THE COLOMBO PLAN

DAP
Drug Advisory Programme

Final Performance Report

CONTINUED NGO ASSISTANCE TO TRAINING AND SPECIALIZED SUBSTANCE USE DISORDERS TREATMENT FACILITIES

SINLEC22LA0388

23 SEPTEMBER 2022 – 28 JANUARY 2025

The "**Continued NGO Assistance to Training and Specialized Substance Use Disorders Treatment Facilities**" project was implemented from 23 September 2022 to 28 January 2025. This initiative, funded by the U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL), aimed to maintain the operation and service delivery of the residential, home-based and outpatient treatment and rehabilitation facilities for drug dependents in Afghanistan.

The Colombo Plan Drug Advisory Programme (CPDAP) received an **Immediate Stop Work Order** issued by the current U.S. Administration suspending initiatives funded by Bureau of International Narcotics and Law Enforcement Affairs (INL) of the U.S. Department of State, enacted as of **28 January 2025**. Subsequently, on **08 April 2025**, CPDAP received a formal **Termination Notice** for the Letter of Agreement (LOA) governing this project. The termination of the LOA has resulted in the cessation of all project-related activities. This **Final Performance Report** summarizes the project's status at the time of termination and ensures compliance with INL's reporting requirements.

CPDAP acknowledges the support provided by the INL throughout the project's implementation. This final performance report is submitted for INL's review to document the termination of activities and ensure a transparent conclusion to the project.

October 2025

CONTINUED NGO ASSISTANCE TO TRAINING AND SPECIALISED SUBSTANCE USE DISORDERS TREATMENT FACILITIES

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DISCLAIMER: All contents are drawn from information collected by the Colombo Plan Drug Advisory Programme from respective programme managers, programme officers, and project staff of CPDAP, including involved stakeholders of respective programme activities. Data provided in this report has not been independently verified.

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Our thanks also go to the CPDAP graphic designer team, for enriching the report with excellent formatting, layout, and graphics.

Although the project was officially paused in early 2025, its implementation phase was marked by notable achievements, dedication, and impact at a certain level. It remains a testament to the collective efforts of all involved in supporting DDR efforts in Afghanistan.

FINAL PERFORMANCE REPORT

Project Title	**Continued NGO Assistance to Training and Specialised Substance Use Disorders Treatment Facilities**
Project Award No	SINLEC22LA0388
Target Area	Afghanistan
Implementing Agency	The Colombo Plan Drug Advisory Programme (CPDAP)
Address	The Colombo Plan Secretariat 5th Floor, M2M Veranda Offices, No, 34, W.A.D. Ramanayake Mawatha, Colombo 02, Sri Lanka.
Funding Agency	Bureau of International Narcotics and Law Enforcement Affairs (INL), United States Department of State, Washinton, D.C. 20520
Period of Performance	23 September 2022 – 28 January 2025
Total Project Budget	**USD 13,602,895.84**
Total Expenditure	**USD 6,355,130.59**
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ABREVIATIONS

AIP	Anticipated Implementation Period
AOR	Agreement Officer Representative
ARC	Afghan Relief Committee
ASI	Addiction Severity Index
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
ASP	Afghan Supporting Point
ATS	Amphetamine-type stimulants
CHATAR	Consortium of civil society organizations working in DDR in Afghanistan
COVID 19	Coronavirus Disease 2019
CP	The Colombo Plan
CPDAP	The Colombo Plan Drug Advisory Programme
DAP	Drug Advisory Programme
DDR	Drug Demand Reduction
DfA	De Facto Authority
DIC	Drop-in Centres
DTC	Drug Treatment Centre
DAWEO	Danner Afghanistan Women Empowerment Organization
EU	European Union
EWGM	Expert Working Group Meeting
FRAMES	Brief Intervention for Risky or Harmful Alcohol Consumption
GRN	Global Recovery Network
GTA	Grant Thornton Advisors LLC
GTIL	Grant Thornton International Limited
HQ	Headquarters
ICAP	International Certified Addiction Professional
ID	Identity Card
IDP	Internally Displaced Persons
IFAC	International Federation of Accountants
INL	Bureau of International Narcotics and Law Enforcement Affairs
IO	International Organization
IP	Implementing Partner

ISRS	International Standard on Related Services
ISSUP	International Society of Substance Use Professionals
JMM	Joint Monitoring Mission
KFO	Kabul Field Office
LoA	Letter of Agreement
M&E	Monitoring and Evaluation
MCN	Ministry of Counter Narcotics
mhGAP	Mental Health Gap Action Programme of World Health Organization
MOA	Memorandum of Agreement
MoPH	Ministry of Public Health
MOU	Memorandum of Understanding
MSP	Money Services Provider
NDAP	National Drug Action Plan
NDCS	National Drug Control Strategy
NGO	Non-Governmental Organization
OFAC	Office of Foreign Assets Control
OHSS	Organization for Health and Social Services
OIC	Officer-in-Charge
OPTC	Outpatient Treatment Centre
P1	Priority 1
P2	Priority 2
PM Plus	Problem Management Plus (PM+)
PMP	Performance Management Plan
PoC	Point of Contact
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance
RAM	Risk Analysis and Management
SHM	Stakeholders Meeting
SIGAR	Special Inspector General for Afghanistan Reconstruction
SOAP	Subjective, Objective, Assessment, and Plan
SOP	Standard Operating Procedure
SSAWO	Social Service for Afghan Women Organization

SUD	Substance Use Disorder
ToR	Terms of Reference
ToT	Training of Trainers
UC	Universal Curricula
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drugs and Crime
UPC	Universal Prevention Curriculum
URC	Universal Recovery Curriculum
UTC	Universal Treatment Curriculum
US	United States
WADAN	Welfare Association for the Development of Afghanistan
WHO	World Health Organization

EXECUTIVE SUMMARY

This final performance report provides a comprehensive account of the implementation, achievements, challenges, and lessons learned from the 2022-AF-003 project in Afghanistan, implemented by the Colombo Plan Drug Advisory Programme with funding support from INL, U.S. Department of State. The project, operational from 23 September 2022 to 28 January 2025, supported 24 DTCs and 1 Data Centre across six provinces of Afghanistan namely Kabul, Badakhshan, Balkh (Mazar-e-Sharif), Nangarhar, Herat and Farah. Despite a volatile operational environment marked by political instability, financial constraints, and banking challenges, the project successfully delivered essential drug treatment and rehabilitation services to over 10,000 individuals, including women, children, and female adolescents during the implementation period.

Key outcomes of the project include the provision of residential, outpatient, and home-based treatment services, enhanced client recovery outcomes, strengthened community engagement, and the successful execution of monitoring activities, both virtual and in-person. Monitoring was conducted quarterly to ensure compliance with treatment protocols, documentation standards, client safety, and effective program delivery. Joint monitoring teams included representatives from UNODC, WHO, and national DDR experts. The project also contributed to capacity building through self-led curriculum development, and efforts were underway to develop self-led Dari versions of UTC courses prior to the project's early termination.

Despite significant challenges, arising from the political transition in Afghanistan in August 2021, restrictions on female staff, staff turnover, and the suspension of formal banking systems, CPDAP demonstrated operational resilience. Adaptations such as virtual monitoring, use of MSPs for fund transfers, and staff retention strategies enabled continuity. However, sanctions compliance, including regular OFAC vetting, was strictly followed throughout the implementation period.

The official closure process initiated following the project's stop-work order on 28 January 2025 and formal termination notice issued on 8 April 2025. The KFO was vacated, assets were inventoried and sold through a competitive process. DTC client transitions were managed with dignity through family reintegration efforts. Most DTCs returned rented premises to landlords, and KFO conducted final verification visits in May 2025 to document DTC closure status.

While the project met its deliverables within the constraints, it also highlighted critical sustainability challenges. The early termination left gaps in service continuity, unpaid dues, and uncertainty for the future of the DTCs. The report concludes with clear recommendations for future programming: the urgent need for new donor support, strategies to retain expert staff, sustained community involvement, and long-term planning for the sustainability of Afghanistan's drug treatment system.

Despite its closure, the project stands as a model of adaptability, commitment, and impact in one of the most complex humanitarian and public health contexts nationwide.

TOTAL BENEFICIARIES REACHED

Given below are the details of the total beneficiaries reached during the project implementation period, from 23rd September 2022 to 28th January 2025.

Figure 1: Total Beneficiaries Reached during the project implementation period

1. PROJECT CLOSURE SYNOPSIS

1.1 SUMMARY OF PROJECT IMPLEMENTATION

As a result of the DDR activities conducted by CPDAP, along with efforts by the then Afghan government and various non-governmental agencies in Afghanistan, the demand for treatment services for substance use disorders were significantly increased. This rise was particularly notable following the establishment of outreach/drop-in centres and the involvement of religious leaders in operating mosque-based prevention, treatment and rehabilitation, and aftercare programmes initiated by CPDAP. These initiatives encouraged more drug-dependent individuals to seek treatment. However, apart from hospital-based treatment services carried out under the Ministry of Public Health (MoPH), there were no other facilities to refer individuals requiring residential treatment and continuum care services. Accordingly, the programme to support DTCs was first established in 2005 with funding from the INL.

Since the inception of the drug treatment programme in 2005, initially on a small scale in Afghanistan, the Ministry of Counter Narcotics (MCN) was operationalized and was responsible for the supervision of all DDR programmes due to the ministry's mandate. The first five Drug Treatment Centres (DTCs) were established in Kabul, Herat, Farah, Bamyan, and Kunduz provinces, each with a capacity of 30–40 beds. Over time, the programme expanded to twenty-eight (28) provinces, supporting a total of 69 DTCs across Afghanistan.

The management of these DTCs were primarily done by the Kabul Field Office (KFO), with assigned treatment coordinators conducting regular physical monitoring visits with the supervision from the CPDAP management at the Headquarter. Initially, this process was implemented through a joint monitoring team comprising representatives from MCN, MoPH, UNODC. Following the decommissioning of MCN between 2016–2017, however, the joint monitoring continued with MoPH, and UNODC until August 2021.

When the COVID-19 outbreak occurred in March 2020, and the detection of numerous positive cases, monitoring shifted from physical to virtual format and continued in this manner until September 2022.

Following the political changes in Afghanistan and the assumption of power by the De facto Authority (DfA) in August 2021, CPDAP consequently ceased all engagements with the concerned government authorities. As the DfA was not recognised by the international community, especially the funding agency, CPDAP also halted all formal engagement and professional interaction with the authorities under the DfA administration. However, the monitoring of treatment facilities were still conducted virtually.

Under the project code **2022-AF-003**: *Continued NGO Assistance to Training and Specialized Substance Use Disorders Treatment Facilities*, which commenced on 23 September 2022, the project supported 24 DTCs and 1 data centre implemented by five NGO partners. These partners delivered residential treatment, home-based care, youth outpatient services, and aftercare programmes. On 28 January 2025, the programme received a Stop-Work Order from the U.S. Department of State, followed by a formal termination letter on 08 April 2025, marking the closure of the project. Relevant notices are included in **Annex 01**.

1.2 GEOGRAPHIC COVERAGE

Under this project, the supported twenty-four (24) DTCs and one (1) Data Centre were geographically distributed across the six provinces Kabul, Mazar-e-Sharif (Balkh), Nangarhar, Badakhshan, Herat, and Farah. The operations were carried out by five implementing partners: Welfare Association for the Development of Afghanistan (WADAN), Social Service for Afghan Women Organization (SSAWO), Afghan Relief Committee (ARC), Afghan Support Point (ASP), and Organization for Health and Social Services (OHSS).

Figure 2: Geographical coverage of DTC operationalized by CPDAP

1.3 KEY OBJECTIVES PROGRESS

Project General objective: To maintain the operation and service delivery of the residential, home-based and outpatient treatment and rehabilitation facilities for drug dependents in Afghanistan.

Progress: *Since the inception of the project on 23 September 2022, CPDAP has financially supported operational expenses of 24 DTCs and 1 Data Centre, continuing until the programme received a Stop-Work Order on 28 January 2025.*

Specific objectives and their progress:

a. To continue service delivery of the INL/ CP supported NGO run residential, home-based and outpatient drug treatment centres
   Progress: The project supported these activities until the Stop-Work Order issued on 28 January 2025.

b. To provide adult, adolescent, and child drug dependents access to treatment and rehabilitation services and that families are involved in the treatment process.
   Progress: The project supported these activities until the Stop-Work Order issued on 28 January 2025.

c. To support national joint monitoring visits to all treatment centres funded by INL/CP across the country.

Progress: Virtual monitoring visits were conducted until the end of 2023 due to the security reasons in Afghanistan. In-person monitoring visits took place since March 2024, September 2024, and January 2025, with final verification visits to DTCs in May 2025.

d. To provide a platform to national and international stakeholders to meet annually for the review of drug demand reduction programs in Afghanistan.

Progress: The Afghan DDR Dialogue was held from 6–8 May 2024 in Astana, Kazakhstan. It was attended by representatives from the five implementing partners, UNODC, WHO, DAWEO, CPDAP HQ staff, and KFO. UN Women, the EU, and the Ministry of Healthcare Kazakhstan also joined virtually. Summary report of the Afghan DDR Dialogue appears in Annex 09.

e. To preserve the trained and experienced human resource capacity of the country and help them remain in the country and work in addiction treatment field esp in view of the post August 2021 situation which has resulted closure of some Govt. run treatment centres.

Progress: During monitoring visits, the staffing requirements of DTC clinical teams were noted, and discussions on the best ways to provide continued support were ongoing until the Stop-Work Order on 28 January 2025.

2. INTRODUCTION

2.1 OVERVIEW OF THE DRUG SITUATION IN AFGHANISTAN

Afghanistan faces a severe and multifaceted drug epidemic, driven by its long history as a global hub for opium production, coupled with widespread socio-economic challenges, conflict, and limited healthcare infrastructure. According to the Afghanistan National Drug Use Survey 2015[1], approximately 11.1% of the general population, equating to between 2.92 million and 3.57 million individuals, tested positive for at least one type of drug or class of drugs. This alarming prevalence underscores the scale of the crisis, which affects diverse segments of society, including vulnerable groups such as women, children, and youth. The survey highlighted that 9.5% of women (690,000 to 850,000) and 9.2% of children (1 million to 1.22 million) were among those testing positive, indicating that drug use permeates even the most vulnerable demographics. The pervasive drug epidemic is further complicated by the country's role as a major producer of opium, which fuels both local consumption and global trafficking networks. The lack of adequate treatment facilities, ongoing conflict, and economic instability exacerbate the situation, making it a public health and security challenge.

The primary drugs of concern in Afghanistan include opioids, cannabis, benzodiazepines, and amphetamine-type stimulants (ATS). The 2015 National Drug Use Survey[1] reported that opioids were the most prevalent, affecting 7.4% of the population (1.94 million to 2.37 million people), followed by cannabis at 3.4% (910,000 to 1.1 million), benzodiazepines at 0.8% (230,000 to 270,000), and ATS at 0.3% (80,000 to 100,000).

According to World Drug Report 2023[2], opioids, particularly heroin and opium, dominate due to Afghanistan's position as the world's leading opium producer, accounting for approximately 70-80% of global supply in recent decades. Cannabis use is also widespread, often perceived as socially acceptable in some communities, while the emerging trend of ATS use, particularly among youth, signals a shift in drug consumption patterns.

The Youth Survey 2018 conducted by UNODC and UNICEF[3] noted that 3.5% of youth reported cannabis use, with ATS use emerging as a growing concern. Additionally, 12% of schoolchildren aged 13-18 reported using substances, including alcohol, highlighting the vulnerability of younger populations to substance abuse.

The drug situation in Afghanistan has evolved significantly following current de facto administration opium cultivation ban in April 2022. While the ban led to a reported 95% reduction in opium poppy cultivation by 2023 as per the UNODC Afghanistan Opium Survey 20234, it has not necessarily curtailed drug use. Instead, changes in local drug availability have driven a notable rise in polydrug use, as observed in drug treatment centres across the country.

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1 Afghanistan National Drug Use Survey 2015: https://colombo-plan.org/wp-content/uploads/2020/03/Afghanistan-National-Drug-Use-Survey-2015-compressed.pdf
2 World Drug Report by UNODC 2023: https://www.unodc.org/res/WDR-2023/WDR23_Exsum_fin_SP.pdf
3 Study on Substance Use and Health among Youth in Afghanistan 2018: https://www.unodc.org/documents/data-and analysis/statistics/Drugs/Drug%20use/Study_on_substance_use_and_health_among_youth_in_Afghanistan_2018.pdf
4 Afghanistan Opium Survey 2023 by UNODC: https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_opium_survey_2023.pdf

The reduced supply of opium has pushed users toward alternative substances, including synthetic drugs like methamphetamine, which are cheaper and easier to produce. This shift has raised concerns about the increasing accessibility of ATS, particularly in urban areas, where economic desperation and unemployment drive experimentation with new substances. The UNODC World Drug Report 2024[5] notes that methamphetamine production in Afghanistan has surged, with makeshift labs replacing traditional opium-based operations, further complicating the drug landscape.

Vulnerable groups, including women, children, and displaced populations, face disproportionate risks. Women, often exposed to drugs through family members or as a coping mechanism for trauma and domestic violence, have limited access to treatment due to social stigma and a lack of gender-specific facilities. Children are particularly at risk, with the 2015 National Drug Use Survey[1] revealing high exposure to drugs, often through passive use or household environments where drug use is prevalent. The UNODC & UNICEF Youth Survey 2018[3] further emphasized the susceptibility of school-aged children, with substance use linked to peer pressure, poverty, and lack of educational opportunities. Internally displaced persons (IDPs) and returnees, who number in the millions due to ongoing conflict and economic crises, are also highly vulnerable, often turning to drugs as a means of coping with displacement and trauma.

The UNODC World Drug Report 2024[5] emphasizes the need for community-based programs to address polydrug use and the rising threat of synthetic drugs. Without sustained efforts to improve healthcare infrastructure, reduce poverty, and provide education and employment opportunities, the drug epidemic will continue to devastate Afghan society, perpetuating cycles of addiction and vulnerability.

2.2 PROJECT BACKGROUND AND OVERVIEW

The INL United States Department of State has been working with the Government of the Islamic Republic of Afghanistan (GIRoA) and CPDAP for developing and sustaining the country's drug treatment system since 2005. Over the past years, INL assistance for the country's substance use treatment program has expanded to the 86 inpatient (residential), outpatient, and outreach programs, which also include 21 residential treatment programs run by the Ministry of Public Health (MoPH) Govt of Afghanistan. Since August 2021, the funding and technical support is being provided only for the operation of 24 DTCs run by NGO implementing partners of CPDAP.

The new funding for Afghanistan treatment centre operation, under the current LOA using SINLEC no. SINLEC22LA0388 under the project code **2022-AF-003: "Continued NGO Assistance to Training and Specialized Substance Use Disorders Treatment Facilities"** approved on 23 September 2022, for twenty-four (24) months. In addition, on 13 September 2024, CPDAP received an extension to the Anticipated Implementation Period (AIP) until 15 November 2024. The project continuation has also received an additional USD 2,130,111.47, repurposed from the remaining balances of expired LOAs related to the aforementioned Afghanistan initiatives. This amendment to the original LOA brings the total project funding to USD 13,602,895.84. The amended LOA is valid until 30 June 2026.

[5] UNODC World Drug Report 2024: https://www.unodc.org/documents/data-and-analysis/WDR_2024/WDR24_Contemporary_issues.pdf

On 28 January 2025, CPDAP received official communication regarding the Immediate Stop Work Order issued by the current U.S. administration. This order suspends initiatives funded by the INL, effective from the same date. This is in line with the U.S. President's Executive Order on Reevaluating and Realigning United States Foreign Aid.

In response, CPDAP has promptly informed all concerned project staff and all Afghan IPs as of 28 January 2025 that all DTC operations have been ceased. A formal termination letter was later issued by the U.S. Department of State on 08 April 2025, marking the official closure of the project.

