibility of a rapid increase in HIV and AIDS among the general population being described as 'very real'.[10] A year later, the Integrated Biological and Behavioural Surveillance Study found that 4.4% of people who inject drugs in Afghanistan were infected with HIV, and 31.2% with hepatitis C.[11] In 2020, rates of infection remained low among the general population, with an HIV incidence rate of <0.1%.[12] The low literacy rates in Afghanistan have resulted in low levels of HIV/AIDS awareness,

Beneath Kabul's Pul-e-Sukhta bridge, open drug use takes place amid pollution, open drains and raw sewage – conditions that some users have nonetheless described as preferable to those found in certain of Afghanistan's drug treatment centres. *© Kaveh Kazemi/Getty Images*

and access to testing is also scarce. Although opioid use has declined since the Taliban's return to power, while the use of methamphetamine has increased, a recent UN report indicated that 8% of respondents had injected drugs, of whom three-quarters had shared syringes. This suggests that the threat of an HIV/AIDS epidemic in Afghanistan remains very real.[13]

Research in Kabul between 2007 and 2009 put the mortality rate for PWUD at approximately 93.4 per 1 000 person-year, a far higher number than average; death by overdose made up 43.9% of that statistic.[14] In a community consultation in 2015, 55.6% of participants had experienced a non-fatal overdose and 94.8% had witnessed a fatal overdose (N = 153). Two-thirds of this cohort had experienced health issues such as abscesses, but owing to stigma, were unable to access medical treatment.[15] Moreover, access to the opioid overdose reversal agent naloxone is limited, with many treatment providers unable to offer this life-saving medication.[16]

Initially, methamphetamine was imported from Iran and used mostly by more affluent members of society.[17] However, in 2015, just over half of the participants (56.8%, N = 153) in a community consultation said that they had tried methamphetamine; 13.7% had tried it and stopped.[18] This is indicative of a notable transition in drug use patterns in Afghanistan, with heroin trafficking slowing from 2022 but methamphetamine production and trafficking intensifying, the latter being cheaper and easier to come by.[19] The growing prominence of methamphetamine is reflected in increased seizures, evidence of domestic cultivation of ephedra to produce ephedrine, and the importation of synthetic precursor chemicals.[20]

Population displacement, economic instability and protracted conflict over the past four decades have negatively affected the coping mechanisms and survival strategies of the local population, placing strain on family structures and increasing people's vulnerability to developing mental health problems, substance use disorders and post-traumatic stress disorder.[21] With approximately 85% of Afghans having

either witnessed or experienced a traumatic event, 50% having experienced psychological distress, and 20% having mental health issues that negatively affect their daily lives and work,[22] it is unsurprising that rates of problematic substance use have soared – from approximately 4% to 10% – since 2005.[23]

A quarter of Afghanistan's PWUD are women and children, and they face increased challenges given their lack of agency and ability to use in private settings.[24] Between 2005 and 2015, the rate of drug use among women increased sixfold, with those who are divorced, widowed or unemployed more likely to experience substance use disorder. Many of these women previously worked as carpet weavers or embroiderers. Women who use drugs in Afghanistan also face a dual stigma owing to the cultural expectation that they will honour their family through chastity and seclusion.[25] Although women tend to use non-injecting routes, findings from a community consultation in 2015 showed that 38% of $N = 38$ had engaged in intravenous use. Findings also highlighted that women who use drugs are vulnerable to sexual harassment, assault or rape by police.[26] The rights of women and their ability to work in NGOs providing support to PWUD have been negatively impacted since the Taliban returned to power.[27]

Since the Taliban's return, coverage of harm-reduction services such as opioid agonist treatment and needle and syringe programmes has declined, and the de facto authorities openly embrace the use of drug detention centres.[28] The Taliban began to round up people in areas where drugs were used publicly, such as the Pul-e-Sukhta bridge in Kabul, where horrific circumstances, such as open drains and no sanitation, prevail.[29] Some 59 bodies were found in fresh graves under the bridge after Taliban authorities cleared out the area in 2023.[30]

In 2023, approximately 82 000 individuals were forcibly placed into rehabilitation. Yet, despite the dire circumstances at these open drug scenes, a user who lived under Pul-e-Sukhta stated that drug treatment was worse than life under the bridge.[31] As many as 114 340 individuals have been subjected to highly visible violent raids on encampments since 2021,[32] although reports from 2024 indicate that round-ups had slowed, with more drug users being offered voluntary treatment and vocational training.[33]

Overall, drug-related criminality in Afghanistan persists despite the Emir's ban on drug production and trafficking in 2022.[34] Sufficient quantities of opium and heroin are produced and trafficked to meet external market demand, with production having shifted from Helmand and Kandahar provinces in Afghanistan to Balochistan in south-western Pakistan, while increased production is also seen in Afghanistan's Badakshan province.[35] Methamphetamine, a major criminal export, is produced in south-west Afghanistan around Bakwa and shipped to global markets, including in Central Asia, Europe and Oceania. The internal markets for methamphetamine and 'tablet K' are thriving, with a higher proportion of lower-grade methamphetamine being produced for domestic consumption.[36]

The 2025 Global Organized Crime Index describes active drug trafficking from Afghanistan and well-established routes through Pakistan, Iran and Turkiye, as well as a recent expansion in synthetic drug production. The Index also assesses resilience to criminality, broken down into four thematic areas. In its assessment of civil society and social protection, it found that 'the Taliban's approach to drug addiction treatment has been marked by forced rehabilitation, with limited medical support for withdrawal'.[37]

Resilience must be understood as the range of measures that a country can implement to protect against and suppress criminal markets and actors. In Afghanistan, the human rights abuses in drug treatment facilities are one of a series of issues compounded by corruption, performative enforcement and inconsistent application of drug bans within the ranks of the Taliban. This report provides a detailed analysis of one aspect of Afghanistan's minimal resilience in the face of drug markets and actors, and the findings illustrate why it has the second-lowest resilience of any country assessed by the Index.

FIELDWORK FINDINGS

Many of the PWUD interviewed identified common reasons for starting to use drugs and for relapsing, including easy access to substances, poverty, unemployment, forced repatriation from neighbouring countries, and a lack of public awareness or social or family support. 'As soon as I leave the house and can't find a job, the mental stress I experience pushes me back towards using drugs again,' one interviewee said.[38] Several respondents indicated that they had started using drugs in Iran.[39]

A worker at a drug treatment centre argued that although the sale of traditional narcotics such as opium and heroin has declined under the Taliban, there has been a rise in young people using 'synthetic and chemical drugs, particularly prescription tablets',[40] which are allegedly smuggled in from neighbouring countries.[41] Another interviewee noted that there has been a sharp increase in the consumption of methamphetamine (locally known as *shisha*) owing to its affordability and ease of production.[42] Several de facto authority representatives noted that the Taliban had made significant efforts to capture and imprison drug dealers and PWUD at drug dealing hotspots (known as *saqi khanas*), but many have since reopened.[43] Interviewees often ascribed the ongoing presence of *saqi khanas* to local corruption.