2.3 POST-AUGUST 2021 CONTEXT: OPERATING ENVIRONMENT IN AFGHANISTAN

Following the events of August 2021, significant restrictions were imposed on women across all regions of Afghanistan including the east, west, south, and north. These restrictions were uniformly applied and severely impacted women's freedom of movement, particularly in relation to work environments. Women were required to be accompanied by a male escort (Mahram) when visiting clinics, hospitals, or other public spaces, which created considerable operational challenges, especially for the CPDAP funded IPs, whose services were focused on women, female adolescents, and children. In addition to movement restrictions, community outreach services targeted toward women were officially banned. Despite these limitations, the project successfully adapted its approach to continue delivering essential services to clients in their respective locations. In some instances, the project was compelled to implement gender-based segregation in the workplace. Female staff had to be separated from male colleagues or placed behind physical partitions in offices and treatment centres.

Furthermore, the absence of formal banking channels for fund transfers into Afghanistan posed a major logistical challenge. As a result, the project relied on the services of a reliable MSP to facilitate financial transactions to both IPs and the KFO.

2.4 THE EVOLUTION OF THE PROJECT THROUGH VARIOUS PHASES

Since its inception in September 2022, the project has encountered a range of challenges, including the remaining effects of the COVID-19 pandemic. Despite these difficulties, virtual monitoring visits were maintained to ensure continued oversight and support to IPs.

In October 2023, a 6.3 magnitude earthquake struck Herat Province, causing structural damage to the ARC DTCs. In response, services were temporarily relocated to tents temporarily. However, this transition was managed swiftly, and full operations resumed within a few days.

In March 2024, after the departure of several treatment coordinators, new staff were successfully recruited, enabling the resumption of in-person monitoring visits. The project also navigated logistical complexities due to the lack of formal banking channels for transferring funds into Afghanistan, opting instead to utilize the services of MSP.

From 6–8 May 2024, an Afghan DDR stakeholder meeting was held in Astana, Kazakhstan. This hybrid event included both in-person and virtual participation from five implementing partners, UNODC, WHO, DAWEO, CPDAP and KFO staff. Additional participants from UN Women, the EU, and the Ministry of Healthcare of Kazakhstan joined virtually.

Throughout its implementation, the project maintained steady momentum. The project team ensured timely payments to IPs, conducted monitoring visits, and held regular coordination meetings between HQ, KFO, and the AOR.

On 28 January 2025, CPDAP received an official stop-work order from the U.S. Department of State, followed by an official termination letter on 08 April 2025. In response, CPDAP promptly issued notifications to all Afghan IPs indicating that funding would only be available through 28 January 2025, despite existing agreements. As a result, KFO operations were also suspended. Given these circumstances, KFO lease agreement was signed through 28 March 2025. Although the stop-work order took effect on 28 January, the lease agreement was finalized, with the understanding that the lease will be limited to two months to serve as the required notice period to the landlord.

Following the termination letter, it was decided that KFO staff would no longer be required. All KFO personnel were released as of 07 July 2025. Prior to their departure, KFO staff conducted final verification visits in May 2025 to assess the status of DTCs, confirm whether buildings were closed or handed over, and document operational conditions through their monitoring reports. Further details on these assessments are provided in Section 9.3: Final DTC Verification Visits.

All KFO assets were liquidated, and the proceeds were used to cover outstanding payments to Afghan IP's pending payments for September 2022. Additionally, termination reimbursements covering February 2025 were also provided to Afghan IPs.

In alignment with the LoA, CPDAP initiated the project closeout procedures beginning 08 April 2025, to be completed by 07 October 2025. The closeout period included preparation of the final performance project report, closure of the KFO, settlement of all remaining obligations to IPs and partners, submission of financial reports, and proper archiving of project files.

2.5 SCOPE AND OBJECTIVES

Scope of the Project

The scope of this project is to maintain and strengthen drug treatment and rehabilitation services in Afghanistan, with a focus on ensuring continuity of care, especially for vulnerable populations including women, female adolescents, and children. Given the evolving political and operational context post-August 2021, the CPDAP, in close coordination with INL, has revised its approach to support 24 treatment centres and 1 data centre, down from the originally planned 39. These include:

- 19 centres for adult females and children
- 5 centres for female adolescents
- 1 centralized data centre (for women and children's data management)

This project also includes support for the Colombo Plan's KFO operations, covering administrative and operational costs essential for the effective implementation, monitoring, and oversight of project activities. Furthermore, the project supports capacity-building initiatives such as the development and dissemination of online self-guided UTC courses in Dari. The Colombo Plan implemented the project through its long-standing NGO partners namely ARC, ASP, OHSS, WADAN, and SSAWO providing technical and financial assistance as per the project's terms.

General Objective

To maintain the operation and service delivery of residential, home-based, and outpatient drug treatment and rehabilitation facilities for drug dependents in Afghanistan.

Specific Objectives

a. To ensure the continued service delivery of INL/CP-supported, NGO-run residential, home-based, and outpatient drug treatment centres across Afghanistan.

b. To provide adult, adolescent, and child drug dependents with access to comprehensive treatment and rehabilitation services, including the involvement of their families in the recovery process.

c. To conduct national joint monitoring visits to all treatment centres supported by INL/CP, ensuring quality assurance and compliance with treatment protocols

d. To offer a platform for national and international stakeholders to convene annually and review the status, challenges, and progress of drug demand reduction efforts in Afghanistan.

e. To retain the trained and experienced addiction treatment workforce in the country, especially in light of the closures of some government-run treatment centres after August 2021, thereby preserving national human resource capacity in the field of drug treatment.

f. Conversion of self-guided UTC courses and translation into Dari language.

2.6 LIST OF TREATMENT CENTRES SUPPORTED BY THE PROJECT

#	Implementing Partner (IP)	Province	Client Population	Clients Served	Client Treatment Type	Number of Beds
1	Welfare Association for the Development of Afghanistan (WADAN)	Badakshan	Adults	Female	Residential	30
2		Badakshan	Children	Male/ Female	Residential	30
3		Badakshan	Adolescent	Female	Residential	10
4		Badakshan	Children	Male/ Female	Outpatient	--
5		Kabul	Adults	Female	Residential	20
6		Kabul	Children	Male/ Female	Residential	30
7		Kabul	Adolescent	Female	Residential	10
8		Kabul	Children	Male/ Female	Outpatient	--
9		Nangarhar	Adults	Female	Residential	25
10		Nangarhar	Children	Male/ Female	Residential	20
11		Nangarhar	Adolescent	Female	Residential	10
12		Farah	Adults	Female	Residential	20
13		Farah	Children	Male/ Female	Residential	15
14	Social Service for Afghan Women Organization (SSAWO)	Kabul	Adolescent	Female	Residential	50
15		Balkh	Adolescent	Female	Residential	15
16		Balkh	Adult	Female	Residential	30
17		Balkh	Children	Male/ Female	Residential	25
18	Afghan Relief Committee (ARC)	Herat	Children	Male/ Female	Residential	25
19		Herat	Adult	Female	Residential	25
20		Herat	Adult	Female	Residential	10
21		Herat	Children	Male/ Female	Residential	20
22		Herat	Children	Male/ Female	Outpatient	--
23	Afghan Support Point (ASP)	Kabul	Adults-Adolescent-Children	Male/ Female	Outpatient	--
24	Organization for Health and Social Services (OHSS)	Kabul	Children	Male/ Female	Outpatient	--

Table 1: Treatment centres supported by the project

2.7 THE COLOMBO PLAN KABUL FIELD OFFICE

The KFO served as the central operational hub for the project implementation, coordination, and oversight of DDR and treatment programs across six provinces in Afghanistan. It played a pivotal role in ensuring effective program delivery through close engagement with IPs based on the supervision of the Programme Manager and the CP management alignment with strategic objectives of the project, and support information from HQ and Programme Manager to further coordinate with INL.

Key Responsibilities of the KFO:

- **Program Coordination and Oversight:**
  The KFO managed and supported 24 DTCs across Afghanistan, including providing technical support under the supervision of Programme Manager.
- **Capacity Building and Training:**
  KFO organized training programs for clinical staff of DTCs including doctors, nurses, psychologists, counsellors, and outreach workers ensuring adherence to evidence-based practices and international treatment standards where necessary, with the initial approval from Programme Manager and INL.
- **Monitoring and Evaluation (M&E):**
  The KFO conducted regular monitoring visits and evaluations to assess the performance, quality of care, outcomes of the DTCs, and problems and obstacles of the project implementation. It ensured data collection protocols and evaluation frameworks were consistently applied.
- **Facilitation of Joint Missions:**
  The KFO team supported and coordinated joint monitoring visits involving national stakeholders, and international partners (UNODC, WHO etc.) to promote transparency and shared learning as well as find the solutions or address the concerns of the IPs.
- **Data Management and Reporting:**
  The KFO was responsible for compiling regular narrative and financial reports, maintaining client treatment data, and ensuring proper documentation of project progress and impact.

Operating under the strategic guidance of the CPDAP HQ through the Programme Manager, the KFO staff ensured that all interventions were tailored to the evolving context of Afghanistan, particularly in response to the restrictions on women's mobility and employment post-August 2021. The field office worked closely with local NGOs to sustain service delivery under increasingly challenging conditions.

The operations of the KFO were significantly affected by an official Stop-Work Order from the U.S. Department of State on 28 January 2025, and a formal termination letter on 08 April 2025. All KFO staff positions were formally terminated by 07 July 2025, following the completion of critical closure tasks including verification visits to Afghan DTCs. In parallel, all KFO assets were liquidated with proceeds redirected to cover outstanding payments to IPs dating back to September 2022.

2.8 ONLINE CURRICULUM DEVELOPMENT

Under the framework of project, CPDAP has prioritized the development and dissemination of online evidence-based training curricula to strengthen global and national capacity in DDR. This aligns with CPDAP's broader mandate to enhance the knowledge, skills, and competencies of addiction professionals, particularly in resource-constrained and crisis-affected contexts such as Afghanistan.

UTC is a standardized, evidence-based training program designed to improve treatment outcomes for individuals and professionals with SUDs. Traditionally delivered through in-person formats, the UTC has proven critical in professionalizing the global addiction treatment workforce.

However, considering the COVID-19 pandemic, which significantly disrupted in-person learning, and ongoing challenges in travel, security, and cost, particularly in Afghanistan, CPDAP initiated the transition of UTC content **into self-led online learning modules.** These modules offer flexible, accessible, and scalable training options, allowing practitioners to learn at their own pace, from any location.

With the support from INL, this effort under project 2022-AF-003 focused on the design, digitization, and translation of selected UTC courses for self-led deployment. The initiative also includes plans to translate the entire UTC Basic Level series (Courses 1–8) into Dari, increasing accessibility for professionals in Afghanistan.

Through partnerships with expert U.S.-based service providers, the project has developed high-quality, interactive, self-led courses hosted on recognized learning platforms such as HealtheKnowledge.org and ISSUP's Online Learning Hub. This transition represents a strategic step toward sustainable, wide-reaching professional development in the addiction treatment sector. More details are included in Section 7: Online Curriculum Development.

2.9 PROJECT TIMELINE

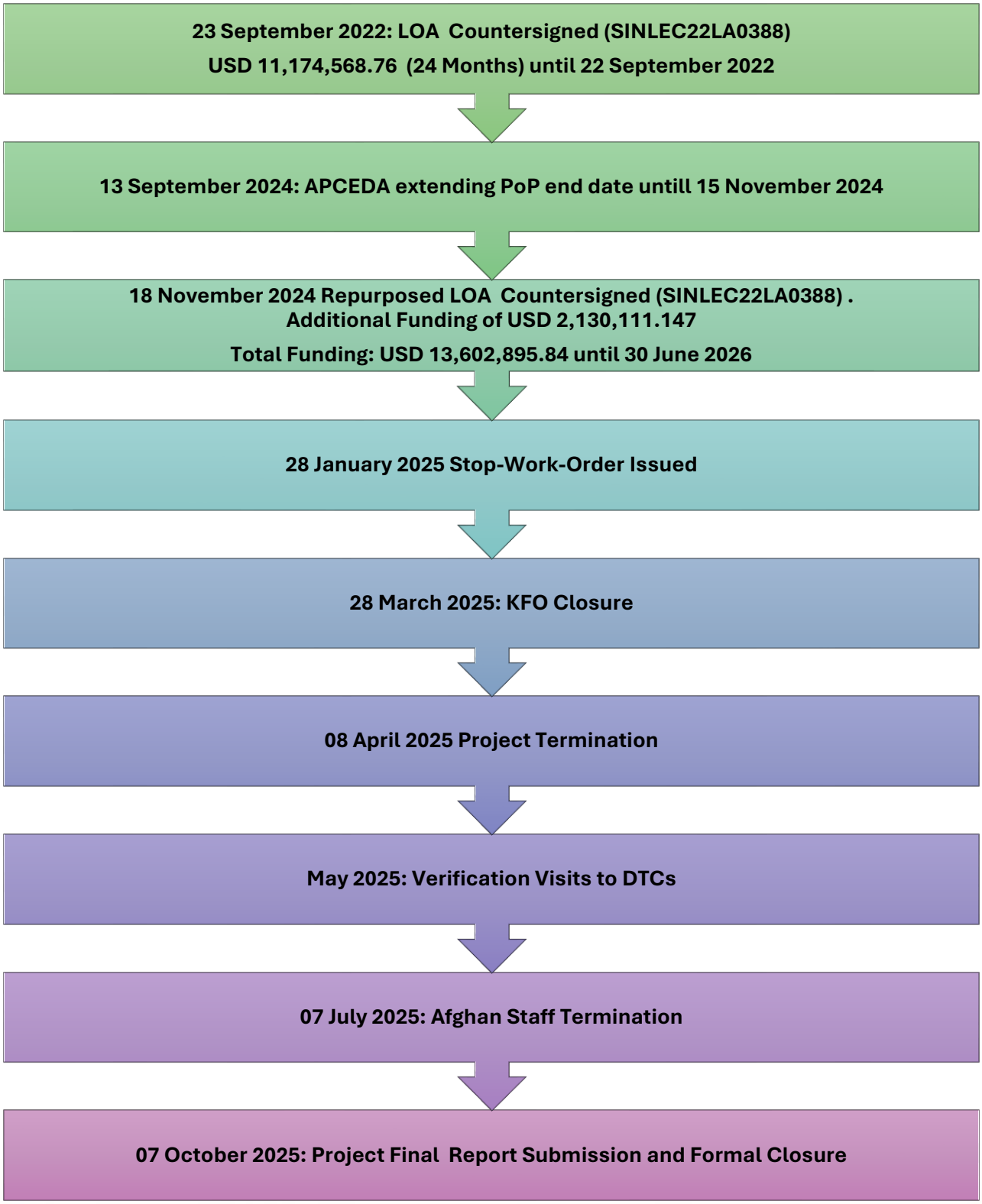

Figure 3: Project Timeline

3. AFGHAN DTC OVERVIEW, AND OPERATIONS

3.1 TREATMENT CENTRE SERVICES AND OPERATIONS

The services were carefully designed to address the needs of the most vulnerable groups, including adult women, female adolescents, and children, while male clients were served exclusively through the Outpatient Treatment Centres (OPTCs). Residential treatment programs were tailored based on age and marital status as well as the level of dependence to maximize effectiveness: adult women and children received 45 days of residential care, while female adolescents participated in 90-day programs that combined therapeutic treatment with structured educational activities aimed to prevent relapse. These educational programs included life skills training, health and hygiene awareness, psychosocial support, and strategies to strengthen resilience and long-term recovery.

Home-based services followed the same treatment approach as residential care for adult women, ensuring continuity and accessibility of care for clients unable to attend centres due to mobility, security, or cultural barriers.

The program also emphasized individualized care plans, regular monitoring, and ongoing assessment to adapt treatment according to each client's progress. In addition to direct clinical services, staff provided individual and group counselling sessions to support reintegration and strengthen family and community support networks.

Across all provinces where services were implemented, the program maintained culturally sensitive practices, prioritizing client safety, dignity, and confidentiality, while promoting sustainable recovery outcomes and community awareness of substance use issues.

#	Client Population	Clients Served	Client Treatment Type	Treatment duration
1	Adults	Female	Residential	45 days
2	Children	Male/Female	Residential	45 days
3	Adolescent	Female	Residential	90 days
4	Adults, Adolescent and Children	Male/Female	Outpatient	

Table 2: Residential and outpatient treatment duration

The operation of the 24 treatment centres comprised a mix of residential and outpatient facilities, tailored to meet the diverse treatment needs of different demographic groups, including adult women, female adolescents, and children.

Treatment Centre Distribution and Capacity

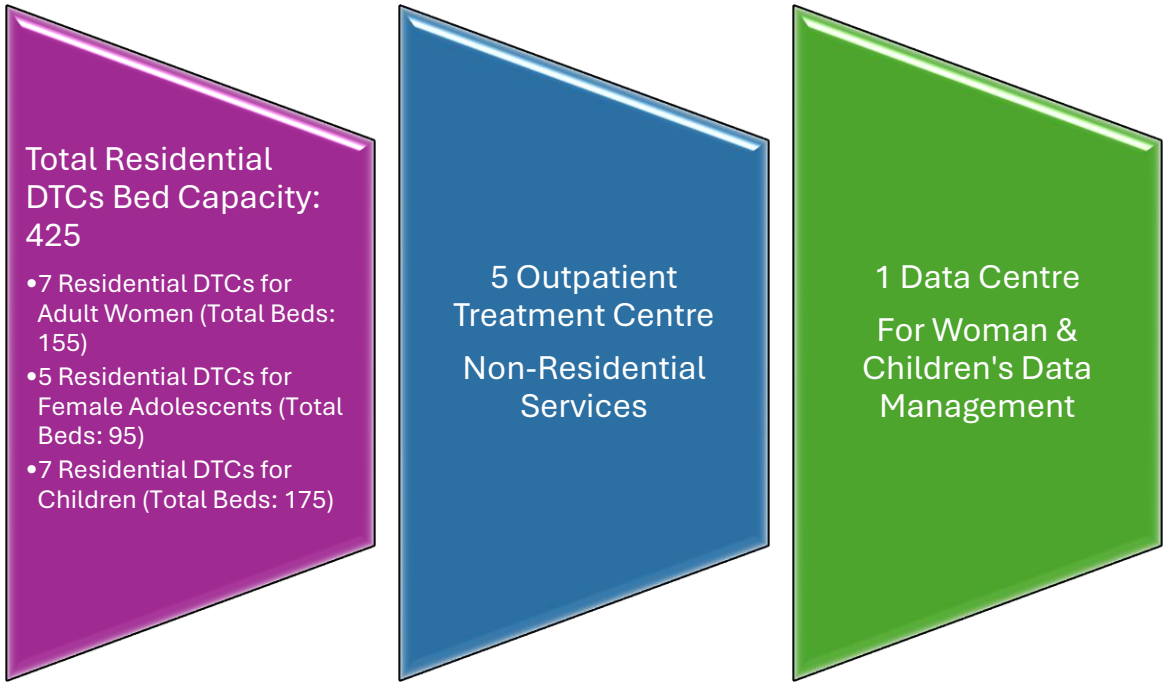

Figure 4: Treatment Centre Distribution and Capacity

Staffing Structure

Each treatment centre was staffed with a multi-disciplinary team to ensure a holistic and client-cantered approach to care. Staffing included:

Clinical Staff:

- Physicians (General Practitioners and Addiction Specialists)
- Nurses
- Psychologists and Psychiatrists
- Addiction Counsellors
- Social Workers

Non-Clinical Staff:

- Administrative and Finance Officers
- Outreach Workers and Community Mobilizers
- Security Personnel
- Cleaners, Cooks, and Support Staff

Gender-sensitive hiring practices were followed to ensure that women and adolescent clients were supported by female staff, in accordance with local cultural norms and restrictions. Staff were regularly trained through CPDAP-led capacity-building initiatives to enhance their knowledge in areas such as evidence-based treatment models, trauma-informed care, and psychosocial support.

Client Demographics

The treatment centres served a highly vulnerable population, primarily:

- Adult women affected by long-term drug dependence, often co-occurring with domestic violence, poverty, and displacement.
- Adolescent girls, many of whom had experienced early exposure to drug use within the household.
- Children, often referred to by child protection agencies, welfare organizations, or community elders, are sometimes accompanied by drug-using family members.

Clients received not only detoxification and medical treatment; however, psychosocial support, vocational training, family counselling, and reintegration services aimed at sustainable recovery.

3.2 TREATMENT MODALITIES

Throughout the implementation phase of the DTC project, the Colombo Plan, working through its network of implementing partners, ensured the continuation of established and long-term treatment modalities that had proven effective in the Afghanistan context. These included inpatient care for clients requiring intensive residential treatment, outpatient care for those able to receive structured support while remaining in their communities, and home-based services designed to reach clients with limited mobility or those facing cultural or logistical barriers to accessing centres.

The services were tailored to meet the needs of the most vulnerable groups on adult women, female adolescents, and children, while the male clients were served only by the OPTCs. To ensure that women and adolescent clients were supported by female staff, female staff were hired in accordance with local cultural norms and restrictions.

Duration of the residential treatment programs varied based on the age and marital status considerations, offering a 45-day residential care for adult female and children and 90 days for female adolescents for their well recovery plus undergoing some educational programs to prevent relapse. Homebased services followed the same modality of treatment for adult female residential care.

Implementation covered six provinces of Afghanistan, enabling broad geographical reach and ensuring that treatment remained available despite challenging operating environments. The program not only provided direct services but also promoted continuity of care, cultural sensitivity, and the safeguarding of clients throughout the treatment process.

Below is the mapping of the treatment programs for different female age groups during the project implementation phase.

Adult Female Residential

Adult Residential Drug Treatment and Rehabilitation Mapping

Pre-Treatment One to Ninety Days (1-90 Days)		Treatment One to Ninty Days (1-90 Days)				Post Treatment Three Hundreds Sixty Five Days (365 Days)		
Awareness	Motivation	Detoxification 01 to 14 days	Primary Treatment 14 to 30 days	Secondary Treatment 30 to 60 days	Aftercare 60 to 90 days	First 3 months	Second 3 months	Final 6 months
Community •School-Based •Mosque •Social Functions **Family** •Family Intervention •Family Counselling **Community Integration** • Referrals **Support Network** • Family Support Group • Peer Support Group	**Motivational Talks** • Motivational Interview **Crisis Intervention** • Family Intervention • Individual Intervention • Community Intervention **Counselling** • Individual • Family • Group	**Assessment** • Medical • Health • Mental Health **Pharmacotherapy** • Symptomatic Medications **Referrals** • Laboratory **Daily Review** • Doctor's Round • Nurses' Round **Counselling** • Individual	**Client Education** • Drug Education • Relapse Prevention • Medical Complications **Counselling** • Individual • Group • Family **Cognitive Behaviour Therapy** **Vocational Skills** • Skill-Based • Handicrafts **Religious Sessions** • Individual • Group • Islamic Studies **Recreational** • Music • Cultural Activities • Sports **Weekly Review** • Doctor's Round • Nurses' Round	**Client Education** • Drug Education • Relapse Prevention • Medical Complications **Counselling** • Individual • Group • Family **Cognitive Behaviour Therapy** **Vocational Skills** • Skill-Based • Handicrafts **Religious Sessions** • Individual • Group • Islamic Studies **Recreational** • Music • Cultural Activities • Sports **Weekly Review** • Peer-Led • Counsellor-Led	**Reintegration** • Life-Skills • Pro-Vocational Skills **Counselling** • Individual • Group • Family **Cognitive Behaviour Therapy** **Recreational** • Music • Cultural Activities • Sports **Self-Help Group** • Peer-Led • Counsellor-Led **Employment** • Job placement	**Once a week** **Counselling** • Individual • Family **Self-Help Group** • Peer-Led • Family Support Group **Monitoring** • Drop-in	**Twice a Month** **Counselling** • Individual • Family **Self-Help Group** • Peer-Led • Family Support Group **Monitoring** • Drop-in	**Once a Month** **Counselling** • Individual • Family **Self-Help Group** • Peer-Led • Family Support Group **Monitoring** • Drop-in
Assessment • Intake Assessment • Initial/Preliminary Interview • Medical • Health • Mental Health								
Pharmacotherapy • Symptomatic Medications								
Documentation						**Second Year (Once in Three Months)**		
☑ Documentation ☑ Record Keeping ☑ Data (Statistics)		☑ Intake Assessment Forms ☑ Medical Records ☑ Counselling Notes ☑ Consent Forms	☑ Service Coordination (Referrals) ☑ Programme Activities ☑ Treatment Planning ☑ Case Management			☑ Counselling ☑ Testing ☑ Visitation ☑ Drop-In	☑ Support Group ☑ Documentation	

Figure 5: Treatment Mapping of Female Adult Residential Centres

Female Adolescent

First Month		2 months		3 months			6 months		
Assessment • Eligibility • Substance Use History • Medical and Social Hx. • Formulate Diagnosis • Treatment Matching	• Referrals • Community-based follow-up	**Counseling** • Individual • Peer Group • Family	**Client Education** • Drug Education • Relapse Prevention • Medical Complications	**Counseling** • Individual • Peer Group • Family	**Client Education** • Drug Education • Peer Pressure • Medical Complications	**Pro-Vocation Skills** • Art Expressions • Embroidery • Clay Making • Painting • Collage	**Intensive Follow-up** 3 months • Re-Entry (live in) • Re-Entry (live out) • Extended Family Care	**Follow-up** 2 months • Re-Entry (live out) • Extended Family Care	**Follow-up** 1 month • Re-Entry (live out) • Extended Family Care
Early Treatment • Detoxification • Pharmacotherapy	**Orientation** • Stages of Treatment • Family/Guardian	**Tertiary Education** • English, Mathematics • History, Civic and Moral.	**Computer Class** • Basic Computer Skills	**Tertiary Education** • English, Mathematics, • History, Civic and Moral.	**Computer Class** • Basic Computer Skills	**Family Education** • Drug Education • Co-dependent • Role of Care Giver • Family Intervention	• Tertiary Education • Substance Use • Defiance's • Conducive Family and Home Environment	• Tertiary Education • Substance Use • Defiance's • Conducive Family and Home Environment	• Tertiary Education • Substance Use • Defiance's • Conducive Family and Home Environment
• Motivational Interviewing • Managing Crisis	• Family Education • Client Education • Individual Counseling • Crisis Intervention • Family Counseling	**Religious Sessions** • Individual • Group • Islamic Studies	**Recreational** • Music • Cultural Activities • Sports • Daily Chores	**Religious Sessions** • Individual • Group • Islamic Studies	**Recreational** • Music • Cultural Activities • Sports • Daily Chores	**Extra Curricula Activities** • Peer Supervision • Life Skills Training • Mountain Tracking • Excursion	• School Report • Random Urine • Home or Community Visitation	• School Report • Random Urine • Home or Community Visitation	• School Report • Random Urine • Home or Community Visitation
Daily Review • Doctor's Round • Nurse Round		**Weekly Review** • Counselor's Round • Individual Case	**Weekly Review** • Doctor's Round • Nurse Round	**Weekly Review** • Counselor's Round • Individual Case	**Weekly Review** • Doctor's Round • Nurse Round	**Home Visitation**	**Fortnightly Review** • Counseling • Professional Led Support Group	**Monthly Review** • Counseling • Professional Led Support Group	**Monthly Review** • Counseling • Professional Led Support Group
Suggested Forms • Consent for Treatment • Drug Use Hx. • Family Genogram • Physical Examinations • Medical Examination • MMSE • Bio Psychosocial Hx.	**Suggested Forms** • Interagency Release of Information • Indemnity • Client Release of Information	**Suggested Forms** • Client Case Documents • Client Program Checklist • Continuation of Record Keeping	**Treatment Methodology** • Cognitive Behavioral Therapy • Bibliotherapy		**Suggested Forms** • Client Case Documents • Client Program Checklist • Continuation of Record Keeping	**Suggested Forms** • Interagency Release of Information • Indemnity • Client Release of Information • Case Summary • Discharge Summary	**Suggested Forms** • Client Case Documents • Client Progress Notes • Continuation of Record Keeping	**Suggested Forms** • Client Case Documents • Client Progress Notes • Continuation of Record Keeping	**Suggested Forms** • Client Case Documents • Client Progress Notes • Continuation of Record Keeping • Closing Case Documentation

Figure 6: Treatment Mapping of Female Adolescent Residential Centres

Children Residential

Figure 7: Treatment Mapping of Children Residential Centres

3.3 TREATMENT PROCEDURE

In Afghanistan, the CPDAP, in collaboration with local implementing partners such as WADAN, SSAWO, ARC, ASP, and OHSS, has established a structured and culturally responsive approach to address problems associated with substance use disorders. The treatment services delivered through CPDAP-supported centres followed a three-phase, abstinence-based model that combined medical care, psychosocial interventions, and community reintegration. This model not only provided clients with essential medical stabilization and counselling but also emphasized family involvement, social support, and community acceptance as key factors for sustained recovery. By implementing the treatment programs in Afghanistan and adopting it to the cultural and social context, the program continuously succeeded to increase accessibility, reduce stigma, and promote long-term rehabilitation outcomes.

1. Pre-Treatment Phase (Motivational Phase)

The treatment process begins with a pre-treatment phase, typically lasting 1 to 3 months. During this stage, outreach workers and counsellors engaged with individuals who were dependent on substances to raise their awareness of the harms of drug use and to increase their motivation to undergo treatment. Many clients were referred by families, community elders, or local authorities. This phase often includes:

- Basic awareness and education
- Individual motivational sessions
- Family involvement and support
- Screening and brief interventions
- Refer to treatment centres

2. Treatment Phase (Inpatient or Outpatient)

Once the client is ready, they entered the treatment phase, which can be residential (inpatient) or outpatient, depending on the severity of dependence and availability of services and consent of the client.

a. *Detoxification*

The initial step in the treatment phase is detoxification, a medically supervised process that typically lasts between 7 to 14 days. The aim is to help the individual safely withdraw from drugs while managing withdrawal symptoms with supportive medication, hydration, rest, and monitoring.

b. Rehabilitation and Psychosocial Therapy

After detox, clients enter the rehabilitation period, which lasts approximately 45 days for residential clients. This phase includes:

- Individual counselling sessions to address underlying psychological and behavioural issues.
- Group counselling/therapy focused on shared experiences, coping strategies, and peer support.
- Family counselling, encouraging family involvement in the recovery process.
- Life skills training (communication, anger management, conflict resolution, etc.).
- Spiritual and cultural activities, aligned with local traditions, to foster a sense of self-identity and purpose.

Figure 8: ARC 50-Bed Female and Children DTC in Herat

3. Aftercare and Reintegration Phase

After completing the structured rehabilitation program, the client transitions into the aftercare phase, which is designed to support long-term recovery and reintegration. This phase include:

- Regular follow-up counselling sessions (weekly or monthly)
- Family involvement and education programs to build a supportive home environment
- Participation in peer support or self-help groups
- Vocational training skills programs to prepare the recovered clients for employment.
- Referrals to educational, employment, or reintegration programs or relevant available services.

Community-based outreach workers play a vital role in relapse prevention by maintaining regular contact with former clients after treatment and closely monitoring their progress within the community. They provide encouragement, identify early warning signs of relapse, and link individuals to further support services when needed. To strengthen this process, family members and respected community elders are often engaged, as their involvement not only provides emotional and social support but also helps reduce stigma associated with substance use. This collaborative approach contributed to fostering a supportive environment, increased accountability, and improves the chances of sustained recovery.

The vocational training programs were not part of the original scope of this project. However, WADAN independently initiated a vocational skills training program in Kabul with financial support from another donor. This program was designed to equip the recovered clients with practical skills that could help them secure employment, improve their livelihoods, and support long-term reintegration into society. Although it was separate from the current project, the initiative complemented the overall objective of empowering vulnerable groups and reducing their dependence on external assistance.

3.4 DTC OPERATIONS OVERVIEW

Daily operations of drug treatment centres in Afghanistan required careful management of several key components. This included routine facility maintenance to ensure a safe and hygienic environment for clients, along with reliable access to supplies and utilities such as food, clean water, electricity, heating, and medical provisions. Effective cash flow management was also essential to cover operational costs such as staff salaries and sustain service delivery without disruption. Together, these elements formed the backbone of smooth day-to-day functioning, allowing treatment centres to focus on providing consistent care and support to clients.

Drug treatment centres in Afghanistan were delivering a wide range of services designed to cover the entire continuum of care, including prevention, treatment, and long-term recovery. These services included, but were not limited to:

- Public awareness: community outreach and education campaigns to reduce stigma and increase understanding of substance use disorders.
- Screening and assessment: initial evaluations to identify the severity of use, co-occurring issues, and treatment needs.
- Motivation and counselling: individual and group sessions to strengthen commitment to recovery and build coping skills.
- Case management: coordinated support to connect clients with medical, psychological, and social services.
- Overdose management: emergency interventions to save lives and provide immediate stabilization.
- Detoxification: medically supervised withdrawal to ensure safe and humane management of substance dependence.
- Co-occurring disorders' management: integrated care for clients with both substance use and mental health conditions.
- Rehabilitation: structured residential or outpatient treatment focused on abstinence, therapy, and life skills.
- Follow-up and relapse prevention: aftercare services, outreach, and community-based support to sustain recovery.

Non-Residential Treatment centres or OPTCs: These facilities delivered the full range of services listed above, along with structured aftercare programs, on an outpatient basis. Clients received treatment and support during the day but returned home afterward, making the services more flexible and accessible for those who could not commit to residential care.

Residential Treatment centres or DTCs: These centres provided all the same services as OPTCs but with the addition of full accommodation. Clients stayed at the facility for the duration of their treatment, benefiting from a structured and supportive environment that allowed for intensive rehabilitation and continuous monitoring.

Figure 9: Vocational Training Programs conducted at DTCs

4. PROGRESS REVIEW

4.1 AFGHAN DDR DIALOGUE

Before the current project implementation period in 2022, the CPDAP has been holding annual Afghanistan DDR Stakeholders Meetings since 2009 in the previous projects. These gatherings bring together Afghan implementing partners, relevant government ministries of the former republic (primarily the Ministries of Public Health, Counter Narcotics, and Education), INL as the donor agency, the Colombo Plan HQ and KFO, as well as international organizations such as UNODC and WHO in order to review progress under ongoing DDR projects, strengthen coordination among stakeholders, build a national system of collaboration, and plan future initiatives.

Over the years, the annual stakeholders' meetings were hosted in various international locations: Singapore (2009), Bangkok (2010), Istanbul (2011), Kabul (2012), Colombo (2013), Chennai (2014), Dushanbe (2014), Bangkok (2015 and 2016), Dubai (2017), Jakarta (2018), and Dubai again in 2019. Since 2020, in-person meetings have not been held due to the COVID-19 pandemic and the fall of the Afghan government in 2021. However, a virtual stakeholders' meeting was conducted in 2021.

Under the framework of this project starting from October 2022, the CPDAP organized one DDR Dialogue bringing together all Afghan IPs, INL, the CPDAP, KFO staff, and other international DDR partner agencies such as UNODC and WHO to review progress under the current ongoing DDR projects, strengthen coordination among stakeholders, and plan future initiatives.

The latest DDR Dialogue was organized from 6-8 May 2024 in Astana, Kazakhstan on a hybrid version accommodating both in-person and online participants and was attended by representatives from the CPDAP HQ and KFO, INL, UNODC, WHO, UN Women, UNFPA, EU and IPs (WADAN, ARC, SSAWO, ASP and OHSS) and Kazakhstan's Republican Centre for Mental Health, Ministry of Healthcare (virtually).

It can be considered that this DDR Dialogue was considered the first progress review under the current project. Participants from every agency shared the presentation related to their DDR work in Afghanistan. More discussion was devoted to the address challenges and recommendations to improve the treatment works in Afghanistan.

Some key challenges and recommendations noted in the meeting are as follows:

Challenges	Recommendations
CPDAP	
- Staff turnover due to recent changes in the country. - Current restrictions affecting services for women. - Coordination among different programs. - Travel challenges for female staff, especially to provinces.	- Provide refresher training for staff who have received UTC training. - Conduct ICAP exams for clinical staff who have completed basic curricula.

Challenges	Recommendations
- Budget concerns related to Mahram and capacity building for new personnel. - Lack of proper structures for DTCs. - Issues with homeless clients staying after treatment completion. - Lack of family acceptance post-treatment. - High employee turnover affects trained staff availability. - Unavailability of monitoring team members for missions. - Lack of shelter and vocational skills for homeless discharged clients. - Gender restrictions and cultural norms affect monitoring team access to DTCs. - Travel restrictions for female staff without Mahram.	- Offer mhGAP[6] and PM[7] Plus training for clinical staff. - Support vocational training programs for clients. - Develop, review, and revise SOPs and guidelines. - Conduct online training on basic and advanced UTC courses. - Organize joint monitoring missions to DTCs for online and in-person assessments. - Conduct capacity-building series and refresher training for staff. - Involve clients in every step of treatment. - Utilize experienced DDR individuals in case of unavailability of certified freelancers. - Implement joint monitoring missions to overcome challenges.
UNODC	
- No explicit challenges listed; implied through recommendations, such as limited services for vulnerable groups, lack of diversified treatment options, and integration into humanitarian efforts.	- Expand evidence-based prevention initiatives involving families, schools, and communities to ensure the well-being and safety of children and youth, particularly the most marginalized. - Continued support for existing residential DTCs and OPTCs. External support is currently vital for effective and ongoing DDR programmes.

[6] The WHO Mental Health Gap Action Programme (mhGAP): https://www.emro.who.int/mnh/mental-health-gap-action-programme/mhgap.html

[7] WHO's Problem Management Plus (PM+): https://www.who.int/publications/i/item/problem-management-plus-(-pm-)-individual-psychological-help-for-adults-impaired-by-distress-in-communities-exposed-to-adversity

Challenges	Recommendations
	- Resuming and expanding drug treatment services in line with the International Standards for the Treatment of Drug Use Disorders and local circumstances to ensure availability for those in need, while ensuring the most vulnerable – homeless, children and women who use drugs are not left behind. - Advocacy and capacity building (in synergy also with other development programmes) for the diversification of treatment services from mainly residential only, to more of a continuum of care that includes elements of outpatient and community-based treatment and care, as described in the International Standards for the Treatment of Drug Use Disorders. - Synergies with Alternative Development programmes might be relevant with a view to community development and sustainable livelihoods programming, that includes people with disorders due to substance use, especially in rural areas. - Expand treatment for drug use disorders and care including harm reduction in currently under covered settings such as prison settings, as feasible.

Challenges	Recommendations
	- Ensure inclusion of people who use drugs, people with drug use disorders, people in recovery and services providing support to them in overall humanitarian assistance, including food, medications. - Mainstream basic understanding on and basic substance use response capacity with humanitarian partners and actors. - Continue to use existing dialogue in line with each agencies existing mandates to advocate for needs of people at risk of drug use, people who use drugs and with drug use disorders.
UN Women GBV program	
- Female survivors face barriers accessing drug treatment facilities due to stigma and shame. - Female survivors face additional challenges accessing services. - Limited access to female-only facilities and stigma hinder support.	- Train frontline service providers to enhance their skills. - Strengthen organizational capacity to deliver essential services effectively. - Create more female-only facilities for survivors. - Collaborate with drug treatment centers to improve access for female survivors
E.U. and WHO	
- Lack of integration of drug treatment services into the health system. - High rates of drug use and mental health issues in the population. - Issues with current drug treatment interventions, including lack of access	- Urgent need for community-based drug treatment services. - Advocacy for voluntary services and evidence-based models. - Emphasis on prevention of substitution of opiates with more harmful substances.