The capacity to meet the treatment needs of PWUD varies significantly across provinces. Bamyan and Baghlan, for example, each have a total capacity of caring for 40 patients, while the total number of PWUD in Baghlan alone exceeds 10 000.[44] In contrast, three treatment centres operate in Ghazni: a 500-bed facility for male patients; a 20-bed centre for women; and an additional 700-bed centre for men, recently established by the Taliban.[45] Some centres continue to be run privately, such as in Herat, where 13 of the 17 available facilities are run privately.[46] Unlike for government-run centres, patients must pay to enrol in these facilities,[47] but they are allowed to exit and re-enter (unlike public centres, which do not allow patients freedom of movement).[48] There are only 50 and 20 beds in Zabul and Uruzgan, respectively, whereas Kandahar operates several large centres, including at least one 4 000-bed facility.[49] Until mid-2024, this meant that PWUD were often transferred from provinces with smaller capacities, such as Nimroz and Uruzgan, to Kandahar. Since then, public health ministry-run facilities in those provinces have improved, so fewer patients are transferred to Kandahar.[50]

The former Russian Cultural Centre in Kabul has become a gathering point for people who use drugs – many of them Afghans deported from Iran, where they had started using heroin. *© Lynsey Addario/Getty Images Reportage*

Mistreatment of patients

Nearly all of the PWUD interviewed reported experiencing mistreatment during their stays at drug treatment centres, including verbal, physical and sexual abuse and torture. A small number of interviewees, mainly those still completing their mandatory stays, stated that there were no cases of mistreatment at their centres. The environment at treatment centres was generally described as harsh, neglectful and punitive.

Interviewees recounted how members of the Taliban and professional staff, as well as fellow patients who had been given leadership roles, abused patients. Physical abuse was sometimes described as punishment for perceived bad behaviour, such as resisting treatment, fighting with other patients, attempting to escape, or arriving late for scheduled activities such as morning prayers. Examples of physical abuse included patients being beaten or whipped,[51] doused with cold water[52] or washed with pressure washers,[53] having their food and water withheld,[54] *falak* (a form of corporal punishment),[55] having their feet chained together, and being placed in isolation rooms. One interviewee referred to the isolation room at his treatment centre as the 'steam boiler', since it was 'made entirely of cement, with no windows or ventilation. There was no oxygen flow into the room.'[56] At another centre, patients were 'thrown into a well for 24 hours as punishment'.[57]

At women-only treatment centres, interviewees noted that staff threatened to shave their heads if they did not follow instructions.[58] Most PWUD interviewees reported that they were not aware of any cases of sexual abuse occurring during their stays at these centres; the few who did mention such cases said they mostly involved patients in positions of power who abused new and younger arrivals, especially adolescent boys.[59]

Several interviewees had either heard about or witnessed deaths of patients at the centres they attended, and cases of suicide or suicide attempts were also mentioned, particularly among patients who had no local family and therefore no official avenues for leaving the centre (see section on 'Exit, entry and reintegration' below).[60] Other PWUD interviewees noted that patients often disappeared. For example, a former patient at a treatment centre in Mazar observed that 'numerous individuals [were] brought in with severe health deteriorations, only to vanish without a trace after a brief period'.[61] One interviewee had heard reports of bodies being found in the centre's septic tank.[62] However, some centres did return the bodies of deceased patients to their families. If a patient's family was not known, the patient's photograph and information would be shared in local WhatsApp groups in an attempt to identify any relatives. If no relative could be found, the deceased would be washed and buried by other patients at the centre. According to another interviewee, this process has now changed, and bodies are handed over to the local municipality.[63]

A number of interviewees noted that patients sometimes died as a result of neglect, although this appears to vary between centres. Such neglect was described as a lack of food, poor hygiene conditions leading to illness, limited protection in cold conditions, and a lack of medical treatment during the withdrawal process. One interviewee, who attended a large treatment centre, recalled that 'every night, five to 10 people died – either from the cold or from drug withdrawal',[64] while another estimated that, on some days, 10–15 people died in the facility where he was treated.[65]

In contrast, most treatment centre staff and de facto authority representatives who were interviewed stated that there were no instances of mistreatment or abuse of patients, and either no or very few deaths at the treatment centres. A doctor at one treatment facility stated 'the mortality rate in here is very low' and 'there is no violence involved with [patients] now; all the staff are professional'.[66] Another interviewee, who worked at a 1 000-bed facility, stated that there were 20 deaths each year at the centre, primarily caused by 'high blood pressure or non-movable blood flow issues' (typically venous diseases and arterial blockages).[67] Some interviewees did, however, acknowledge isolated instances of members of the Taliban or professional staff physically abusing patients. In response to a question regarding complaints made by patients, one official said: 'There are thousands of addicts in these camps. Of course, we can't give each one personal treatment, like one doctor per patient. We face many problems and challenges.'[68]

Notably, at one particular facility, patients had organized a demonstration after the centre's well had run dry, leading to a water shortage. The Taliban were unable to regain control of the camp and requested reinforcements. In the process of subduing the patients, members of the Taliban used 'an electrical shock device' and some patients were severely injured.[69]

Living conditions at treatment centres

As with instances of mistreatment, the living conditions and available amenities vary significantly across drug treatment centres. Several interviewees (including staff members)[70] described the centres as being more like prisons than rehabilitation centres, a sentiment reflected in the living conditions.[71]

Some PWUD described not receiving sufficient food or water, access to hygiene facilities or beds. One interviewee noted that the only way to receive additional food, clothing or hygiene products was if their family brought them in from outside.[72] At one women-only facility, patients received items such as baby formula or medication only if these were donated by a charity organization.[73] Some centres

banned the sale of items on the premises, while others either provided a daily allowance[74] or permitted family members to bring patients cash to buy items.[75]

With reference to food provisions, many patients noted that the quality of the food was not bad (although meals were occasionally described as rotten and inedible).[76] However, there was no variation in the food offerings[77] and meals were not sufficiently filling, with patients reporting being constantly hungry. An interviewee described the three meals patients received at one centre as follows: 'In the morning … they gave us one glass of milk with one [portion of] bread … For lunch, we got beans. Nothing else, just beans with bread. For dinner, we got rice.'[78] Another interviewee noted that the portions were small and only large enough to prevent starvation.[79] Interviewees who had attended women-only centres noted that patients with children received additional portions of food.[80] Concerningly, not all centres had clean drinking water. As one interviewee in a medium-sized facility explained, 'We had no idea if the water was clean or safe, and most of the time it had a bad smell – but we had no other choice.'[81]

Large camps generally did not have enough shower and toilet facilities for all the patients, and the ones that did exist were typically not clean. One interviewee noted that there were insufficient toilets at a centre housing approximately 700 people.[82] Another described a typical morning routine as follows: 'We were forced to wake up at 3.45 a.m. Our turn to use the restroom came around 5.30 a.m., but we had to wait in long queues. Some would lose control before reaching the toilet. Each room, designed for 22 people, had one toilet and one shower, but these were locked or used as storage. About 300 patients shared a single external restroom.'[83]

Some treatment centres had showers, although they often had only cold water or no water at all.[84] At one centre, patients reportedly bathed in a nearby canal.[85] Not all facilities provided soap or other hygiene items to patients either.[86] In some cases, certain hygiene practices were conducted by the centre's staff, such as at one facility, where a male patient described how 'every 20 days, our heads were publicly shaved, and our underarms were cleaned using closed razors or machine blades'.[87] One interviewee noted that, owing to poor hygiene practices, all patients at their centre had lice.[88] In some treatment centres, patients were provided with uniforms,[89] whereas in others, patients wore the same clothes they arrived in[90] or were made to wear dirty, used clothing.[91]

Many treatment centres were found to operate above their intended capacity. A psychiatrist working at one facility explained that the number of rooms 'are completely inadequate for housing up to 1 000 patients, which results in extreme overcrowding'.[92] A PWUD described a centre with capacity for 1 000 housing between 4 000 and 5 000 patients.[93] Subsequently, patients often had to sleep on the floor or in hallways, which led to physical altercations over sleeping spaces.[94] One interviewee said that 'at night, we slept in our rooms like books on a shelf – patients lying side by side, shoulder to shoulder, with absolutely nothing'.[95] In a handful of cases, interviewees noted that their facilities were operating either at or under capacity.[96] Interviews with staff and de facto authority representatives raised broader issues regarding infrastructure, including centres not being connected to the local electricity grid.[97]