Challenges	Recommendations
to basic needs, high financial burden, and high relapse rates.	- Scaling up Opioid Agonist Maintenance Treatment programs. - Addressing the challenges of residential/inpatient compulsory drug treatment interventions.
CPDAP Implementing Partners	
- Adequate funding and effective management. - Poverty, hopelessness, returnees, and IDPs. - PTSD and psycho-social issues. - Myths and lack of adequate attention. - Disruption of national drug treatment systems. - Lack of comprehensive strategies and modalities. - Lack of coordination among stakeholders and sectors. - Lack of capacity with trained staff and experts.	- Empower local NGOs and expand the CHATAR network. - Promote science-based and evidence-based approaches. - Expand DDR services at community, village, and home levels. - Raise funds and promote ownership with grassroots communities. - Build trust, confidence, accountability, and transparency. - Increase the number of drug treatment centers. - Provide technical expertise to relevant departments. - Participate in international forums. - Create a drug control board and DDR subcluster. - Create a drug control research center and higher education institute for SUD treatment programs.

Table 3: 2024 Afghan DDR Dialogue - Summary of Challenges and Recommendations

Summary report of the meeting appears in **Annex 09.**

4.2 KEY ACHIEVEMENTS ON PROJECT EXPECTED OUTCOMES

The following analysis summarizes progress made against the project's expected outcomes under project 2022-AF-003 during implementation period.

Project Deliverable	Actual (until project closure)
24 INL/ CP funded treatment centres will remain operational for 21 months to provide services to drug dependents and their families in Afghanistan	24 DTCs (19 residential, 5 outpatient), and 1 data centre were fully operational from 23 September 2022 to 28 January 2025. Totally 28 months. Following the stop-work order, DTCs were reimbursed for termination-related expenses incurred in February 2025.
Treatment of around 8,000 drug dependents, including, female, adolescent, and child drug dependents assisted by residential, home-based and outpatient centres	As of 28 January 2025, 5,530 residential admissions, 486 home-based admissions, and 21,310 individuals screened at youth outpatient centres.
Regular reporting on the progress of the treatment centres, which will be recorded monthly and submitted quarterly through, quarterly narrative reports, yearly financial reports, and yearly stakeholder meetings.	Quarterly progress reports submitted by CPDAP, detailing performance data across residential, home-based, outpatient, and post-recovery service lines and overall project progress. Afghan Drug Demand Reduction Stakeholder Dialogue was held from 6–8 May 2024 at Hilton Astana, Kazakhstan, with both in-person and virtual participation. Participants included: Five implementing partners (ARC, ASP, OHSS, SSAWO, WADAN), UNODC, WHO, DAWEO, CPDAP (Colombo & Kabul), UN Women, the EU, and the Ministry of Healthcare of Kazakhstan. Due to the project's early termination, a second stakeholder meeting could not be implemented.
All of treatment centres run by NGOs are monitored by the joint monitoring team at least twice a year. 4 times per year Following each site visit, a report is to be produced, complete with recommendations for improvement to be shared with treatment centre management.	Virtual joint monitoring visits to DTCs (with UNODC and local DDR experts): • Oct–Dec 2022 • Apr–Jun 2023 • Jul–Sep 2023 • Oct–Dec 2023

Project Deliverable	Actual (until project closure)
	In-person monitoring visits: • Jan–Mar 2024: 9 in-person visits conducted by joint monitoring teams. • Apr–Jun 2024 and Jul–Sep 2024: Further in-person visits completed. • May 2025: Monitoring and Verification visits conducted to assess the status of DTC closure, client transitions, and facility handovers. More details on monitoring visits are included under Section 05: In-Person and Virtual Monitoring Visits
A Data centre, based in Kabul and run by an NGO partner, will continue to maintain data for clients of the women and children's centres in a computer database. The purpose of this data collection is to assess changes in client behaviour and condition while passing through different stages of services (i.e. pre-treatment, admission, discharge, and follow-up).	A dedicated data centre in Kabul, operated by an NGO partner WADAN, remained active throughout the project's duration. It systematically collected and analysed client data across all service stages: pre-treatment, admission, discharge, and follow-up. It was financially supported through a dedicated centre within the project.
11 identified UTC courses are developed into online self-guided courses.	UTC Basic Series (Courses 1–8) and Advanced Courses UTC 16 & 22 were successfully developed into interactive, self-led online modules (UTC 16 and 22 available in English and Spanish). Hosted on platforms ISSUP Learning Hub and HealtheKnowledge.org.
16 online self-guided UTC courses are available in Dari language	Preliminary discussions and quotations were obtained from two translation agencies: • Khatiz Organization for Rehabilitation (Canada) • Ayamodine Kamaal Freelance Services (Germany) However, translation was not implemented due to the stop-work order and project termination.

Table 4: Progress made against the project's expected outcomes during the implementation period

4.3 PAYMENTS TO IPS

The five IPs supported by the project — ARC, ASP, OHSS, SSAWO, and WADAN have received payments from 01 October 2022 to 28 January 2025. These IP budgets are the main components of the overall project budget. Additionally, the remaining payments owed to the IPs, dating back to September 2022, were disbursed using project funds and termination costs for the IPs incurred in February 2025.

Initially, under the LoA countersigned on 23 September 2022, the project budget encompassed funding for the 24 DTCs ,1 data centre, and 15 new DTCs that were to be established in provinces where treatment services for men were lacking. These 15 DTCs were intended to be staffed by already-trained practitioners familiar with treatment systems and service delivery. However, in response to the uncertainties following the fall of the Afghan government in 2021, CPDAP, in consultation with the INL, decided to withhold support for the 15 DTCs. These centres were partly managed by the Ministry of Public Health of the DfA, and the political landscape in Afghanistan posed significant risks to the project's continued viability in that context.

Consequently, the project focused on supporting the 24 DTCs and 1 data centre and reallocated the funds that were previously designated for the 15 DTCs to support the 24 DTCs in order to ensure continued support for the existing facilities. This adjustment aligned with prior high-level discussions between CPDAP and INL, emphasizing a strategic shift to focus on operational facilities in light of the changing political environment. This decision was communicated to the former INL Director in 2020 and reaffirmed in multiple meetings, including discussions with INL officials in May 2022 and January 2023.

Each DTC and data centre budget incorporated various operational expenses, including staff salaries (clinical, non-clinical, and support), facility maintenance costs (vehicle fuel, generator fuel, rent, utilities, stationery, internet, etc.), and other necessary operational expenditures (food, medical supplies, hygiene materials, educational materials for clients). Similarly, the Data Centre budget included costs related to salaries for data collection officers, data analysts, guards, and other office-related operational expenses.

Agreements were signed with each respective IP, outlining specific budget provisions for each centre. Payments were transferred on a quarterly basis, either as advances or reimbursements. If an advance payment was made, subsequent payments reflected deductions for any unspent funds from the prior period. IPs submitted financial documents on a quarterly basis, providing detailed reports of expenses alongside supporting documents, receipts, rental agreements, and payroll data etc.

4.3.1 ROLE OF KUDOS (FORMERLY GRANT THORTON AFGHANISTAN)

Kudos was contracted to verify the financial reports submitted by the IPs, ensuring that the funds allocated to them were being utilized appropriately. Kudos' primary task was to provide assurance on the proper use of CPDAP funds by the IPs. Since 1 April 2022, Kudos has reviewed all financial documents submitted by the IPs and conducted a thorough examination based on the following standards.

- **International Standard on Related Services (ISRS) 4400**: Engagements to perform Agreed-upon Procedures regarding Financial Information, as promulgated by the International Federation of Accountants (IFAC).
- **Code of Ethics for Professional Accountants**: Issued by IFAC, ensuring compliance with ethical standards.

Although ISRS 4400 does not mandate independence for agreed-upon procedures engagements, Kudos adhered to the ethical standards outlined by IFAC and maintained independence per GTIL policies.

The review process involved applying procedures to the expenditures reported by the IPs in their quarterly financial reports. A sample of expenditures was selected based on the auditor's risk assessment and professional judgment. The expenditure verification covered the reported expenditures, with a detailed breakdown of each facility's expenses. Key tasks conducted during the verification included:

- Verifying the alignment of reported expenses with the agreements, approved budgets, and program implementation reports.
- Examining supporting documents, such as receipts, contracts, and timesheets.
- Engaging with IP staff or conducting on-site visits to clarify any questionable expenses.
- Tracking fund flows (advances and reimbursements) to determine the remaining balance with each IP.
- Recommending payment amounts (as either reimbursement or advance) based on the review findings.
- Offering further recommendations based on the analysis of IP financial documents.

The verification process included an analytical review, risk-based expenditure verification, and a check for compliance with budgeting rules, variances, and the accuracy of financial reports. A risk-based approach was employed to select the transactions for review, and variance analysis was conducted by comparing total expenditures with the approved budget.

Kudos ensured that all transactions were supported by adequate documentation and that the costs were consistent with the terms of the agreement. Furthermore, expenditures were cross-checked with IP policies to ensure that appropriate approvals and processes were followed.

4.4 PROFESSIONAL RETENTION AND STABILIZATION POST-2021

Following the political transition in Afghanistan in August 2021, the drug treatment sector faced unprecedented disruptions. These challenges particularly affected the retention of qualified professionals, operational continuity, and service delivery. Despite the turbulent environment, coordinated efforts by the CPDAP, NGO IPs and other key stakeholders helped maintain the treatment system and core services across Afghanistan.

1. Challenges in Retaining Skilled Addiction Treatment Professionals
    a. Loss of Trained Personnel: Many trained professionals, medical doctors, psychologists, counsellors, and outreach workers migrated or transitioned to other sectors or other countries due to heightened security risks, limited job security, and closure or downsizing of DTCs. The impact was particularly severe for female professionals, who faced mobility restrictions and increased societal pressures.

    b. Security and Operational Instability: The overall lack of safety and instability in the country deterred new professionals from entering the sector and created uncertainty for existing staff, especially in remote provinces.

2. Retention Efforts and Adaptations
    a. Continued Engagement through IPs: CPDAP, through its KFO and close collaboration with IPs, facilitated the renewal of contracts, ensured timely payments, and worked towards maintaining local-level operational continuity. This helped retain a majority of the core workforce, particularly in leadership and clinical roles of the DTCs.

3. System Stabilization
    a. Standardized Treatment Protocols: All active Treatment centres (DTCs and OPTCs) continued implementing internationally recognized protocols, including the UTC, UNODC screening tools, and other established clinical and psychosocial guidelines. This ensured continuity and quality of care, despite administrative changes in governance.

    b. Monitoring and Technical Supervision by CPDAP-KFO: The CPDAP Kabul Field Office played a critical role in maintaining program standards through routine monitoring, virtual supervision, and in-person site visits (where security permitted). Feedback loops with national and international partners helped ensure responsive adaptation and technical support.

    c. Community Engagement and Local Buy-In: Community-based support mechanisms including outreach to religious leaders, family members, and local elders strengthened protection for DTC staff and increased acceptance of services, especially for female clients and professionals.

    d. Despite the situation in Afghanistan, 24 DTCs (19 residential and 5 outpatient) remained operational with core staff retained. These centres continued to offer comprehensive services including detoxification, counselling, rehabilitation, aftercare, and outreach.

5. IN-PERSON AND VIRTUAL MONITORING VISITS

Monitoring visits, both virtual and in-person were integral to ensuring the quality, consistency, and accountability of all project-supported DTCs and OPTCs. These visits allowed CPDAP, in collaboration with national and international partners, to regularly assess service delivery, identify gaps, and provide timely feedback for improvements.

Monitoring visits were conducted with the aim to:

- Ensure the number of clients and staff aligns with the funding and service delivery requirements of the project.
- Confirm that all necessary data, records, and documentation are properly maintained and up to date.
- Verify that client files are complete, accurate, and reflect the client's journey through the treatment process.
- Assess that clients are receiving a full package of services, including clinical, psychological, social, medical, physical health, recreational, vocational, and referral services.
- Monitor the implementation of daily program activities to ensure adherence to approved schedules and treatment protocols.
- Evaluate the general safety and security of the facilities, including staff and client protection measures.
- Check for adherence to standard documentation and compliance with CPDAP-approved formats and protocols.
- Promote the assimilation of key lessons from previous visits into day-to-day clinical practice.

The monitoring process reviewed compliance with SOPs including:

- General SUD treatment delivery SOPs.
- Community outreach work protocols (for OPTCs).
- Detoxification protocols for opioids, codeine, and amphetamines.
- Mapping charts for treatment pathways.
- Infection prevention and control guidelines.
- Pharmacy management protocols.
- Psycho-social intervention protocols.
- Safety and security frameworks.

Given below is the monitoring visit check list when planning a monitoring mission.

Before Visit	During the Visit	After Visit
- Identifying goals and objectives of the mission. - Scheduling activities. - Prepare budget for the visit. - Coordination with the assigned partners (IOs, Freelancers) - Arrange transportation and other logistics. - Review of the last monitoring report available for the respective DTC.	- Ensure that correct protocols and guidelines are followed during the visit. - Conduct interviews with clients. - Conduct interviews with DTC staff. - Check on technical issues. - Personal observation of the DTC. - Collecting evidence for the services offered/lacking. - Check the progress of the recommendations from the previous visit.	- Preparing the draft mission report. - Circulate among the monitoring mission team members and DAP HQ. - Incorporate feedback and revise the report. - Share the finalized report. After the visit, continue to follow up with the DTC on, - Progress on recommendations. - Action plan for the changes/improvement of services in the monitored DTC.

Table 5: Monitoring visit check list

5.1 VIRTUAL MONITORING VISITS

Given below are descriptions of the virtual monitoring visits approach, tools used, frequency, and coverage during the project implementation period.

5.1.1 APPROACH AND TOOLS USED

After the COVID-19 pandemic and the complex security environment during the post-August 2021 scenario, virtual monitoring visits were introduced as an adaptive strategy to maintain program oversight to address the challenges of travel and security aspects. The approach leveraged readily available communication tools and focused on maintaining consistent engagement with DTC/OPTC staff and clients.

- Communication Tools: WhatsApp groups were established between joint monitoring team members and DTC coordinators to facilitate real-time communication. Google Meet was used for scheduled sessions, including team orientations, centre walkthroughs, and interviews.
- Client Selection Process: Each centre submitted a list of currently admitted clients to the monitoring team in advance via email. For each session, clients were randomly selected for file reviews, interviews, or case studies based on this list to ensure objectivity and representative sampling.

5.1.2 FREQUENCY AND COVERAGE

Virtual monitoring was carried out during the following periods to all DTCs/OPTCs:

- October – December 2022
- January – March 2023
- April – June 2023
- July – September 2023
- October – December 2023

This virtual monitoring approach was initially adopted during the outbreak of the COVID-19 pandemic and was later sustained due to ongoing mobility and security limitations across different provinces. Despite the challenges, virtual visits provided valuable oversight and maintained a consistent line of communication and support between CPDAP, IPs, and treatment centres.

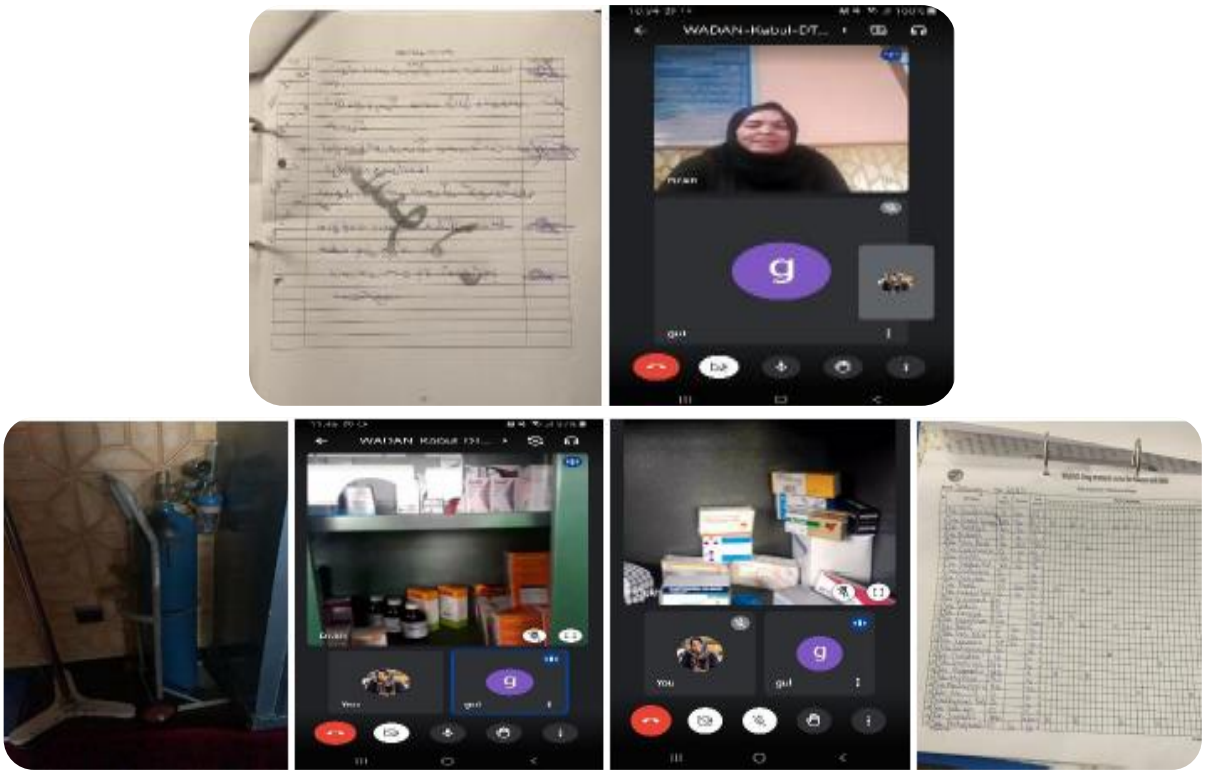

Figure 10: Images taken during virtual monitoring visit to WADAN 10-Bed Female Adolescent Centre in Kabul

Figure 11: Images taken during virtual monitoring visit to SSAWO 15-Bed Female Adolescent DTC in Balkh

5.2 IN-PERSON MONITORING VISITS

Following the virtual monitoring period, in-person monitoring visits resumed as part of the project's quality assurance framework. These missions continued in order to clearly assess the functionality, compliance, and quality of service delivery in reality across all active DTCs and OPTCs funded under the project.

A joint monitoring team comprising representatives from the KFO, UNODC, WHO, and local freelance DDR experts was formed to ensure impartiality, credibility, and technical rigor in the monitoring process.

5.2.1 APPROACH AND TOOLS USED

Each visit followed structured monitoring guidelines developed by CPDAP, covering both clinical and administrative components of service delivery. Tools used during monitoring visits included:

- Structured observation checklists
- Client file audits
- Staff and client interviews
- Facility walkthroughs and environmental assessments
- Headcounts and daily schedule verification.

Monitoring areas included:

- Staffing levels and qualifications (clinical and non-clinical)
- Intake and admission processes, including screening and assessment
- Treatment planning and delivery of psychosocial, clinical, and medical services
- Implementation of daily therapeutic and rehabilitative activities
- Health, safety, and infection control protocols
- Documentation and use of standardized protocols (e.g., detoxification, outreach, pharmacy management, psychosocial interventions)
- Use of training materials and integration of knowledge from previous CPDAP/UTC trainings.

After each monitoring visit, detailed reports were compiled for record-keeping and follow-up action.