Health concerns and medical care

The quality of medical treatment, especially during the initial withdrawal period, appears to vary significantly across centres. The more organized drug treatment centres were able to provide injections to manage initial withdrawal symptoms (referred to as 'hangovers') upon arrival. PWUD listed

various medications that were provided during this period, including glucose solutions,[98] methadone, buprenorphine and lofexidine.[99] In combination with the injections, patients were also expected to submerge themselves in cold water and were sometimes threatened with punishment if they refused.[100] This 'detox period' usually lasted three days. One interviewee noted that diazepam injections were also administered to calm down aggressive patients.[101]

At some centres, blood tests were conducted to check for HIV infection, hepatitis and other diseases, but communication regarding the purpose or results of these tests was inconsistent.[102] However, the majority of treatment centres did not have the capacity to conduct these tests.[103] Some PWUD also relayed that urine samples were taken when they arrived at the treatment centre to identify which drugs were still in their system;[104] one interviewee noted having had to pay for this test.[105] One doctor stated that the facility he works at also has the capacity to test and treat malaria patients, although these patients 'often receive little special attention'.[106]

Barring a handful of interviewees mentioning that they continued to receive pills to manage withdrawal symptoms, interviewees generally said they did not receive additional medicine after the initial detox period. Drug treatment centres generally did not provide any form of medication to patients or, if they did, it was limited to paracetamol.[107] One interviewee described the centre he attended as akin to a 'cold storage facility',[108] where patients were forced to stop taking drugs but were not provided with any form of medical support during the process. The lack of facilities and medicine in many treatment centres resulted in patients suffering from health complications or even dying, frequently during the initial withdrawal period.[109] One interviewee said that at the centre he attended, there was a room called the 'death hall', where 'patients in very poor condition or [those who were] unconscious were taken … Even if a patient was capable of recovery, once left in that hall unattended, the chances of dying increased.'[110] Similarly, one de facto authority representative noted that the lack of regular medication given during the withdrawal period amounted to 'abuse of addicts, in the sense that they are forced to quit drugs not through proper medication, but by dry force'.[111]

The poor living conditions in many of the facilities also negatively affected the health of patients. Several interviewees noted that patients suffered from tuberculosis and other diseases (e.g. skin disorders).[112] Testing for tuberculosis varied. At one centre, staff from the local public health department would come to collect samples to test for tuberculosis, but no follow-up treatment was provided based on the results.[113] One interviewee cited the centres' unsanitary conditions as being the cause of severe (and, in some cases, fatal) gastrointestinal illnesses.[114]

If patients became severely ill, staff at a centre would sometimes contact the family to take the patient to the local hospital, where they would be supervised by Taliban guards until they were well enough to return. However, one interviewee noted that at their centre 'if a patient's health deteriorated severely, the Taliban would call their family to take them home'.[115] Relatedly, one interviewee from a women-only facility noted that if a 'patient has a serious or advanced disease, they are referred to the government hospital in the city and are not admitted here'.[116]

Not all centres had doctors or nurses on staff;[117] this applied especially to large facilities. As a result, some interviewees were not attended to by any medical staff, whether upon arrival or for the remainder of their stay.[118] Several staff interviewees noted that this was a serious barrier to providing treatment to patients.[119] One doctor from a treatment centre in the south-west claimed that 'all centres with more than 50 beds have laboratories where the diagnosis of [HIV and hepatitis] can be made', but this does not appear to be true.[120]

Rehabilitation efforts and treatment methods

The treatment centres covered by interviews in this report rarely had formal rehabilitation programmes. There were few or no options for patients to receive psychological support or engage in vocational training or other forms of programming. Some centres allowed patients to receive visitors, but this was not universally applied, and visitors were often required to navigate bureaucratic or opaque systems to meet with patients. When visits were allowed, they would usually be only on set days and for limited periods. One interviewee who attended a large facility in Herat explained the process as follows: 'We never had any phone contact with our families. When our families came to visit, they had to request an appointment from outside the camp and were given a small slip. They would wait outside the camp until an announcement was made over the loudspeaker. When the patient reached the gate, their family was called inside. There was no designated place for visits inside the camp. There was only an area in the middle of the courtyard, surrounded by wire fencing on all four sides, where we sat and talked with our families. Each visit lasted only five minutes.'[121]

Religious studies were reported to form a considerable part of available programming; several interviewees described being woken for morning prayers and having to study the Quran multiple times a day[122] (this often appears to be the case at centres with higher levels of Taliban involvement in their day-to-day management).[123] One interviewee explained that 'the only interaction that the addicts have is with a few designated teachers who wake them up in the morning for prayers. Following the prayers, they recite the Holy Quran and engage in physical exercises before being served morning tea.'[124]

These religious studies often overlapped with other forms of support. Doctors and psychiatric professionals would speak to groups of patients regarding the harms of drug addiction. For example, an interviewee quoted health workers telling patients: 'Drugs shorten your life. They damage your body. You have no respect in society, no respect at home, no respect among your peers, or in village life. And in the afterlife too, you will be like how you are in this world – humiliated and miserable.'[125] These sessions were usually structured like lectures, where the counsellor would speak to a large group regarding mental health for 'about half an hour'.[126] The availability of counselling was not consistent,[127] and in some centres it was not an option at all.

At a women-only facility, an interviewee (who was still living at the centre at the time) stated that individual psychological counselling was provided twice a week, group counselling once a week, and family counselling could be arranged upon request.[128] Another interviewee, who attended a much larger women-only centre, stated that there was no psychological counselling available for women, only religious training, and that they did not receive 'any vocational training or other learning opportunities, because the authorities did not give permission'.[129]

Some exercise programmes existed for patients, but they appear to be inconsistent and optional. At one centre, a trainer would visit the camp occasionally, but out of 300 patients, only 10 participated.[130] Several interviewees, including staff, noted that there were limited options for physical activity; in one, there was no 'large outdoor yard or recreational area where patients can play sports like football or volleyball'.[131] Similarly, a staff interviewee noted that while there was a field for football and volleyball at their centre, no equipment was available for these activities.[132]

Formality regarding vocational training varied significantly. For instance, one interviewee noted that 'around 700 people were trained inside the camps with NGO support', with programmes focusing on tailoring, shoemaking and electrical work.[133] At one centre, vocational sessions were organized

by the Ministry of Martyrs and Disabled Affairs, who ran classes focused on water pump repair, plumbing and electrical work.[134] At other centres, vocational training was reported to be highly theoretical and involved concepts being explained on a chalkboard, which prevented illiterate patients from benefiting.[135] Some patients were placed in vocational training programmes after leaving the treatment centre.[136] For example, one interviewee noted: 'I was under treatment for six months at the rehabilitation centre. After recovering, I was placed into vocational training programmes for nearly one year to help reintegrate into society. And now I am working as a cook in a market.'[137] Interviewees attending treatment centres that did not offer vocational training described their days as 'boring', with one saying: 'Many patients, including myself, feel bored because there are no programmes or workshops that teach useful skills or provide meaningful activities during our stay. Having access to vocational training or other educational opportunities could help us use our time better and prepare us for life after discharge.'[138]

A de facto authority representative described the current vocational training programmes as 'symbolic' because the teachers are underqualified, saying that no qualified teacher would work for the low wages provided by the centres.[139]

Some interviewees noted that they helped to maintain the facilities they attended through doing laundry, washing dishes or cleaning, although this work was voluntary.[140] Some interviewees reported being given an additional piece of dry bread for doing these tasks.[141] One interviewee, who attended a large facility, explained that 'forced labour was a part of the rehabilitation programme, although it was framed as vocational training'.[142] Overall, rehabilitation strategies appear to follow what a former PWUD described as 'a very basic method … [the Taliban] just kept people away from drugs for a few months. If someone died, they died. If they survived, they'd be clean from drugs.'[143]

A drug rehabilitation centre in Kabul. Many of these facilities have been criticized for their harsh, often prison-like conditions and inadequate care for residents. *© Samiullah Popal/picture alliance via Getty Images*

Social dynamics and patient relations

A subject that was rarely discussed by staff but came up regularly in interviews with PWUD was the power dynamic between patients. At many centres, patients make up a large part of the staff, often taking on leadership and representative roles. One staff member explained that 'these leaders are responsible for maintaining order within their respective sections. They live among the patients, managing daily activities, ensuring discipline, and acting as mediators between the patients and staff.'[144] In addition, they are also – unofficially – responsible for introducing new patients to the centre's rules and schedule.[145] This system exists for two reasons, an interviewee explained: 'First, drug addicts know how to work with each other. Second, it saved staff because there were not enough staff to watch over 5 000 drug addicts.'[146]

Interviewees who talked about patient representatives had a negative view of their role. Several suggested that people take advantage of the benefits of their position;[147] some argued that because there is no accountability for the actions of representatives, they 'extort money, make indecent demands, and sexually exploit the vulnerable individuals [new arrivals at a centre]'.[148] Patients-turned-staff were often referred to as 'elected representatives',[149] although no details were given as to how they were elected.

In an effort to maintain control or punish patients, representatives reportedly often resort to violence and physical abuse. As one interviewee described: 'Some individuals, particularly a few of the boys, take on unofficial roles as leaders or representatives for the rest of the patients. They feel a sense of responsibility in maintaining order, but sometimes this leads to conflicts. These self-appointed leaders may try to enforce their authority by demanding that others obey them, and if someone disagrees, there is a risk of physical altercations.'[150]

Because of the lack of food, hygiene products and sleeping space, patients often fight one another for access to these resources. One interviewee described that 'stronger individuals would forcibly take medication from weaker patients, creating a chaotic and unfair system'.[151]

Entry, exit and reintegration processes

Most of the PWUD who were interviewed said they did not go to treatment centres of their own accord but were picked up during Taliban raids on drug user 'hotspots' or during regular Taliban patrols. Some were forcibly brought to centres by family members. A small number of interviewees voluntarily enrolled at treatment centres. Interviews suggested that treatment did not vary based on whether someone went to a facility by choice or force. In some cases, people who were interviewed had been held in prisons and tortured by the Taliban before officially entering treatment.[152]

One interviewee described how he had spent a night at a police station after a Taliban round-up: 'We were warned that lying about our addiction would result in harsher consequences, as they had the necessary equipment to conduct urine tests … Negative results would lead to release, while positive results would result in transfer to a different facility.'[153] This procedure, where drug users spend a night at the local police station after being picked up by a patrol before being transferred to the Directorate of Narcotics for questioning, appears to be relatively common (at least in cities such as Mazar) and was described by several interviewees.[154]

Patients generally stayed at treatment centres for 30–90 days, but the most common duration appears to be 45 days. At some facilities, a general rule seemed to be that 'every patient who is brought to this centre … must be treated for 45 days' at least.[155] When asked whether any legal proceedings were instituted before a PWUD was taken to a treatment centre by the Taliban, a de facto authority representative from a major city explained that 'we do not send drug addicts to a judge. When we detain the drug addicts, we keep them [in the centre for a] minimum of three months. The duration can be as long as the officials deem it necessary.'[156] Some PWUD noted that 45 days was too long 'because patients are completely cured within a month',[157] whereas others voluntarily chose to extend their stay at the centres.[158] For other interviewees, the duration of their stay felt unfair and determined on an arbitrary basis by treatment centre staff. As one interviewee noted, 'If someone was brought to the camp for the first time, they'd be hospitalized for three months; second time, six months; and third time, one year. This was my second time. Initially, I didn't even have the money for the drug test, and even without testing me, they decided to admit me for six months.'[159]

At one treatment centre, a patient described how 'individuals caught with hashish are typically held for 45 days, while those caught with tablets or stronger substances are required to stay for three months'.[160] Exit procedures were found to vary significantly across drug treatment centres and were determined by factors such as the types of drug used by the patient; whether they had been to a treatment centre before; whether any drugs were still in the patient's system; or whether they had been arrested by the Taliban before entering.[161]

At some treatment centres (often those with a 45-day mandatory stay), leaving the facility was reported to be contingent on a review from the medical team and whether 'doctors are confident that the patient has responded well to treatment and is no longer dependent on substances'.[162] At others, the review is typically conducted by a committee that includes the head of the centre and other Taliban representatives. One interviewee explained that his release was determined exclusively by the head of the camp: 'After spending three months in the camp, the head of the centre called me to his office. He looked directly into my eyes and observed my face. We had a personal conversation where he asked about my past, my family, and what I planned to do after my release. I told him honestly that I deeply regretted everything I had done, especially the pain I had caused my family. I told him I was no longer addicted and that I wanted to return home and rebuild my life. He could see how ashamed and broken I was. I became emotional and pleaded with him for a second chance. After hearing me and seeing the sincerity in my face, he made the decision on his own to release me.'[163]

Nearly all treatment centres require family involvement during the exit process. A staff member at one centre noted that family members may also ask a facility to keep the patient for longer – up to a year.[164] Several interviewees noted that they had heard about bribes being paid to facilitate the discharge of patients,[165] and a family member of a PWUD described how he paid 'US$500 to someone who helped transfer his son' from a large facility with poor conditions to a smaller centre where conditions were significantly better.[166] This means that for patients without a family capable of advocating for them (for example, if they live in a different province or are unaware of the patient being at the specific treatment centre), there are few avenues that allow them to be discharged. Several interviewees pointed out that some of their fellow patients had been at drug treatment centres for years as a result.[167]

A patient's male relatives are required to ensure that the person does not return to drug use.[168] In some cases this is done informally, while in others it is a 'long bureaucratic process: writing a petition, getting the local malik's [village representative's] signature, then verifying it with the police department, and finally submitting everything to the Directorate of Narcotics'.[169]

An interviewee who had attended a medium-sized facility in the north explained the even more onerous process involved in his release:

> The individual's family must file a petition with the Directorate of Narcotics confirming that the person has successfully completed treatment and is no longer addicted. The petition must include a photo of the individual, as well as a guarantor. Then [the] *wakil guzar* [community leader] must confirm that the person has spent three months in the camp and he is not addicted. Then the PD [police district] must confirm that the *wakil guzar* is real. Once the PD confirms the petition, it is resubmitted to the provincial Directorate of Narcotics. After the three-month period, a four-member committee is convened, consisting of the camp manager, a court representative, a doctor and a representative from the Directorate of Narcotics. This committee meets on Wednesdays to review each individual's application, assess their physical well-being, and inquire about their ability to refrain from substance abuse in the future. If the committee determines that the individual is no longer addicted, they issue a release order. Following approval by the committee, the camp administrator finalizes the necessary documents, and the individual's parents are notified to come and collect them.[170]

Patients are hardly ever followed up after discharge. Some interviewees suggested that between 50%[171] and 90%[172] of patients relapse owing to a lack of employment opportunities and the poor quality of treatment.[173] One interviewee described the experience after being in a treatment centre as follows:

> We spend three months living in a place that feels like a prison, and after that, we return home. We no longer have any contact with the support staff, doctors, counsellors or anyone else. We just go back to our old routine – the same friends, the same neighbours, the same environment. If we start to feel cravings for drugs again, we can't tell anyone out of fear that we might be sent back to the camp. There is no doctor or person available to help us manage cravings, or to guide us through the emotional problems and stress that come after release.'[174]