5.2.2 FREQUENCY AND COVERAGE

The monitoring missions were carried out on quarterly basis per DTC, aiming for four (4) visits annually.

5.3 MONITORING VISIT FINDINGS BASED ON MISSION REPORTS (IN-PERSON AND VIRTUAL)

The primary purpose of a monitoring visit is to ensure that activities are implemented by DTCs as outlined in the project plan and the agreement between the CPDAP and IPs. These visits typically involve meetings with DTC staff and, and direct observation of centre operations and service delivery.

5.3.1 SUMMARY OF FINDINGS DURING MONITORING VISITS

IP	DTC	Date	Findings
SSAWO	50 Beds Female Adolescent Residential (Kabul)	30 October 2022	Treatment plan not based on assessment summary. Follow-ups need to be conducted as per the plan. Distinguish between individual and group counselling.
		22 May 2023	Record brief intervention for all clients. Improve narrative summary and prepare treatment plans based on it. Naloxone should be available in the centre. Use SOAP format. Distinguish between individual and group counselling.
		24 August 2023	Record brief intervention for all clients – No improvement. Use SOAP format – No improvement.
		27 November 2023	There's improvement in recording brief interventions and using SOAT format.
		06 February 2024	Quality of counselling sessions have improved. Distinguish between individual and group counselling has been sorted.
		19 September 2024	Clients have been referred for vocational training.
	15 Beds Female Adolescent Residential (Balkh)	29 November 2022	Need to improve formulating clinical notes, records. Ethical codes for professionals need to be available. Enough medication needs to be maintained to address client's detoxification and general health concerns. Vacant clinical staff positions.

IP	DTC	Date	Findings
SSAWO		25 January 2023	Record brief intervention for each client. Naloxone should be amiable in the centre. Use SOAP note format. Revise treatment plan once in the period of treatment.
		19 March 2023	Trained staff must apply lessons learnt from UTC training. Detailed treatment plans need to cover more points. Enough medicine is now available to address client's detoxification and general health concerns. Vacant clinical staff positions.
		18 June 2023	New staff hired. Improve motivational counselling as per UTC 4.
		28 September 2023	Brief intervention records should be done.
		25 December 2023	Brief intervention records should be done.
		19 September 2024	Brief interventions have been carried out. Not adequately and needs improvement using FRAMES.
	25 Beds Children Residential (Balkh)	29 November 2022	Staff should apply lessons learnt from UTC training to enhance clinical application. Needs descriptive treatment plans and record brief interventions. Enough medicine should be maintained for both detoxification and other general health concerns.
		19 March 2023	Brief interventions were recorded compared to last visit.
		18 June 2023	Conduct public awareness sessions. Increase no. of counselling sessions and record them in detailed.

IP	DTC	Date	Findings
		28 September 2023	Motivation counselling sessions were decreased. Other counselling sessions have been increased.
		25 December 2023	Assessment summary should be more detailed.
		21 September 2024	Detoxification summary needs to be reported.
	20 Beds Women Residential (Kabul)	29 November 2022	Treatment plans should include duration and time frame for each intervention to be made. Fill vacant positions (clinical staff). Counselling notes should be descriptive.
	30 Beds Women Residential (Balkh)	29 November 2022	Fill vacant positions (clinical staff). Treatment plans must be reviewed and recorded at mid-term of treatment for all clients.
		18 June 2023	Vacant positions have been filled. Conduct more on-job training sessions.
		28 September 2023	Brief interventions need to be recorded. Treatment plans must be reviewed and recorded at mid-term of treatment for all clients has been improved.
		19 September 2024	On-job training sessions for newly hired staff by former employees. Brief interventions have been carried our in-target areas. Not implemented adequately using FRAMES.
WADAN	30 Beds Children Residential (Kabul)	25 October 2022	Treatment plan formulation needs to be improved. Vacant positions need to be filled CHILD curriculum for staff recommended.

IP	DTC	Date	Findings
WADAN		29 January 2023	Improved treatment plan formulation could be seen. Vacant positions need to be filled
		28 May 2023	CHILD curriculum for staff recommended.
		23 August 2023	Improve individual counselling sessions and record them Vacant positions need to be filled.
		20 November 2023	Need to use motivational approach. Should organize support groups.
		23 January 2024	A refresher training required for newly hired staff.
		15 September 2024	A refresher training required for newly hired staff.
	20 Beds Women Residential (Kabul)	25 October 2022	Vacant positions need to be filled No vocational skills training for the client.
		29 January 2023	Content of individual counselling sessions need to be improved. No vocational skills training for the client.
		28 May 2023	Recruitments were done for vacant positions. Need space between bed frames. Each supervision session requires an action plan.
		23 August 2023	Content of individual counselling sessions need to be improved. Vacant positions need to be filled
		20 November 2023	Use structure of family counselling in UTC 4.
		23 January 2024	Staff need refresher training on counselling and use of ASSIST and ASI.

IP	DTC	Date	Findings
WADAN		15 September 2024	Treatment plan and narrative summary need to be based on assessment findings and comply with each other.
	10 Beds Female Adolescent Residential (Kabul)	25 October 2022	Improve recording of individual case files. Need detailed treatment plans based on assessment findings. Medicine list needs to be available and updated.
		29 January 2023	Staff needs CHILD training to improve service delivery. Counselling records must be in SOAP format. Clients should have access to recreational facilities. Vacant positions.
		28 May 2023	Staff have improved documentation by reviewing treatment plan in UTC 5. Centre must document every referral or case management activity. Vacant positions have been filled.
		23 August 2023	Improve recording of individual case files. Vacant positions have been filled.
		20 November 2023	Organize support groups.
		23 January 2024	Staff need refresher training on counselling and use of ASSIST and ASI.
		15 May 2024	Quality of counselling sessions should be enhanced.
		15 September 2024	Staff should apply lessons learnt from UTC training to improve treatment.
	Outpatient Centre (Kabul)	27 February 2023	Conduct sessions based on motivational interviewing. Update the organizational chart.
		21 June 2023	Quality of the content of counselling sessions should be highly improved. Ensure that fire extinguisher is functional.

IP	DTC	Date	Findings
WADAN		24 September 2023	No notable change on conducting sessions based on motivational interviewing. Quality of the content of counselling sessions should still needs improvement.
		15 December 2023	Brief intervention should be applied and recorded.
		17 January 2024	No notable change on conducting sessions based on motivational interviewing. Fire extinguisher has been fixed.
		14 May 2024	Centre is conducting sessions based on motivational interviewing.
		15 September 2024	Conducting sessions based on motivational interviewing have improved.
	20 Beds Women Residential (Farah)	30 November 2022	Need to improve counselling recordings in individual case files. Existing medicine list needs to be available and updated.
		27 March 2023	Fill vacant positions. Keep distance between client beds. Counselling recording of individual case files needs to be improved. Existing medicine list needs to be available and updated.
		22 June 2023	Use motivational approaches such as decision balancing and readiness. Treatment plan should be based on narrative summary.
		19 September 2023	Use SOAP format for individual counselling.
		19 December 2023	Use SOAP format for individual counselling.
		30 March 2024	ASSIST and ASI forms need to be filled properly. Medicine list needs to be available and updated.
		21 September 2024	ASSIST and ASI forms need to be filled properly.

IP	DTC	Date	Findings
WADAN	15 Beds Children Residential (Farah)	30 November 2022	Prepare action plan to assessment finding. A supervisor is not available to provide onsite supervision on clinical duties to treatment team. Existing medicine list needs to be available and updated. Ethical codes need to be available.
		27 March 2023	Fill vacant positions. Keep standard distance between client beds. Existing medicine list needs to be available and updated. Keep a copy of all protocols.
		22 June 2023	Use motivational approaches such as Decision Balancing and readiness. Keep a copy of all protocols.
		19 September 2023	Use SOAP format for individual counselling.
		19 December 2023	Use motivational approaches such as Decision Balancing and readiness.
		30 March 2024	ASI and ASSIST forms need to be filled properly. Medicine list should be available and updated.
		21 September 2024	Keep standard distance between client beds – done. Staff are using motivational approaches such as Decision Balancing and readiness. Medicine list is available and updated.
		28 November 2022	Brief intervention records should be maintained. Staff need UTC training.

IP	DTC	Date	Findings
WADAN	30 Beds Women Residential (Badakhshan)	21 December 2022	Record attendance and take notes on psycho education. Increase follow-up care program. Develop mapping for referral services. Keep a copy of protocols.
		27 May 2023	Still the techniques such READS, core counselling skills and Stephen-Rollnik`s ruler was not applied. Now the centre records attendance and takes notes on psycho education.
		26 August 2023	Techniques such READS, core counselling skills and Stephen-Rollnik`s ruler have been applied.
		25 November 2023	Need to write treatment plans more professionally. Need mid-term treatment review and documentation.
		16 September 2024	Treatment plan writing has improved. Need mid-term treatment review and documentation.
	10 Beds Female Adolescent Residential (Badakhshan)	28 November 2022	Treatment plan formulation needs to be improved. No of individual and group counselling sessions needs to be increased.
		21 December 2022	Clinical staff need to apply lessons learnt from UTC training to enhance clinical applications. Medicine list needs to be updated. Counselling notes need to be detailed.
		27 May 2023	Still clinical staff need to apply lessons learnt from Staff needs UTC training to enhance clinical applications.
		26 August 2023	Still summary not prepared as described in UTC 5.

IP	DTC	Date	Findings
WADAN		25 November 2023	Still summary not prepared as described in UTC 5. Treatment plan formulation needs to be improved.
		16 September 2024	Medicine list need to be updated.
	30 Beds Children Residential (Badakhshan)	28 November 2022	The motivational interviewing tool (readiness ruler) must be used and recorded. Children case filed need to organize and include necessary screening and assessment forms. CHILD curricula training recommended for staff.
		21 December 2022	Beds spacing should be increased. Medicine list needs to be updated. Ethical codes need to be available. Rooms need to be well-lighted.
		27 May 2023	Urgent client problems should be reflected in assessment summary and prioritized and selected as a goal. Still the techniques such READS, core counselling skills and Stephen-Rollnik`s ruler was not applied.
		25 November 2023	Case files should contain a detailed narrative summary to help formulate a therapeutic treatment plan. Lighting and ventilation of classrooms for children need to improve.
		17 September 2024	Ethical codes need to be made available.
	Outpatient Centre (Badakhshan)	22 December 2022	Follow-up on care programmes. Ethical codes need to be available.
		28 February 2023	Should conduct family counselling sessions. Increase outreach services. Kitchen condition should improve.

IP	DTC	Date	Findings
WADAN		24 June 2023	Develop organizational chart. Fill vacant positions. Increase follow-up care programmes.
		30 September 2023	Staff need UTC and CHILD training.
		14 December 2023	Aftercare service should include extensive counselling and support recovery issued.
		17 September 2024	Aftercare service should include extensive counselling and support recovery issued – needs more attempts. Staff have received UTC training.
	10 Beds Female Adolescent Residential (Nangarhar)	31 December 2022	Case files should include narrative reports. Psycho-education sessions should be conducted daily. Needs a detailed discharge plan with objectives to help follow-up with clients during post-treatment. Rooms, roof, walls need painting. CHILD curricula is recommended for the staff to improve service delivery.
		30 April 2023	Readiness Ruler Stephen Rollnick and Decisional Balancing should be recorded. Update organizational chart. ASSIST treatment plan should be based on narrative summary.
		25 July 2023	Revise treatment plan in the mid of treatment.
		21 October 2023	Revise treatment plan in the mid of treatment.
		04 March 2024	Revise treatment plan in the mid of treatment.
		19 September 2024	Revise treatment plan in the mid of treatment.

IP	DTC	Date	Findings
WADAN	25 Beds Women Residential (Nangarhar)	31 December 2022	Screening form ASSIST must be used for all clients, brief intervention for clients who obtained lowest score need to be recorded. Readiness Ruler Stephen Rollnick and Decisional Balancing should be recorded. Case files should include standard forms – screening, assessment, and narrative summary reports. Medical room should include suction machine and infirmary cot. Needs to produce detailed discharge plans.
		30 April 2023	Readiness Ruler Stephen Rollnick and Decisional Balancing should be recorded. Update organizational chart.
		25 July 2023	Revise treatment plan in the mid of treatment.
		21 October 2023	Prepare narrative summary based on assessment. Revise treatment plan in the mid of treatment.
		03 March 2024	Revise treatment plan in the mid of treatment.
		18 September 2024	Improvements in using UTC 4 motivational counselling. Revise treatment plan in the mid of treatment.
	25 Beds Children Residential (Nangarhar)	31 December 2022	Needs space between beds. Medicine list needs to be updated. Use SOAP format for individual counselling. Ethical codes should be available.
		30 April 2023	Counselling sessions need to be held based on goals identified in client's treatment plan. Increase distance between beds (at least 3 ft.).
		25 July 2023	Revise treatment plan in the mid of treatment.

IP	DTC	Date	Findings
		21 October 2023	Revise treatment plan in the mid of treatment.
		04 March 2024	Brief intervention records should be kept.
		19 September 2024	Brief intervention records should be kept.
ARC	25 Beds Women Residential (Herat)	21 December 2022	Some education sessions were recorded as counselling.
		19 April 2023	Improvement could be seen in recording education sessions. Improve service documents and they should be supervised by centre manager. Vocational skill training should be provided to clients. Staff needs UTC training.
		23 July 2023	Staff needs UTC training. Vocational skill training should be provided to clients.
		25 October 2023	Vocational skill training should be provided to clients.
		27 March 2024	ASI and ASSIST formed need to be properly filled. Centre coordinator needs to update protocols.
		17 September 2024	Staff needs UTC training.
	25 Beds Children Residential (Herat)	21 December 2022	Service documents were not supervised by the centre manager.
		19 April 2023	Directory/list of external resources must be prepared to facilitate case management process. UNODC database could be used for this purpose.

IP	DTC	Date	Findings
ARC		25 October 2023	Staff needs UTC, CHILD training to refresh their skills.
		26 March 2024	Staff needs UTC, CHILD training to refresh their skills.
		17 September 2024	Staff needs UTC, CHILD training to refresh their skills.
	Outpatient Centre (Herat)	21 December 2022	Protocols need to be properly documented.
		29 April 2023	Incorporate motivational interviewing. Newly hired staff need UTC training.
		24 July 2023	No. of educational and counselling sessions have increased. Staff need UTC training and CHILD training.
		28 October 2023	Motivational interview should be conducted and recorded well.
		27 March 2024	Newly hired staff need UTC training.
		19 September 2024	Newly hired staff need UTC training. Pharmacy management has improved.
	10 Beds Women Residential (Herat)	22 December 2022	Newly recruited clinical staff need UTC training. Some education sessions were recorded as counselling.
		29 April 2023	Goal selection in the treatment plan should be improved. Staff should conduct more counselling sessions to meet goals of treatment plans.
		19 July 2023	Goal selection in the treatment plan improved compared to last visit. No. of family and group sessions were increased.
		22 October 2023	The goal selection is still improper. Staff select similar goals for different clients.

IP	DTC	Date	Findings
ARC		26 March 2024	Goal selection in the treatment plan has been improved. Urine test was done only for morphine. Should test for multiple drugs. New staff need UTC training.
		18 September 2024	Staff are using ASSIST and include a scoring summary to determine the intervention. Urine tests for multiple drugs conducted.
	20 Beds Children Residential (Herat)	22 December 2022	Newly recruited clinical staff need UTC training.
		29 April 2023	Newly recruited clinical staff need UTC training.
		22 October 2023	Some education topics are recorded under counselling sessions.
		18 September 2024	Newly recruited clinical staff need UTC training.
ASP	Outpatient Centre (Kabul)	27 December 2022	Records related to the usage of Rollnick Ruler or Decisional balancing need to be visible in the motivational counselling notes. Referral sheets should be complete and dated. Individual counselling notes should include required details and present in a standard format. OPTC should have a detailed discharge plan. Vacant positions need to be filled.
		29 March 2023	UTC training for newly hired staff. Fill vacant positions. Public awareness sessions should be increased.
		25 June 2023	Naloxone should be purchased and available for emergency cases. Apply motivation techniques as in the UTC series: READS, FRAME, Readiness Ruler during sessions.

IP	DTC	Date	Findings
		21 September 2023	Readiness ruler and decision balancing were applied. Naloxone was purchased.
		16 January 2024	Apply motivation techniques as in the UTC series: READS, FRAME, Readiness Ruler during sessions. No plan to cascade internal training programmes.
		29 May 2024	Medicine should be sorted in alphabetical order. Apply motivation techniques as in the UTC series: READS, FRAME, Readiness Ruler during sessions.
		21 September 2024	UTC training required for newly hired staff.
OHSS	Outpatient Centre (Kabul)	29 October 2022	Needs a senior staff assigned on a supervisory role to monitor and provide onsite supervision on clinical duties to treatment team. Ethical code for addiction professionals available but not signed by. Medicine list needs to be updated.
		30 January 2023	Does not use SOAP format for counselling sessions. Use a discharge plan and conduct follow-up services.
		23 May 2023	Still does not use SOAP format for counselling sessions. Use a discharge plan and conduct follow-up services.
		22 August 2023	Increase no. of counselling sessions for clients with SUD at risk. Strongly require improvement in discharge plan and coordination for client post-treatment phase.
		26 November 2023	No. of counselling sessions and outreach visits need to be increased.
		26 March 2024	New staff need UTC training.
		16 September 2024	Referral and aftercare serviced need to increase.

Table 6: Summary of findings during monitoring visits

Key observations and analysis from monitoring visits findings

Common Issues Across Centres

The following themes consistently appear across multiple centres, indicating systemic challenges:

1. Documentation and Record-Keeping:

   - Many centres have documentation issues, such as incomplete or missing brief intervention records, narrative summaries, and treatment plans not aligned with assessments.
   - SOAP (Subjective, Objective, Assessment, Plan) format for counselling notes is frequently recommended, however, not consistently implemented.
   - Narrative summaries and treatment plans often lack detail or fail to incorporate assessment findings.
   - Brief interventions, a critical component of SUD treatment, are either not recorded or inadequately documented.

2. Staff Training and Capacity:

   - There is a recurring need for UTC and CHILD curriculum training for staff to improve clinical practices.
   - Newly hired staff frequently require refresher or initial training on motivational interviewing techniques (e.g., READS, FRAMES, Readiness Ruler, Decisional Balancing) and tools such as ASSIST and ASI.
   - Vacant clinical staff positions are a persistent issue, delaying service improvements.

3. Medication and Resource Management:

   - Many centres lack updated medicine lists or sufficient medication for detoxification and general health needs.
   - Naloxone, critical for opioid overdose reversal, is often unavailable or only recently acquired (e.g., SSAWO 50 Beds Female Adolescent Residential, Kabul; ASP Outpatient Centre, Kabul).
   - Ethical codes for professionals are frequently unavailable or not adhered.

4. Counselling Practices:

   - Ability to distinguish between individual and group counselling is a recurring issue, with centres often failing to clearly document or differentiate these sessions.
   - Motivational interviewing techniques (e.g., Readiness Ruler, Decisional Balancing) are underutilized.
   - Family and group counselling sessions are often insufficient or not structured properly.

5. Facility and Infrastructure Issues:

- Physical infrastructure issues include inadequate bed spacing, poor lighting, and lack of recreational facilities.
- Some centres lack functional fire extinguishers or proper kitchen conditions (e.g., WADAN Outpatient Centre, Kabul; Outpatient Centre, Badakhshan).

Progress and Improvements

Despite the challenges, some centres have shown improvements over time:

- Documentation:
  - SSAWO 50 Beds Female Adolescent Residential (Kabul) improved brief intervention recording and SOAP format use by November 2023.
  - SSAWO 15 Beds Female Adolescent Residential (Balkh) addressed medication shortages by March 2023 and filled vacant positions by June 2023.
  - WADAN 30 Beds Children Residential (Kabul) improved treatment plan formulation by January 2023.