Centres that do engage in follow-ups usually do home visits or require their former patients to check in with a local authority periodically.[175] One staff interviewee also mentioned 'community-based monitoring' but did not clarify what that entails.[176]

Role of the Taliban

The level to which members of the Taliban are involved in the daily running of treatment centres varies. They appear to be almost solely responsible for the raids and arrests of drug users, with some support from local police departments. Although claims of casualties during these raids were denied,[177] one PWUD who had been caught during a Taliban raid described how 'addicts tried to run, but the Taliban opened fire. I witnessed one person being killed and another seriously injured right before my eyes.'[178]

At some centres, interviewees noted that members of the Taliban rarely visited the camp and were hardly aware of daily operations,[179] while at others they handled the centre's security and were involved in punishing patients. One PWUD explained that the Taliban had a 55-person department at a particular centre, where they were 'responsible for administering severe physical punishment in cases of fighting or chaos, often resulting in broken limbs'.[180] Others suggested that members of the Taliban working in drug treatment centres have not been trained in the rehabilitation of PWUD and that their behaviour 'depended on how the patient behaved – sometimes it was violent'.[181] Members of

the Taliban were described as inflicting the 'most severe and terrifying' punishments.[182] At one centre, they were said to also be responsible for the burial of patients who died and had no family nearby.[183]

Treatment staff noted that the Taliban had shut down several treatment centres for women and children since 2021.[184] Some also mentioned rumours of private centres being forced to shut down following orders from the Ministry of Health.[185] Interviewees indicated that they found the Taliban's approach to drug addiction and treatment to be significantly harsher than the Republic's methods.[186] A PWUD who had attended drug treatment centres under both the Republic and Taliban regimes, said: 'While the Republic system had its flaws, physical abuse was less common, and patients were not forced to endure excessively long stays in rehabilitation centres.'[187] However, this was not a universally held opinion among interviewees. Another PWUD suggested that while the Taliban government has fewer facilities, it has provided a 'more structured approach to rehabilitation' and does a better job of ensuring 'recovery opportunities were available'.[188] In addition, several staff members commented on there being less corruption under the Taliban regime,[189] although not all interviewees agreed with this view.[190]

Professional staff

Some interviewees described staff members at larger treatment centres[191] as uneducated, with either no or very little specialized training in working with PWUD.[192] 'Instead of treating patients, they beat them with whips,' said one respondent.[193] Many staff members reportedly come from backgrounds in agricultural and veterinary work.[194]

In addition, some PWUD and family members mentioned corruption at treatment centres, with staff reportedly accepting bribes to discharge patients early.[195] A former patient who worked at a treatment centre as a night guard described this informal release process as follows:

> I personally saw patients being released in exchange for money. For example, a patient who had a good phone would talk to this particular person. A guard, who was stationed at the gate, would say, 'Give me your phone and I'll release you.' They took 10 000 to 15 000 afghanis, sometimes more or less, for releasing a patient. Some were freed in exchange for the promise of a weapon. The process was to fill out a blank application form, and within two or three days, the patient would be released. Sometimes the guards themselves would forge the paperwork and falsely state that the patient was discharged. Two or three people from my room paid money and were released this way.[196]

Another PWUD explained that although all services within their centre were free, the patients 'who had money or personal connections were placed in better rooms and had a more comfortable stay compared to the rest of us'.[197] At a different centre, the camp director had apparently employed a relative as vocational instructor, who 'only showed up to collect his salary'.[198] An interviewee at this centre also described a case of personnel and guards confiscating a donation of colourful blankets meant to be distributed among the camp members.[199]

Staff members who were interviewed listed numerous challenges in connection with their work at drug treatment centres, including low and inconsistent wages, limited benefits, a lack of training opportunities, and safety concerns. One interviewee noted that there is no hazard pay or transportation assistance, which poses a challenge for employees who have to travel the 10 kilometres from the city to reach the centre.[200] It appears that before the Taliban takeover, many staff salaries were paid by

NGOs or donors, but now most (if not all) salaries are covered by the government.[201] The number of professional staff working at treatment centres varied between 0.35 and 0.9 staff members to one bed.[202]

Public outreach and awareness

Several staff members noted that their centres did not run formal public awareness or outreach campaigns in collaboration with mosques, schools or other community institutions. This was either because the idea had not been raised before or because of logistical barriers, such as a lack of transport options for staff to run such programmes.[203] At centres that did organize public outreach and awareness initiatives, staff were not specific about their design or implementation, beyond noting that 'they conduct activities to raise awareness about the harms of drug use and the benefits of quitting, while also referring addicted individuals for treatment'.[204] One staff member noted that mosques and local communities collaborated with their centre to identify addicted individuals.[205]

Interviewees generally felt that public awareness regarding drug use was low, especially in remote and rural areas.[206] Members of the public were described as being 'uninformed about the dangers of substance abuse'.[207] In addition, one interviewee suggested that the public are not 'satisfied [with] or confident' in treatment centres, and they are not perceived as effective.[208] This view was contrasted by another staff interviewee, who noted that 'the public perception of the centre is positive. Communities are hopeful these programmes will reduce addiction and are generally very cooperative with the organizations involved. People express strong interest in expanding services and support so that patients do not relapse.'[209]

A woman stands beside an anti-drug poster at a women's community-based rehabilitation facility in Kabul. Most drug treatment centres in Afghanistan cater exclusively to adult men. *© Paula Bronstein/Getty Images*

The father of a PWUD who was interviewed argued more broadly that many families are unwilling to bring their loved ones to proper treatment centres because of shame: 'They fear that admitting their child's addiction will ruin the family's reputation and damage the future of their son.'[210] This same interviewee further recommended that religious leaders should play a pivotal role in shifting the narrative surrounding drug addiction and the need for reintegration, explaining that he has 'seen young men who, after being released from these harsh camps, were unable to return to society because their own families turned them away. With no support, many fell back into addiction, feeling hopeless and unwanted.'[211]

This view was supported by a family member of another PWUD, who said: 'In our society, once a person is sent to one of these camps, their family's name becomes tarnished. Even if the individual returns clean and rehabilitated, the community does not forget. Many people begin to treat them as if they are dangerous criminals. Some families refuse to allow their children to associate with them. Others avoid any social interaction altogether, fearing that the person may steal or bring shame to their home. As a result, families are isolated, judged and stigmatized simply for having a relative who was caught using drugs.'[212]

Experiences of women and children

Most drug treatment centres in Afghanistan are exclusively for adult men, although some do accept children and teenagers, who in certain cases are kept separate from the main camp population.[213] Otherwise, it appears that adolescent boys are largely treated the same as adult men with regard to the provision of 'water, food and general living conditions'.[214] An interviewee also noted that 'punishments were similar to those given to adults, as disciplinary measures were strict, including beatings and forced restrictions'.[215] However, children and teenagers were allegedly housed in relatively better conditions at some centres.[216] There are also a small number of facilities specifically for boys between the ages of 10 and 18.[217] Larger centres appear to be more likely to have separate sections for women and men. This is true, for example, of the 4 000-bed facility in Herat, where a women's section had recently been built.[218]

Treatment centres that are geared exclusively towards women almost always also seem to take in the patients' children. One PWUD explained that the children have often been exposed to drugs through their parents, and that children are also given medicine 'in the first week'. After this, 'they stop the medicine and only do some exercises for them; they have teachers who teach them'.[219] Women-only treatment centres appear to have only female staff, except for the security guards, who are typically male.[220] Women-only centres make provision for services unique to women, such as offering hygiene products during menstruation.[221]

Not all provinces have dedicated treatment centres for women, however. These include Khost,[222] Paktia,[223] Zabul[224] and Bamyan.[225] In Zabul, a women-only treatment centre has been closed for several years owing to a lack of patients.[226] Moreover, the ones that do exist tend to be significantly smaller (20–40 beds) than those catering for male patients.[227] As noted previously, several women-only centres have been shut down since the Taliban takeover, although it is not clear whether this is due to national policy or based on decisions at the provincial or local level.[228]

CONCLUSION

From a structural perspective, the Taliban's handling of drug treatment was chaotic from 2022 into early 2023. Facilities were poorly managed, funding was irregular, and there was no clear system for making decisions about treatment or release. By mid-2023, there were signs of foundational development. Budgets began to arrive more regularly, and commissions were created to decide what to do with each individual patient. These commissions, which sometimes included local officials and Taliban commanders, ostensibly introduced more structure. On paper, the system appeared more organized, but given damning observations regarding human rights abuses and health conditions, the system does not appear sustainable. Running the facilities costs billions of afghanis, which puts a heavy burden on limited resources. There is uncertainty about whether the Taliban can continue to fund the system. Even with better organization, there is little evidence that patients are supported after discharge, as the focus remains on short-term isolation rather than long-term support.

The Taliban claim to have taken steps to curb drug trafficking from Afghanistan. The Emir's ban in 2022 and subsequent eradication measures have destroyed poppy fields, methamphetamine laboratories, and significant quantities of opiates and synthetics. But the drug markets and their operators remain active, and methamphetamine production has in fact increased since the Taliban came to power. The abuse of PWUD in treatment facilities, as highlighted in this report, is indicative of a faltering approach to building resilient systems and processes to combat illegal drug production in Afghanistan.

The findings from our fieldwork are both damning and deeply alarming. The research highlights the need for a systematic analysis of the health and human rights implications and abuses experienced within these camps. Although the findings echo experiences in drug detention facilities elsewhere in the world,[229] the scale of abuse documented here appears unprecedented. The international community has broadly overlooked the large-scale round-up of citizens and their confinement to facilities where there are no standards in place to prevent the kind of abuses expected in such scenarios.

A Taliban security officer stands guard as people who have undergone rehabilitation await discharge from a centre in Kandahar. Under the Taliban, the emphasis remains on short-term confinement rather than long-term support. *© Sanaullah Seiam/AFP via Getty Images*

NOTES

1 Shehryar Fazli, The impact of Afghanistan's drug trade on its neighbours: The case of Pakistan, Iran and Tajikistan, SOC ACE Research Paper 25, SOC ACE and GI-TOC, November 2023, https://globalinitiative.net/wp-content/uploads/2023/11/SOCACE-RP25-AfganDrugTradeImpact-20Nov23.pdf.

2 Prem Mahadevan et al, Illicit market adaptation: Drugs and arms markets in Balochistan, GI-TOC, forthcoming.

3 Shehryar Fazli, The impact of Afghanistan's drug trade on its neighbours: The case of Pakistan, Iran and Tajikistan, SOC ACE Research Paper 25, SOC ACE and GI-TOC, November 2023, https://globalinitiative.net/wp-content/uploads/2023/11/SOCACE-RP25-AfganDrugTradeImpact-20Nov23.pdf.

4 International Crisis Group, Trouble in Afghanistan's opium fields: The Taliban war on drugs, 2024, https://www.crisisgroup.org/sites/default/files/2024-09/340-afghanistan-opium-fields.pdf.

5 Ibid.

6 Prem Mahadevan et al, Illicit market adaptation: Drugs and arms markets in Balochistan, GI-TOC, forthcoming.

7 Almost three-quarters (71.5%) of Afghans live in rural communities, and rural opium use has been found to be 2.5 times higher than in urban areas. See: Jelena Bjelica, Treating drug users in Afghanistan: How to respond to a massive problem?, Afghanistan Analysts Network, 25 August 2024, https://www.afghanistan-analysts.org/en/reports/rights-freedom/treating-drug-users-in-afghanistan-how-to-respond-to-a-massive-problem; Abdul Subor Momand and Hendrée E Jones, Drug use among women and children in Afghanistan: The complexities of an important public health issue, *HSOA Journal of Addiction & Addictive Disorders*, 7, 1 (2020).

8 Wayne D Hall and Louisa Degenhardt, Afghanistan has a sizeable problem with opioid use, *Lancet Global Health*, 2, 10 (2014), https://doi.org/10.1016/S2214-109X(14)70299-2.

9 Ministry of Public Health, Islamic Republic of Afghanistan & UNAIDS, UNGASS Country Progress Report: Afghanistan (Reporting period: January 2008 to December 2009), 30 March 2010, https://www.unaids.org/sites/default/files/country/documents//file%2C69980%2Cfr..pdf.

10 Ministry of Public Health, Islamic Republic of Afghanistan & UNAIDS, UNGASS Country Progress Report: Afghanistan (Reporting period: January 2008 to December 2009), 30 March 2010, https://www.unaids.org/sites/default/files/country/documents//file%2C69980%2Cfr..pdf.

11 Abdul Alim Atarud, Drug addiction challenges in Afghanistan and the way forward 'public health perspective', 2019, https://www.researchgate.net/publication/345001399_Drug_Addiction_Challenges_in_Afghanistan_and_the_Way_Forward_Public_Health_Perspective; Alireza Noroozi et al, Drug policies and responses in Afghanistan, *Lancet Psychiatry* 11, 2 (2024), pp 90–91, https://doi.org/10.1016/S2215-0366(23)00390-5.

12 Ministry of Public Health, Islamic Republic of Afghanistan & UNAIDS, Country progress report: Afghanistan (Reporting period: January 2020 to December 2020), 2021, https://www.unaids.org/sites/default/files/country/documents/AFG_2020_countryreport.pdf.

13 UN Development Programme, UNDP and UNODC report shows the human toll of drug use and the way forward for Afghanistan, June 2025, https://www.undp.org/afghanistan/publications/undp-and-unodc-report-shows-human-toll-drug-use-and-way-forward-afghanistan.

14 Catherine S Todd et al, Hepatitis C and HIV incidence and harm reduction program use in a conflict setting: an observational cohort of injecting drug users in Kabul, Afghanistan, *Harm Reduction Journal*, 12, 22 (2015).

15 Coact, Report of community consultation and situation assessment with people who inject drugs, at risk women and men who engage in high risk behaviour in Afghanistan, unpublished report.

16 UN, Afghanistan: Surge in synthetic drugs could threaten public health, 27 November 2024, https://news.un.org/en/story/2024/11/1157551.

17 'It can become a cancer': Rising crystal meth use worries Afghanistan, NBC News, 29 May 2013, http://www.

nbcnews.com/news/world/it-can-become-cancer-rising-crystal-meth-use-worries-afghanistan-flna6C10110057.

18 Coact, Report of community consultation and situation assessment with people who inject drugs, at risk women and men who engage in high risk behaviour in Afghanistan, unpublished report.

19 Alireza Noroozi et al, Drug policies and responses in Afghanistan, *Lancet Psychiatry*, 11, 2 (2024), pp 90–91, https://doi.org/10.1016/S2215-0366(23)00390-5.

20 Prem Mahadevan et al, Illicit market adaptation: Drugs and arms markets in Balochistan, GI-TOC, forthcoming.

21 UNODC, Afghanistan Drug Insights Volume 3, Mapping of facilities for treatment of substance use disorders: Addressing service provision challenges in a humanitarian crisis, November 2024, https://www.unodc.org/roca/uploads/documents/2025/Afghanistan_Drug_Insights_Volume_3_web.pdf.

22 Alireza Noroozi et al, Drug policies and responses in Afghanistan, *Lancet Psychiatry*, 11, 2 (2024), pp 90–91, https://doi.org/10.1016/S2215-0366(23)00390-5.