- Counselling:
  - SSAWO 50 Beds Female Adolescent Residential (Kabul) resolved issues with distinguishing individual and group counselling by February 2024.
  - ARC 10 Beds Women Residential (Herat) improved goal selection in treatment plans by March 2024 and began conducting multi-drug urine tests by September 2024.
  - WADAN Outpatient Centre (Kabul) improved motivational interviewing by September 2024.

- Staffing:
  - Vacant positions were filled in several centres, such as SSAWO 30 Beds Women Residential (Balkh) and WADAN 10 Beds Female Adolescent Residential (Kabul) by mid-2023.

Persistent Challenges

Some issues persist through multiple visits, indicating slow progress or systemic barriers:

- Brief Interventions: Centres like SSAWO 15 Beds Female Adolescent Residential (Balkh) and 30 Beds Women Residential (Badakhshan) still struggle with adequately recording brief interventions, even after multiple recommendations.
- SOAP Format: Despite repeated recommendations, centres like OHSS Outpatient Centre (Kabul) and 15 Beds Children Residential (Farah) fail to consistently use SOAP format.
- Staff Training: The need for UTC and CHILD training remains a recurring issue, many centres still requiring training as of September 2024.

- Mid-Term Treatment Plan Reviews: Centres like 10 Beds Female Adolescent Residential (Nangarhar) and 25 Beds Women Residential (Nangarhar) repeatedly fail to revise treatment plans mid-term, despite recommendations spanning multiple visits.
- Aftercare and Follow-Up: Aftercare services and follow-up programs are consistently underdeveloped, as seen in WADAN Outpatient Centre (Badakhshan) and OHSS Outpatient Centre (Kabul).

5.3.2 RECOMMENDATIONS FOR IMPROVEMENT

Based on the initial analysis, the following recommendations could address the issues:

- Training Programs for Clinical Staff: Implement mandatory such as regular UTC and CHILD training for all staff, with refresher courses for employees.
- Improved Documentation Systems: Introduce standardized templates for SOAP format, brief interventions, and treatment plans to ensure compliance.
- Resource Allocation: Ensure consistent availability of medicine (Naloxone etc.) and other essential medications across all centres. Maintain updated necessary medicine lists and ethical codes, with regular audits to verify compliance.
- Staff Recruitment and Retention: Develop a strategy to fill vacant positions promptly and retain trained staff to reduce turnover. Assign senior staff to supervisory roles to provide ongoing clinical oversight.
- Enhanced Counselling Practices: Train staff on distinguishing between individual and group counselling and properly recording sessions. Emphasize motivational interviewing techniques (e.g., READS, FRAMES, Readiness Ruler) through practical workshops.
- Aftercare and Follow-Up: Develop structured aftercare programs, including detailed discharge plans and follow-up services. Increase public awareness and outreach to support post-treatment recovery.
- Infrastructure Improvements: Address physical infrastructure issues like bed spacing, lighting, and fire safety equipment. Provide vocational and recreational facilities to enhance client engagement and recovery.
  Monitoring Visits' summary report is included in **Annex 03.**

Figure 12: In-person Monitoring Visit to ASP OPTC in Kabul

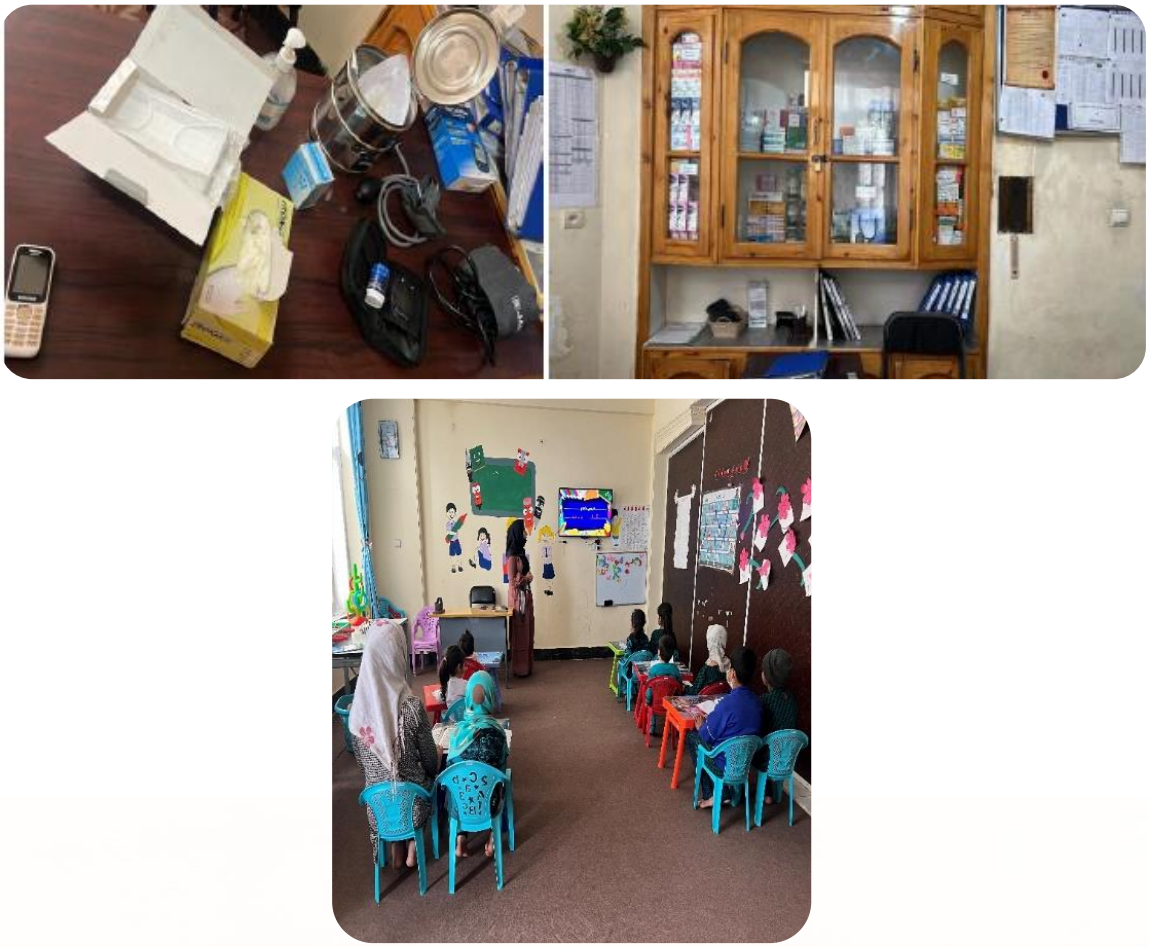

Figure 13: Images taken during In-person Monitoring Visit to ARC 20-Bed DTC in Herat

6. DTC DATA COLLECTION AND ANALYSIS

6.1 OVERVIEW

This section discusses the progress made under key reporting indicators for the DTCs during project implementation period. To facilitate clarity, data has been categorized into four-month reporting periods. In this section, we highlight the overall progress of these indicators, with more detailed data provided in the relevant subsections. **This section is based solely on the data included in the progress reports submitted by the IPs**.

During the project implementation period, a total of **5,530 residential admissions** were recorded across the residential treatment centres, of which **4,914 were new residential admissions**, directly benefitting from the project.

In addition, there were **486 home-based admissions** and **21,310 individuals screened and assessed** through youth outpatient services.

The project also supported a strong recovery network, with **13,648 received after care support**, demonstrating its wide-reaching impact in treatment, and recovery support.

6.1.1 TOTAL RESIDENTIAL ADMISSIONS

The total trend in residential admissions for treatment services has been tracked since 01 October 2022 across the reporting periods. These services are delivered through 19 residential treatment centres, which are detailed in Section 2.6: Treatment Centres supported by the project.

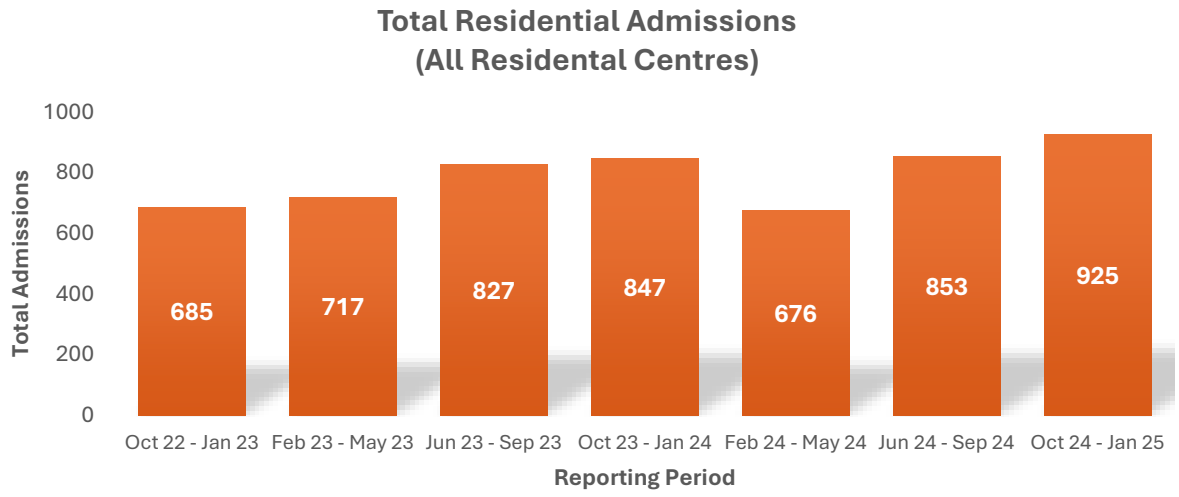

Figure 14: Total Residential Admissions by 4-month period

The total number of residential admissions across all treatment centres has experienced a consistent upward trajectory from October 2022 to January 2025 except for February 2024 – May 2024 reporting period. However, the increase indicates a growing reliance on residential treatment services, reflecting the success of the centres in meeting demand and the potential improvement of service offerings over time.

6.1.2 TOTAL HOME-BASED PROGRAM ADMISSIONS

Home-based services have been an integral part of the treatment services and are provided by several WADAN centres located in different regions: WADAN – Nangarhar, WADAN – Farah, WADAN – Badakhshan, and WADAN – Kabul.

These services aim to deliver effective treatment and support directly to clients in their home environments.

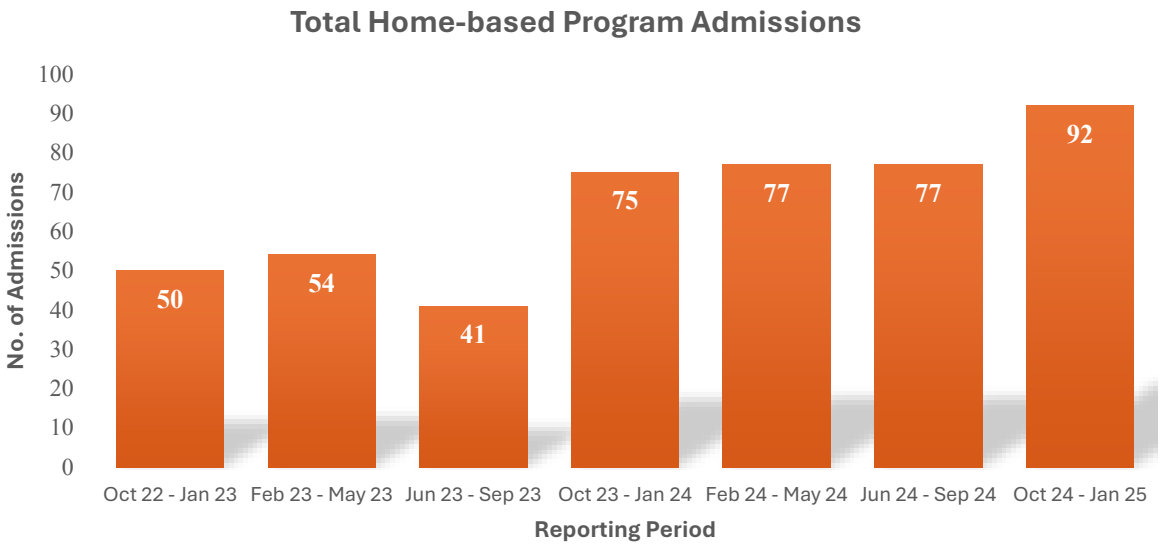

Figure 15: Total home-base programme admissions by 4-monthe period

The admissions for home-based services have been more variable, however, also showed a general upward trend. In the first period (Oct 22 - Jan 23), there were 50 admissions, and this number gradually increased to 54 by Feb 23 - May 23. However, it declined to 41 during Jun 23 - Sep 23, likely due to external factors or shifts in demand. From then on, the number began to rise again, reaching 92 by the period Oct 24 - Jan 25. The home-based services provided by centres like WADAN in various regions (Nangarhar, Farah, Badakhshan, and Kabul) indicate adaptability in catering to a wider range of clients, with a significant boost in the last reporting period.

6.1.3 YOUTH OUTPATIENT: NUMBER OF CLIENTS SCREENED AND ASSESSED

Youth outpatient services are offered by five centres: WADAN – Badakhshan, WADAN – Kabul, ARC – Herat, OHSS – Kabul, and ASP – Kabul.

Given is the number of clients screened and assessed by all centres for each reporting period:

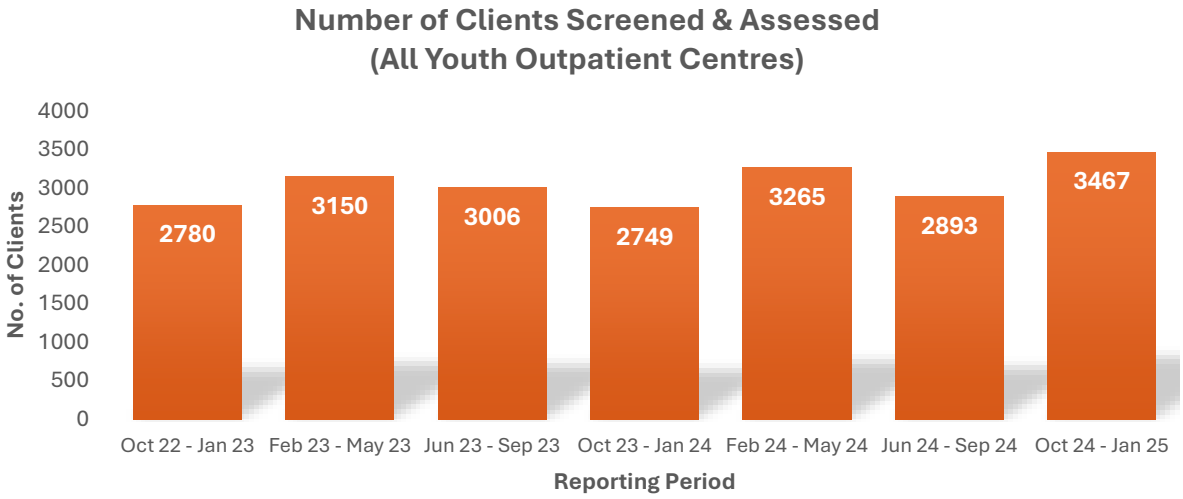

Figure 16: No. of clients screened & assessed at outpatient centres by 4-month periods

The data for youth outpatient services shows significant fluctuation in the number of clients screened and assessed. Starting with 2780 clients screened and assessed in the first period (Oct 22 - Jan 23), the number increased to 3150 in Feb 23 - May 23.

However, there was a slight decline in Jun 23 - Sep 23 (3006 clients). This fluctuation could be due to a variety of factors such as changes in outreach or seasonal factors affecting demand. The figures rose again in Feb 24 - May 24, reaching 3265 clients, before slightly dropping to 2893 in Jun 24 - Sep 24. The last period (Oct 24 - Jan 25) shows a significant rise to 3467 clients, indicating a surge in demand for outpatient screening and assessments as the project evolves.

Overall, the data demonstrates a positive trend in service provision across various treatment and outreach areas, with home-based services and youth outpatient services showing fluctuating, however, generally upward trends, and residential admissions continuing to rise steadily.

6.2 RESIDENTIAL TREATMENT SERVICES

Residential treatment centres primarily offer inpatient services. Nineteen (19) residential treatment centres had been supported under this project, managed by three (3) Implementation Partners (IPs), as detailed in Section **2.6: Treatment Centres supported by the project.**

These treatment centres cater to specific demographics based on gender and age. There are seven (7) centres for adult females, seven (7) centres for children, and five (5) centres for adolescent females.

The classification is as follows:

- **Children**: Ages 4–7 years
- **Adolescent Females**: Ages 8–17 years
- **Adult Females**: Ages 18 years and above

Total Residential Admissions encompasses both new admissions and re-admissions. New admissions refer to individuals who have been admitted to a residential treatment centre for the first time, while re-admissions are clients who have previously been treated at any centre for drug addiction and are now seeking treatment again.

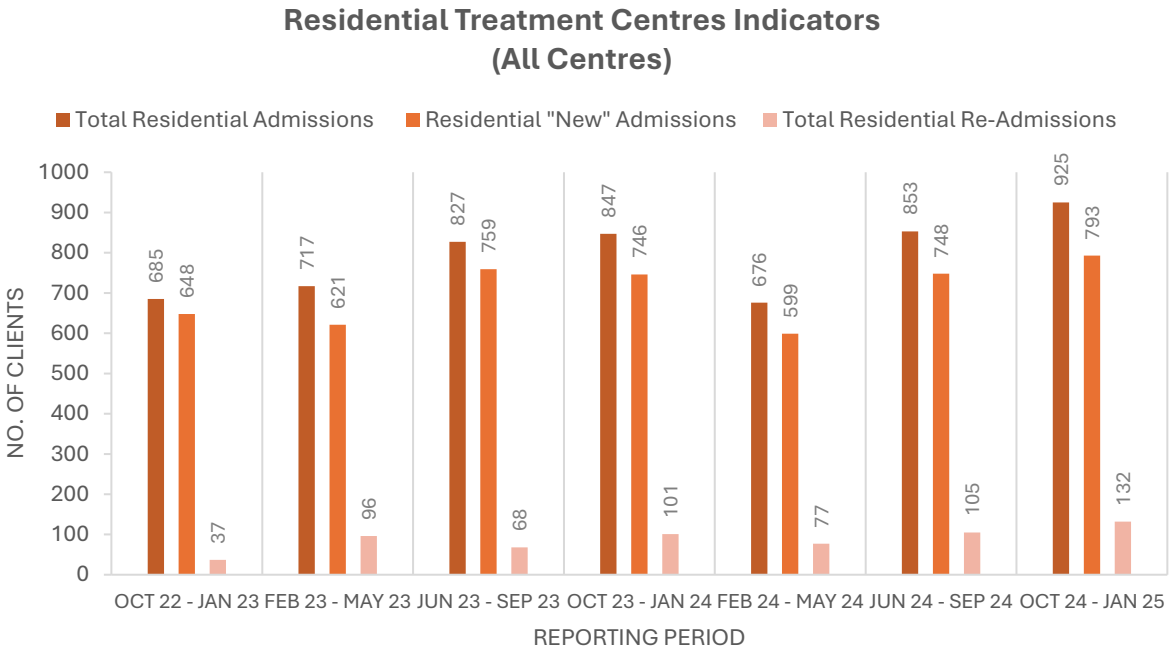

Figure 17: Residential treatment centre major indications by 4-month period

The data for residential treatment admissions reveals a consistent trend in both new admissions and re-admissions over the project period from October 2022 to January 2025. The total number of residential admissions has steadily increased, from 685 in the Oct 22 - Jan 23 period to 925 in the Oct 24 - Jan 25 period. This overall growth is primarily driven by the increase in new admissions, which started at 648 in Oct 22 - Jan 23 and rose to 793 in Oct 24 - Jan 25. However, there has been variability in the number of re-admissions, which fluctuated from 37 in Oct 22 - Jan 23 to a peak of 132 in Oct 24 - Jan 25. The data shows a general increase in both new admissions and re-admissions, highlighting a growing demand for residential treatment services throughout the project period.

A graph below illustrates the demographic breakdown of the patient population across these residential treatment centres during the project period. This breakdown highlights the distribution of patients by age and gender, providing insights into the primary groups served.

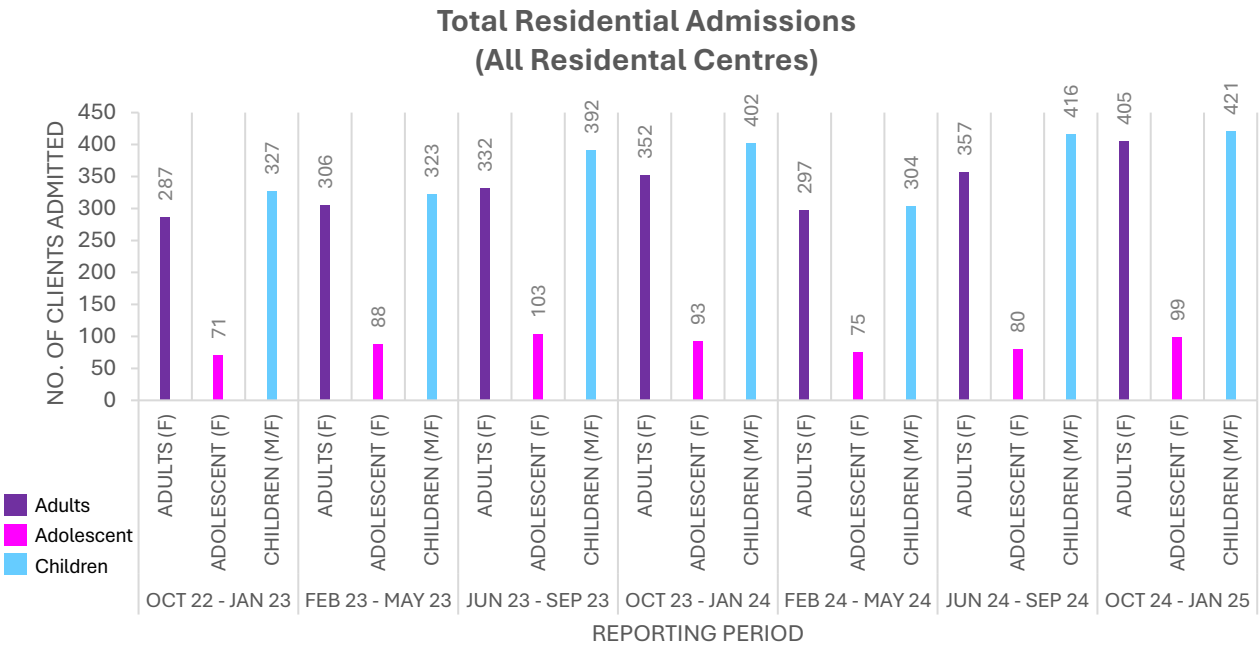

Figure 18: Total residential admissions across all residential DTCs by 4-month reporting period

The data provided shows a detailed demographic breakdown of total residential admissions at all residential centres across the project period. The admissions are segmented by age and gender for three distinct groups: Adults (Female), Adolescent Females, and Children (Male and Female).

In the Oct 22 - Jan 23 period, the total number of admissions was distributed as follows: 287 adult females, 71 adolescent females, and 327 children (male and female). As we move to the Feb 23 - May 23 period, adult female admissions slightly increased to 306, adolescent female admissions rose to 88, and children admissions remained relatively stable at 323. In the Jun 23 - Sep 23 period, the numbers again show an increase, with adult female admissions reaching 332, adolescent females at 103, and children at 392.

The Oct 23 - Jan 24 period shows further increases across all groups: adult females at 352, adolescent females at 93, and children at 402. In the Feb 24 - May 24 period, the trend continues, albeit with a slight drop in adolescent female admissions (75), and a decrease in adult female admissions to 297, while children admissions increased to 416. The Jun 24 - Sep 24 period saw another rise, with adult females at 304, adolescent females at 357, and children at 416, maintaining a consistent high for children. Finally, in the Oct 24 - Jan 25 period, the total admissions peaked with 405 adult females, 99 adolescent females, and 421 children, marking a significant increase in all groups, particularly for children.

This data illustrates a general upward trend in admissions over the project periods, particularly for children, while adult female and adolescent female admissions have fluctuated slightly over time. This suggests an increasing demand for residential treatment services across all demographic groups, with children showing the highest growth in admissions.

Next, a chart summarises the demand and capacity trends of the residential treatment centres throughout the project period. The Total Demand is calculated as the sum of the total number served plus any clients on the waiting list, while the Total Demand Met is calculated as the ratio of Total Number Served to Total Demand.

$$Total\ demand\ met = \frac{Total\ Number\ Served}{Total\ Demand}$$

Equation 1: Calculation for "Total demand met" at DTCs

$$Total\ Demand = Total\ Number\ Served + Clients\ on\ Waiting\ List$$

Equation 2: Calculation for "Total Demand" at DTCs

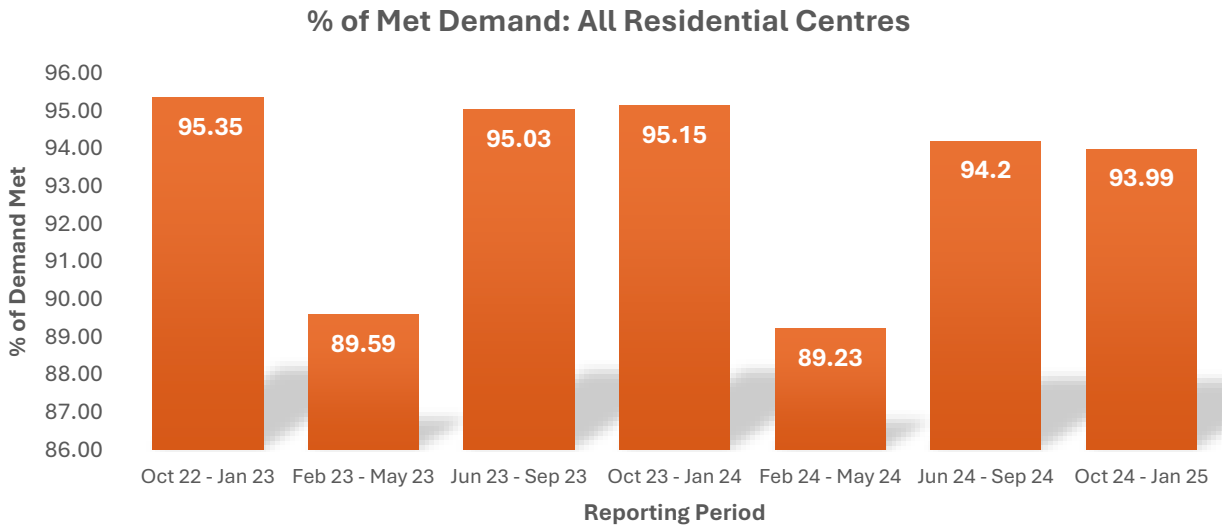

Figure 19: % of Demand Met across all residential centres by 4-month reporting period

To evaluate the performance of each individual residential treatment centre, the following metric is considered: *Percentage of Demand Met*. This percentage provides insights into how effectively each centre is meeting the treatment needs of its designated client group.

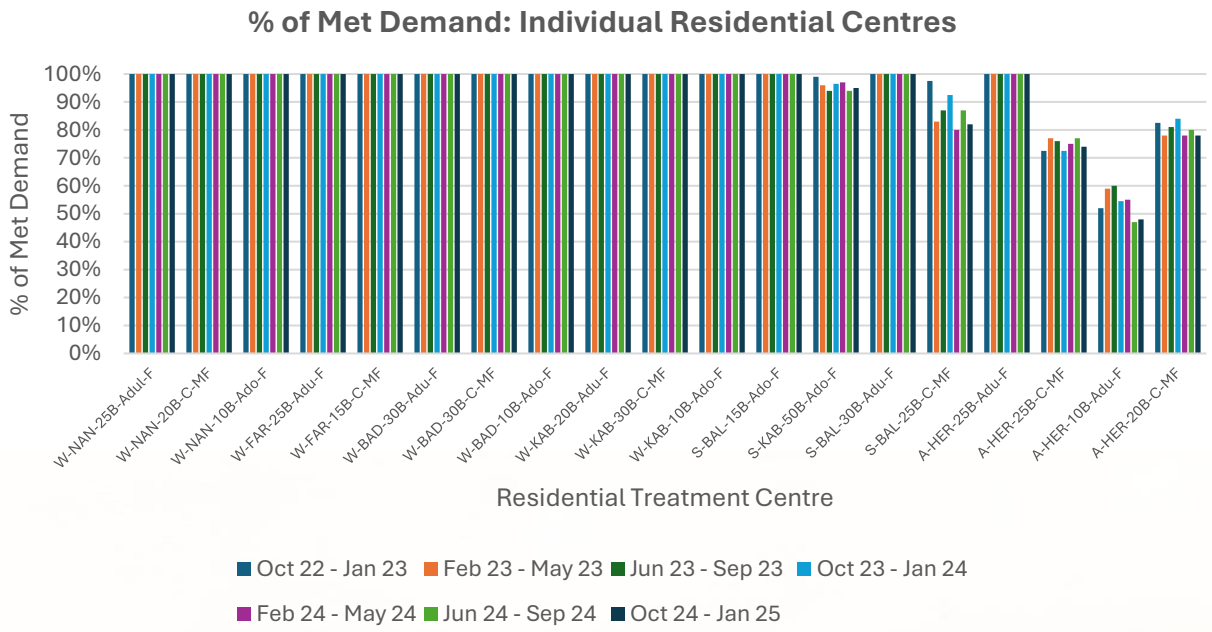

Figure 20: % of Demand Met of each individual residential centre by 4-month reporting period

Key:

W=WADAN, S=SSAWO, A=ARC

NAN = Nangarhar, FAR = Farah, BAD = Badakhshan, KAB = Kabul, BAL = Balkh,

HER = Herat

Adu = Adult, C = Child, Ado = Adolescent

F = Female only, MF = Male and Female

6.3 HOME-BASED TREATMENT SERVICES

Home-based treatment services have been offered by the WADAN treatment centres in Nangarhar, Farah, and Kabul. Home-based treatment programmes target clients with less severity drug use problems. These programmes provide enhanced motivation to exit substance use compared to residential treatment programmes which focus on more chronic and severe clients. During the project period, home-based treatment programs only provided services to adult female clients.

The following bar chart demonstrates total home-based new admission trends covering all home-based treatment programs:

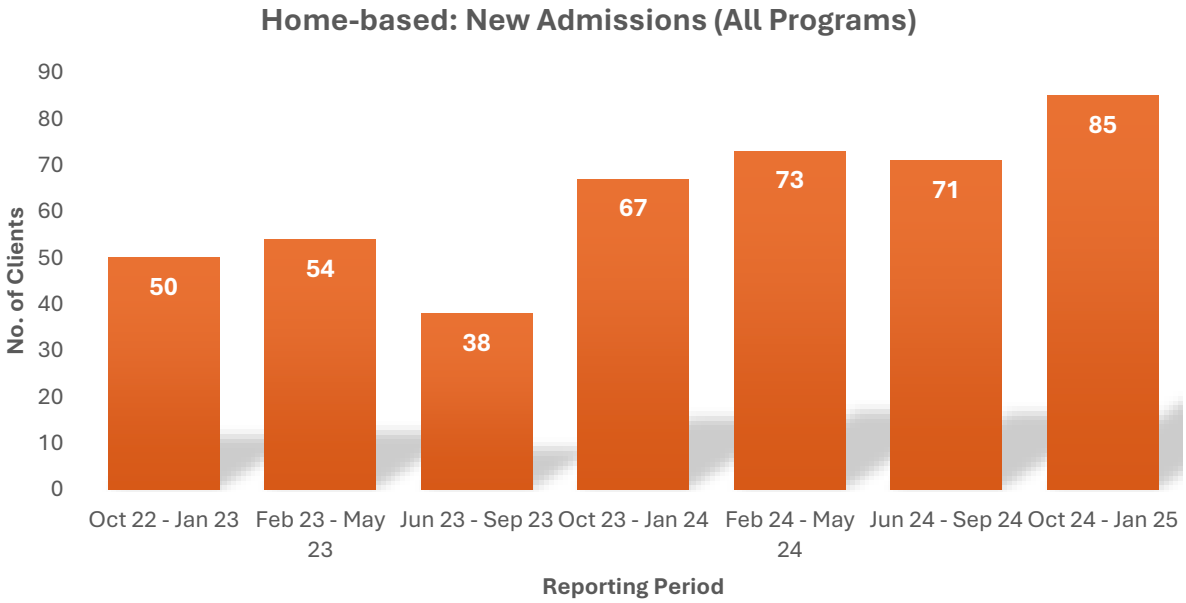

Figure 21: Home-based new admissions by 4-month reporting period

Starting with 50 new admissions in the Oct 22 - Jan 23 period, the number rose slightly to 54 in Feb 23 - May 23. However, during the Jun 23 - Sep 23 period, there was a decrease to 38 new admissions. The trend reversed in the following periods, with a significant increase in new admissions to 67 in the Oct 23 - Jan 24 period, followed by 73 in Feb 24 - May 24. The numbers slightly vary in the Jun 24 - Sep 24 period, with 71 new admissions, and peaked at 85 new admissions in the Oct 24 - Jan 25 period.

The total number of home visits for each reporting period:

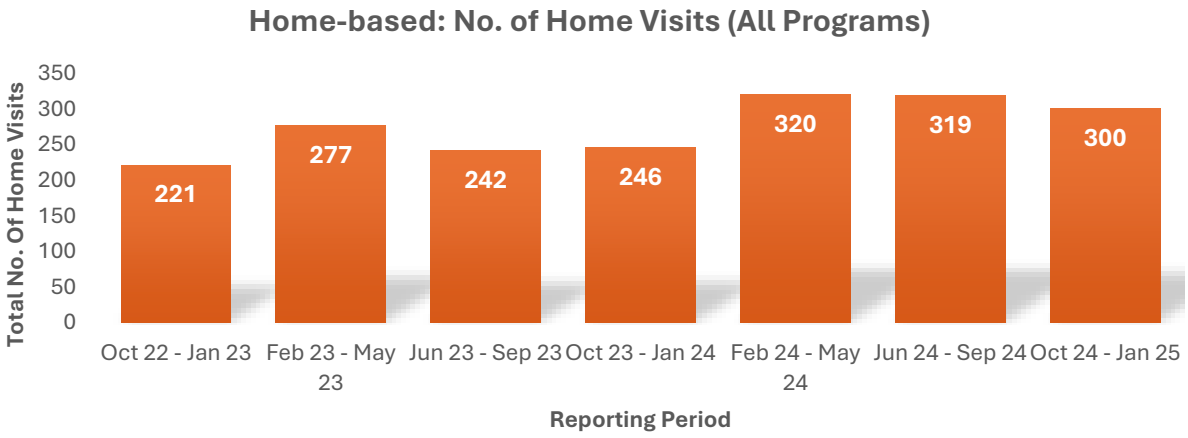

Figure 22: Home-based no. of home visits by 4-month reporting period

The data for home-based services shows the total number of home visits conducted during each reporting period from October 2022 to January 2025. Initially, in the Oct 22 - Jan 23 period, there were 221 home visits. This number increased in the following period (Feb 23 - May 23) to 277, indicating a higher level of service engagement. In Jun 23 - Sep 23, the number of home visits slightly decreased to 242. However, this decline was short-lived, and the Oct 23 - Jan 24 period saw a rise back to 246 home visits. The numbers peaked in Feb 24 - May 24 with 320 home visits, continuing to remain high in the following periods with 319 home visits in Jun 24 - Sep 24 and 300 in the Oct 24 - Jan 25 period. This trend suggests a continued and growing demand for home-based services, reflecting an increase in outreach and the overall success of the program.

Given below is the percentage (%) met demand of each program. The % of met demand has been calculated using the same formula used for the residential centres.

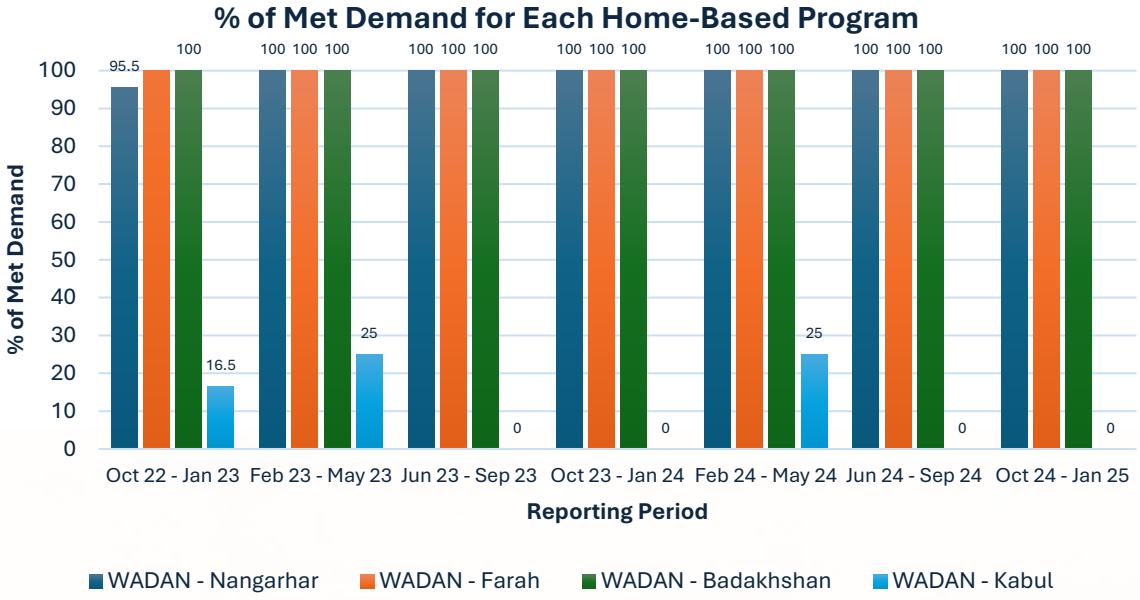

Figure 23: % Demand met of home-based programs by 4-month reporting periods

The data shows the percentage of demand met for home-based services by various WADAN centres across the reporting period.

- **WADAN - Nangarhar** consistently met nearly 100% of demand across all periods, starting from 95.5% in Oct 22 - Jan 23 and increasing to 100% for all subsequent periods. This indicates the centre's reliable capacity to meet demand over time.

- **WADAN - Farah** also showed significant improvement, with a marked increase from 100% in Oct 22 - Jan 23 to 100% for all subsequent periods.

- **WADAN - Badakhshan** consistently met 100% of demand in every period, showing stable and reliable service delivery across all reporting periods.

- **WADAN - Kabul** faced some challenges in meeting demand for home-based services. The centre only met 16.5% of demand in Oct 22 - Jan 23 and 25% in Feb 23 - May 23, with a significant drop to 0% in Jun 23 - Sep 23 and Oct 23 - Jan 24. However, there was a slight recovery, with 25% of demand met in Feb 24 - May 24 and 0% again in the following periods.

These variations in the percentage of demand met, particularly in WADAN - Kabul, may suggest potential issues with resource allocation, outreach capacity, or other operational challenges that hindered service delivery during certain periods, while other centres managed to meet the demand consistently.