23 UNODC, Afghanistan Drug Insights Volume 3, Mapping of facilities for treatment of substance use disorders: Addressing service provision challenges in a humanitarian crisis, November 2024, https://www.unodc.org/roca/uploads/documents/2025/Afghanistan_Drug_Insights_Volume_3_web.pdf.

24 International Crisis Group, Trouble in Afghanistan's opium fields: The Taliban war on drugs, September 2024, https://www.crisisgroup.org/sites/default/files/2024-09/340-afghanistan-opium-fields.pdf.

25 Abdul Subor Momand and Hendrée E Jones, Drug use among women and children in Afghanistan: The complexities of an important public health issue, *HSOA Journal of Addiction & Addictive Disorders*, 7, 1 (2020).

26 Coact, Report of community consultation and situation assessment with people who inject drugs, at risk women and men who engage in high risk behaviour in Afghanistan, unpublished report.

27 Abdul Subor Momand and Hendrée E Jones, Drug use among women and children in Afghanistan: The complexities of an important public health issue, *HSOA Journal of Addiction & Addictive Disorders*, 7, 1 (2020).

28 Alireza Noroozi et al, Drug policies and responses in Afghanistan, *Lancet Psychiatry*, 11, 2 (2024), pp 90–91, https://doi.org/10.1016/S2215-0366(23)00390-5.

29 Luis de Vega, Kabul's last circle of hell: The bridge of drug addicts, *El País*, 23 August 2022, https://english.elpais.com/international/2022-08-23/kabuls-last-circle-of-hell-the-bridge-of-drug-addicts.html.

30 Manija Mirzaie, Afghanistan's drug users face violence, stigma and segregation, Health Policy Watch, 30 August 2024, https://healthpolicy-watch.news/afghanistan-addiction-violence-stigma; Matin Mehrab and Azada, Taliban subject drug addicts to brutal rehab, fierce beatings and forced labour, *Zan Times*, 19 June 2023, https://zantimes.com/2023/06/19/taliban-subject-drug-addicts-to-brutal-rehab-fierce-beatings-and-forced-labour; Dozens of bodies discovered after Taliban clears Kabul district known for drug use, RFE/RL's Radio Azadi, 9 March 2023, https://www.rferl.org/a/afghanistan-drugs-bridge-kabul-crackdown-/32306978.html.

31 Elhan Afzal, Taliban ban on opioid production in Afghanistan, *Bylines Scotland*, 3 August 2024, https://bylines.scot/news/world/taliban-ban-on-opioid-production-in-afghanistan.

32 Manija Mirzaie, Afghanistan's drug users face violence, stigma and segregation, Health Policy Watch, 30 August 2024, https://healthpolicy-watch.news/afghanistan-addiction-violence-stigma.

33 International Crisis Group, Trouble in Afghanistan's opium fields: The Taliban war on drugs, September 2024, https://www.crisisgroup.org/sites/default/files/2024-09/340-afghanistan-opium-fields.pdf.

34 Charlotte Greenfield and Jibran Ahmad, Taliban bans drug cultivation, including lucrative opium, Reuters, 3 April 2022, https://www.reuters.com/world/asia-pacific/taliban-bans-drug-cultivation-including-lucrative-opium-2022-04-03.

35 Paddy Ginn and Danial Husain, Heroin trafficking along the northern and southern routes, GI-TOC, July 2026, https://globalinitiative.net/analysis/heroin-trafficking-along-the-northern-and-southern-routes.

36 GI-TOC research into synthetic drug markets, January–May 2026, pending publication. 'Tablet K' is an umbrella term for a range of illicit synthetic street drugs, frequently containing low-grade methamphetamine and sometimes mixed with pharmaceuticals such as opioids and benzodiazepines.

37 GI-TOC, Global Organized Crime Index 2025 – Afghanistan, https://ocindex.net/country/afghanistan.

38 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).

39 Interview with a male patient (P16); interview with a government official (GO6).

40 Interview with a worker at a small hospital for men and a small hospital for women and children (S1).

41 Interview with the general manager of a treatment centre (S7).

42 Ibid.

43 Interview with a government official on three treatment centres (GO2).

44 Interview with a worker at a small hospital for men and a small hospital for women and children (S1); interview with hospital staff at a small treatment centre for men (S2).

45 Interview with a nurse at a treatment centre (S3).

46 Interview with an NGO (O1).

47 Interview with a PWUD (P19).

48 Interview with a government official (GO6).

49 Interview with a doctor at a treatment centre (S11).

50 Interview with a government official (GO7).

51 Interview with a former PWUD (P13).
52 Interview with a male patient at a medium-sized treatment centre (P11).
53 Interview with a male patient at a large treatment centre (P4).
54 Interview with a male PWUD (P1).
55 Ibid.
56 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
57 Interview with a male patient at a medium-sized treatment centre (P22).
58 Interview with a female patient at a small treatment centre for women and children (P21).
59 Interview with the brother of a PWUD (FM2).
60 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
61 Interview with a male patient at a medium-sized treatment centre (P20).
62 Interview with a male patient at a medium-sized treatment centre (P22).
63 Interview with a male patient at a large treatment centre (P4).
64 Interview with a male patient (P16).
65 Interview with a male patient at a medium-sized treatment centre (P11).
66 Interview with a doctor at a treatment centre (S11).
67 Interview with a PWUD (P19).
68 Interview with a government official (GO4).
69 Interview with a psychiatrist at a treatment centre (S8).
70 Interview with hospital staff at a small treatment centre for men (S2).
71 Interview with a male PWUD (P1); interview with a male patient (P25); interview with a worker at a small hospital for men and a small hospital for women and children (S1); interview with the brother of a PWUD (FM2).
72 Interview with a male patient at a large treatment centre (P4).
73 Interview with a female patient at a large treatment centre (P6).
74 Interview with a government official (GO6).
75 Interview with a female patient at a small treatment centre for women and children (P21); interview with a male patient (P16).
76 Interview with a male patient at a medium-sized treatment centre (P22).
77 Interview with a female patient at a small treatment centre for women and children (P21).
78 Interview with a male patient at a medium-sized treatment centre (P11).
79 Interview with a male patient at a medium-sized treatment centre (P20).
80 Interview with a female patient at a small treatment centre for women and children (P21).
81 Interview with a male patient at a medium-sized treatment centre (P22).
82 Interview with a male patient at a medium-sized treatment centre (P20).
83 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
84 Interview with a male patient at a medium-sized treatment centre (P20).
85 Interview with a male former PWUD (P10).
86 Interview with a male patient at a medium-sized treatment centre (P22).
87 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
88 Interview with a male patient at a large treatment centre (P4).
89 Interview with a female patient at a small treatment centre for women and children (P5).
90 Interview with a male patient at a large treatment centre (P4).
91 Interview with a male patient at a medium-sized treatment centre (P18).
92 Interview with a psychiatrist at a treatment centre (S8).
93 Interview with a male patient at a medium-sized treatment centre (P11).
94 Interview with a male patient at a medium-sized treatment centre (P20); interview with a male patient at a medium-sized treatment centre (P22).
95 Interview with a male patient at a large treatment centre (P4).
96 Interview with a government official (GO6); interview with a male PWUD (P1).
97 Interview with a government official (GO5).
98 Interview with a PWUD (P19). There is a common misconception that opium use lowers blood glucose levels, and therefore treatments sometimes involve glucose solutions to alleviate the effects. There is scant scientific basis for this belief (see, for example, Hamid Najafipour and Ahmad Beik, The impact of opium consumption on blood glucose, serum lipids and blood pressure, and related mechanisms, *Frontiers in Physiology*, 7 (2016)).
99 Interview with an underage male patient in a small treatment centre (P23).
100 Interview with a female patient at a small treatment centre for women and children (P21).
101 Interview with a PWUD (P19).
102 Interview with a male patient, discussing three treatment centres (P14).
103 Interview with a male PWUD (P1).
104 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
105 Interview with a male patient at a large treatment centre (P4).
106 Interview with a PWUD (P19).
107 Interview with a male patient (P12).
108 Ibid.
109 Interview with a male patient at a medium-sized treatment centre (P18).
110 Interview with a male patient at a large treatment centre (P4).
111 Interview with a government official (GO3).
112 Interview with a male patient at a medium-sized treatment centre (P20).

113 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
114 Ibid.
115 Interview with a male patient, discussing three treatment centres (P14).
116 Interview with a female patient at a small treatment centre for women and children (P7).
117 Interview with a male patient at a medium-sized treatment centre (P17).
118 Interview with a male patient at a medium-sized treatment centre (P22).
119 Interview with a psychiatrist at a treatment centre (S8).
120 Interview with a doctor at a treatment centre (S11).
121 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
122 Interview with a male patient at a medium-sized treatment centre (P20); interview with a male patient at a large treatment centre, 20 days after discharge (P3).
123 Interview with a male patient at a large treatment centre, 20 days after discharge (P3); interview with a government official on three treatment centres (GO2).
124 Interview with a male patient at a medium-sized treatment centre (P20).
125 Interview with a male patient (P9).
126 Interview with a male PWUD (P1); interview with a male patient at a medium-sized treatment centre (P22).
127 Interview with a PWUD (P19).
128 Interview with a female patient at a small treatment centre for women and children (P5).
129 Interview with a female patient at a small treatment centre for women and children (P7).
130 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
131 Interview with a male patient at a small hospital treatment centre (P24).
132 Interview with a government official (GO7).
133 Interview with a male patient (P12).
134 Interview with a government official (GO7).
135 Interview with a male patient at a large treatment centre (P4).
136 Interview with a patient at a large treatment centre (P15); interview with a male patient, discussing three treatment centres (P14).
137 Interview with a patient at a large treatment centre (P15)
138 Interview with a male patient at a small hospital treatment centre (P24).
139 Interview with a government official (GO6).
140 Interview with a male PWUD (P1).
141 Interview with a male patient at a large treatment centre (P4).
142 Interview with a patient at a large treatment centre (P15).
143 Interview with a former PWUD (P13).
144 Interview with a psychiatrist at a treatment centre (S8).
145 Ibid.
146 Interview with a male patient at a medium-sized treatment centre (P11).
147 Interview with an underage male patient in a small treatment centre (P23); interview with a female patient at a small treatment centre for women and children (P21).
148 Interview with a male patient at a medium-sized treatment centre (P20).
149 Ibid.
150 Interview with an underage male patient in a small treatment centre (P23).
151 Interview with a male patient, discussing three treatment centres (P14).
152 Interview with the brother of a PWUD (FM2).
153 Interview with a male patient at a medium-sized treatment centre (P20).
154 Interview with a male patient at a small hospital treatment centre (P24); interview with a male patient at a medium-sized treatment centre (P22); interview with a psychiatrist at a treatment centre (S8).
155 Interview with a female patient at a small treatment centre for women and children (P21).
156 Interview with a government official (GO5).
157 Interview with a female patient at a small treatment centre for women and children (P5).
158 Interview with a female patient at a small treatment centre for women and children (P21).
159 Interview with a male patient at a large treatment centre (P4).
160 Interview with a male patient at a small hospital treatment centre (P24).
161 Interview with a male patient at a medium-sized treatment centre (P17).
162 Interview with staff at a small women's treatment centre (S9).
163 Interview with a male patient at a medium-sized treatment centre (P17).
164 Interview with a government official (GO7).
165 Interview with a male patient (P12).
166 Interview with the father of a PWUD (FM1).
167 Interview with a male patient at a medium-sized treatment centre (P20).
168 Interview with a patient at a large treatment centre (P15).
169 Interview with a male patient (P16).
170 Interview with a male patient at a medium-sized treatment centre (P20).
171 Interview with a male patient (P12).
172 Interview with a PWUD (P19).
173 Interview with a male PWUD (P1).
174 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
175 Interview with an underage male patient in a small treatment centre (P23).
176 Interview with a nurse at a treatment centre (S3).
177 Interview with a doctor at a treatment centre (S11).

178 Interview with a male patient at a medium-sized treatment centre (P17).
179 Interview with a male patient at a medium-sized treatment centre (P20); interview with a male patient at a medium-sized treatment centre (P17).
180 Interview with a male patient at a medium-sized treatment centre (P20).
181 Interview with a male patient (P12).
182 Interview with a male patient at a medium-sized treatment centre (P22).
183 Interview with a patient at a large treatment centre (P15).
184 Interview with hospital staff at a small treatment centre for men (S2).
185 Interview with a nurse at a treatment centre (S3).
186 Interview with the brother of a PWUD (FM2); interview with a male patient, discussing three treatment centres (P14).
187 Interview with a male patient, discussing three treatment centres (P14).
188 Interview with a patient at a large treatment centre (P15).
189 Interview with a government official (GO6).
190 Interview with a government official on three treatment centres (GO2).
191 This refers to professional staff working at drug treatment centres, not the patients who act as representatives.
192 Interview with a male patient (P25); interview with a psychiatrist at a treatment centre (S8).
193 Interview with a male patient (P25).
194 Interview with a psychiatrist at a treatment centre (S8).
195 Interview with a male patient (P12); interview with the brother of a PWUD (FM2).
196 Interview with a male patient at a large treatment centre (P4).
197 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
198 Interview with a male patient at a large treatment centre (P4).
199 Ibid.
200 Interview with a worker at a small hospital for men and a small hospital for women and children (S1).
201 Interview with a doctor at a treatment centre (S11).
202 Interview with a worker at a small hospital for men and a small hospital for women and children (S1); interview with a psychiatrist at a treatment centre (S8); interview with a nurse at a medium-sized treatment centre (S6).
203 Interview with a worker at a small hospital for men and a small hospital for women and children (S1).
204 Interview with the general manager of a treatment centre (S7).
205 Interview with a worker at a small hospital for men and a small hospital for women and children (S1).
206 Ibid.
207 Interview with a doctor (S5).
208 Interview with a PWUD (P19).
209 Interview with a female staff member who is a former PWUD (S4).
210 Interview with the father of a PWUD (FM1).
211 Ibid.
212 Interview with the brother of a PWUD (FM2).
213 Interview with a male patient at a large treatment centre, 20 days after discharge (P3).
214 Ibid.
215 Interview with a male patient, discussing three treatment centres (P14).
216 Interview with a male patient at a large treatment centre (P4).
217 Interview with an underage male patient in a small treatment centre (P23).
218 Interview with a male patient at a large treatment centre (P4); interview with a female patient at a large treatment centre (P6).
219 Interview with a female patient at a small treatment centre for women and children (P21).
220 Interview with staff at a small women's treatment centre (S9). However, one centre for men had female guards to search the female visitors (interview with a psychiatrist at a treatment centre (S8)).
221 Interview with a female patient at a small treatment centre for women and children (P21).
222 Interview with the general manager of a treatment centre (S7).
223 Interview with a doctor at a treatment centre (S10).
224 Interview with a doctor at a treatment centre (S11).
225 Interview with hospital staff at a small treatment centre for men (S2).
226 Interview with a doctor at a treatment centre (S11).
227 Ibid.
228 Interview with hospital staff at a small treatment centre for men (S2).
229 World Health Organization, Compulsory drug detention and rehabilitation centres, May 2020, https://www.who.int/news/item/01-06-2020-compulsory-drug-detention-and-rehabilitation-centres.

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