6.4 OUTPATIENT TREATMENT SERVICES FOR YOUTH

Outpatient Treatment Programs for Youth (OPTC) have been established as an integrated approach to drug treatment, aiming to engage the community actively in both planning and implementation. The goal is to ensure the positive impact of community-based rehabilitation, making treatment more accessible and relevant to the local population. These services target the youth population, specifically males and females aged 15–24 years. Currently, OPTC services are offered by four IPs, which are focused on youth treatment, as follows:

- WADAN – Badakhshan and Kabul
- ARC – Herat
- OHSS – Kabul
- ASP – Kabul

The total number of clients screened and assessed:

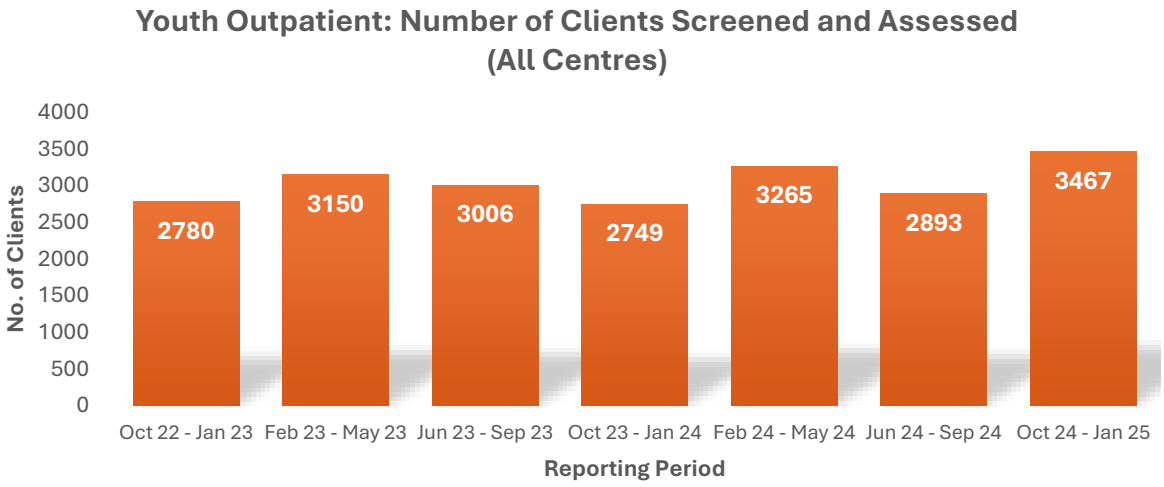

Figure 24: No. of clients screened and assessed at youth outpatient centres by 4-month reporting period

The number of clients screened and assessed began at 2,780 in the Oct 22 - Jan 23 period, reflecting initial outreach and assessment efforts at the beginning of the project. This number increased to 3,150 in Feb 23 - May 23, showing a significant rise in demand for youth outpatient services. However, in the Jun 23 - Sep 23 period, the number slightly decreased to 3,006, possibly due to external factors or fluctuations in demand. The number further decreased in Oct 23 - Jan 24, with 2,749 clients screened and assessed. In Feb 24 - May 24, the trend reversed, and the number reached a peak of 3,265, indicating an increase in outreach accessibility. The number remained high in Jun 24 - Sep 24 at 2,893, before reaching 3,467 in Oct 24 - Jan 25, marking the highest recorded number of youth clients screened and assessed during the project period. This upward trend, particularly in the later periods, reflects an increasing engagement with the youth population, due to growing awareness and availability of outpatient services.

The total number of clients registered as drug users:

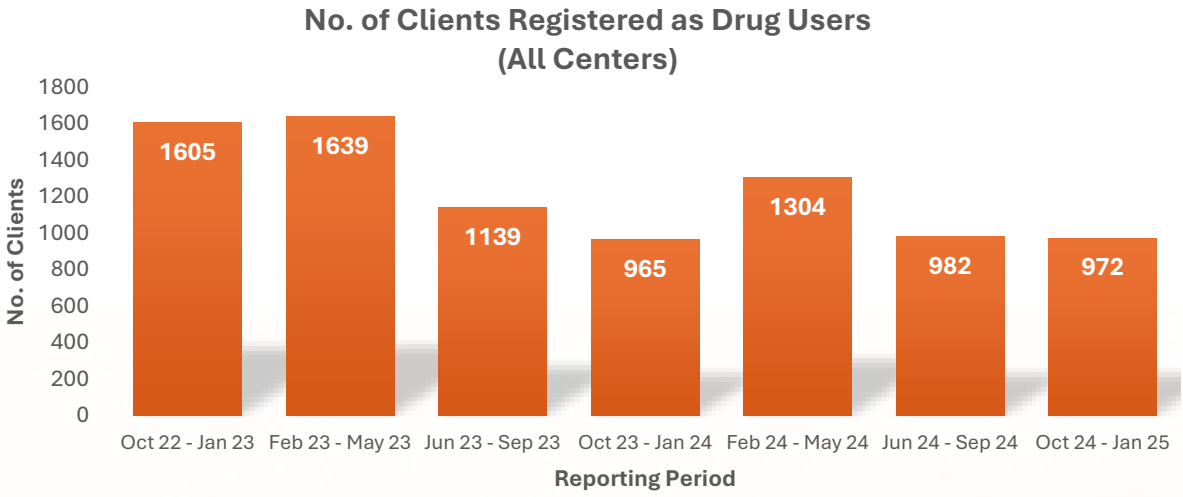

Figure 25: No. of clients registered as drug users at outpatient centres by 4-month reporting period

The initial period, Oct 22 - Jan 23, saw 1,605 youth clients registered. This number slightly increased to 1,639 in Feb 23 - May 23. However, in the following period, Jun 23 - Sep 23, the number dropped to 1,139, possibly indicating a fluctuation in demand or outreach efforts. This trend continued in Oct 23 - Jan 24, with the number further decreasing to 965. The data then shows a rebound in Feb 24 - May 24, with 1,304 youth clients registered, highlighting an uptick in outreach or an increase in the number of youths in need of drug treatment services. The number stabilized at 982 in Jun 24 - Sep 24 and remained relatively steady at 972 in Oct 24 - Jan 25.

Number of clients registered as drug users by each DTC:

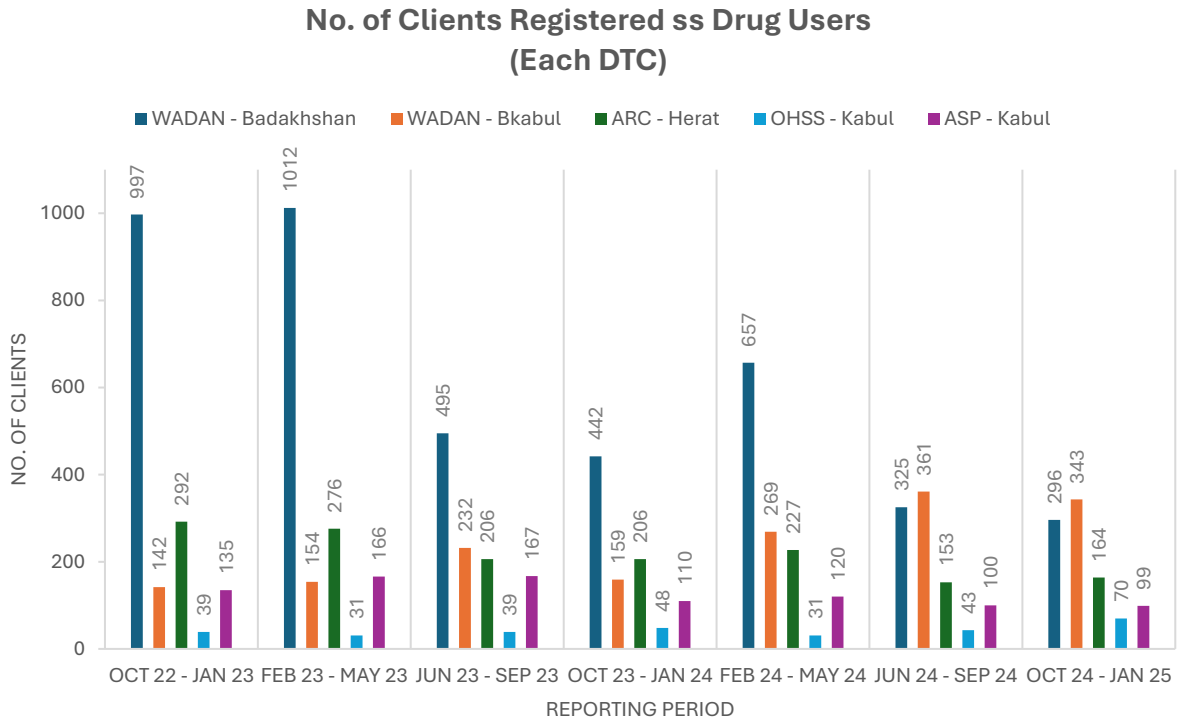

Figure 26: No. of clients registered as drug users by each outpatient centre by 4-month reporting period

- **WADAN - Badakhshan** showed the highest number of registrations, starting with 997 clients in Oct 22 - Jan 23 and rising to 1,012 in Feb 23 - May 23. However, the number decreased significantly in the following periods, with 495 in Jun 23 - Sep 23, 442 in Oct 23 - Jan 24, and 325 in Oct 24 - Jan 25, reflecting a downward trend over time.

- **WADAN - Kabul** had a much smaller number of registrations compared to Badakhshan, however, still experienced fluctuations. It started with 142 in Oct 22 - Jan 23 and grew to 154 in Feb 23 - May 23, before increasing to 232 in Jun 23 - Sep 23. The number continued to rise, reaching 269 in Feb 24 - May 24, and further increasing to 343 by Oct 24 - Jan 25, showing consistent growth in registrations.

- **ARC - Herat** initially had 292 clients in Oct 22 - Jan 23, which decreased to 276 in Feb 23 - May 23. It continued to decline to 206 in Jun 23 - Sep 23 and remained stable at 206 in Oct 23 - Jan 24. A further decline occurred in Jun 24 - Sep 24, with only 153 clients, before slightly increasing to 164 in Oct 24 - Jan 25.

- **OHSS - Kabul** had the smallest number of clients registered, starting with 39 in Oct 22 - Jan 23. The numbers fluctuated slightly with 31 in Feb 23 - May 23 and 39 in Jun 23 - Sep 23. Afterward, it reached 48 in Oct 23 - Jan 24, then decreased again to 31 in Feb 24 - May 24, and later grew to 70 in Oct 24 - Jan 25.

- **ASP - Kabul** showed relatively stable registrations. It began with 135 clients in Oct 22 - Jan 23, rising slightly to 166 in Feb 23 - May 23 and 167 in Jun 23 - Sep 23. However, the number decreased to 110 in Oct 23 - Jan 24 and remained low at 99 by Oct 24 - Jan 25.

This data highlights varied trends across the centres, with some showing growth in the number of clients registered over time (particularly WADAN - Kabul) while others, like WADAN - Badakhshan and ARC - Herat, saw a decrease in registrations.

6.5 POST TREATMENT SERVICES

Upon receiving treatment at a treatment facility, post-care will be provided to clients. The post-treatment care services involve screenings for STI/ HIV and Hepatitis, recovery groups, referrals to hospitals and providing vocational training. Post-treatment care services were offered by all 24 DTCs.

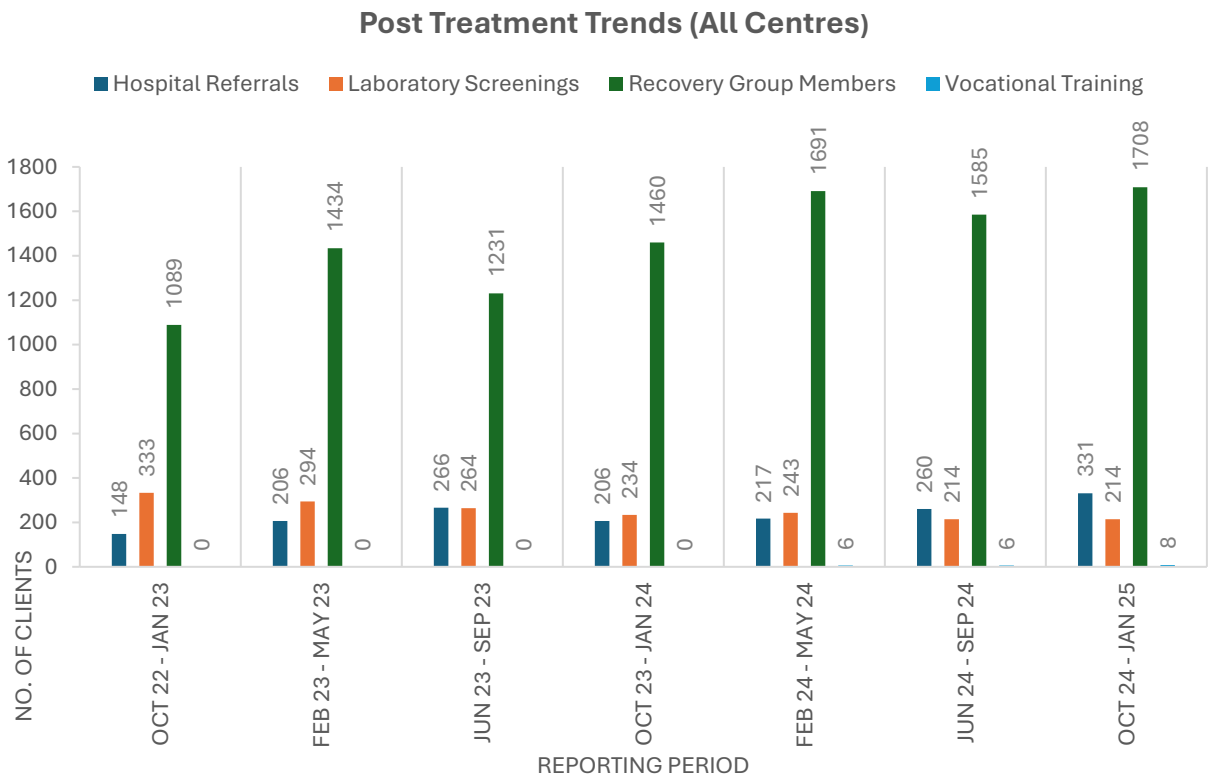

Figure 27: Progress of different post treatment indicator trends by 4-month reporting period

The data for post-treatment services reveals trends across several key service categories from October 2022 to January 2025, including hospital referrals, laboratory screenings, recovery group members, and vocational training.

- **Hospital Referrals**: This service has shown a steady increase over time, starting with 148 referrals in Oct 22 - Jan 23 and rising to 331 in Oct 24 - Jan 25. There was a consistent upward trend in each reporting period, reflecting the growing need for post-treatment medical support and follow-up.

- **Laboratory Screenings**: Initially, laboratory screenings were high at 333 in Oct 22 - Jan 23, however, the number decreased gradually, reaching 214 by Oct 24 - Jan 25. The data indicates a steady reduction in laboratory screenings over time.

- **Recovery Group Members**: There was a significant increase in the number of recovery group members, from 1,089 in Oct 22 - Jan 23 to 1,708 in Oct 24 - Jan 25. The figures show a general upward trend, indicating that more individuals are engaging in group support as part of their recovery process. This rise highlights the success and expansion of group recovery initiatives.

- **Vocational Training**: Vocational training services were initially not provided. However, these services resumed in Feb 24 - May 24, with 6 participants, growing slightly to 8 participants by Oct 24 - Jan 25. The number of participants is relatively low.

Each post-treatment service centre treats a certain gender base and age demographic. The following diagram reviews the demographic breakdown of the patient population of post-treatment services.

Hospital Referrals:

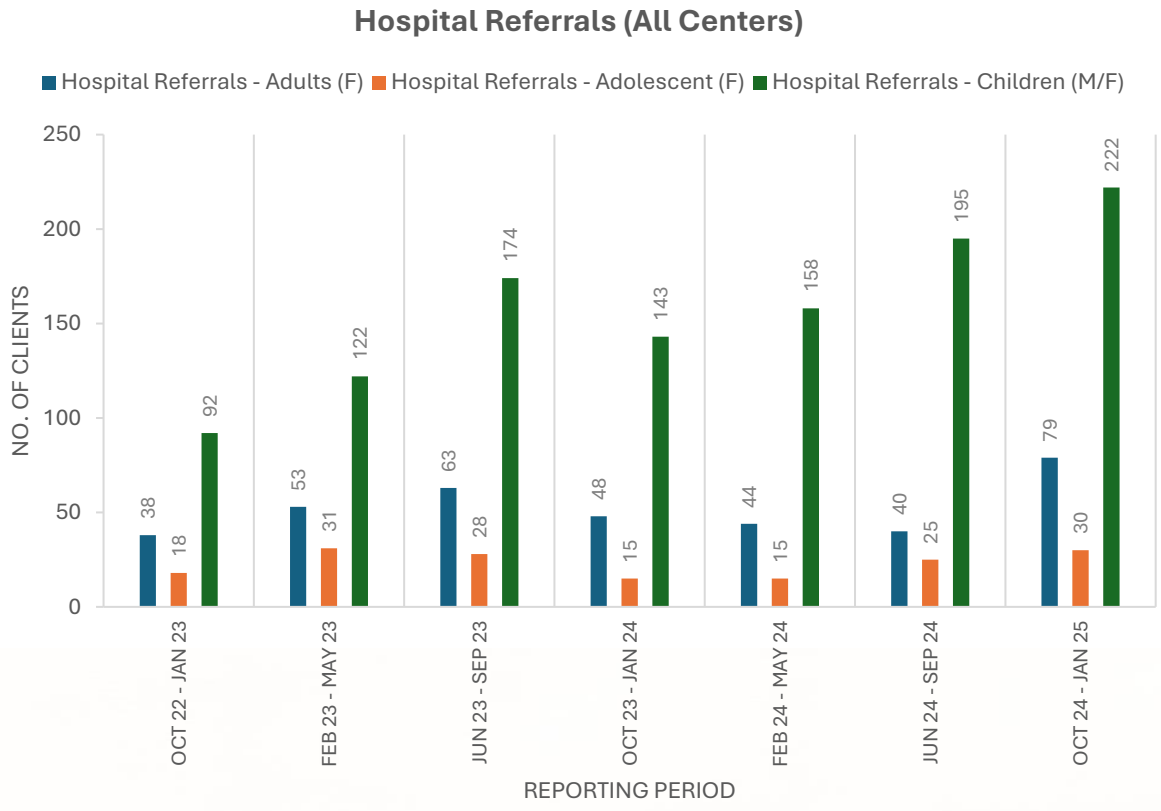

Figure 28: Hospital referrals by all centres as per demographics by 4-month reporting period

The data for hospital referrals across different demographic groups from October 2022 to January 2025 shows a consistent trend of increasing referrals, particularly for children.

In the Oct 22 - Jan 23 period, there were 38 hospital referrals for adult females, 18 for adolescent females, and 92 for children. This trend continued in Feb 23 - May 23, with adult female referrals rising to 53, adolescent females to 31, and children's referrals increasing significantly to 122. The numbers fluctuated slightly in Jun 23 - Sep 23, with 63 referrals for adult females, 28 for adolescent females, and 174 for children.

In Oct 23 - Jan 24, the number of hospital referrals remained steady, with adult females receiving 44 referrals, adolescent females 15, and children 158. The Feb 24 - May 24 period saw further increases for children, with 195 referrals, while adult female referrals remained at 40 and adolescent female referrals at 25.

In Jun 24 - Sep 24, children's referrals were at 195, while the numbers for adult and adolescent females stayed steady at 40 and 25, respectively.

Finally, in Oct 24 - Jan 25, hospital referrals continued to rise for children, reaching 222, with adult female referrals increasing to 79 and adolescent female referrals to 30.

Overall, the data highlights a growing need for medical care, especially for children, post-treatment, emphasizing the importance of ongoing healthcare support across all demographic groups.

Laboratory Screening:

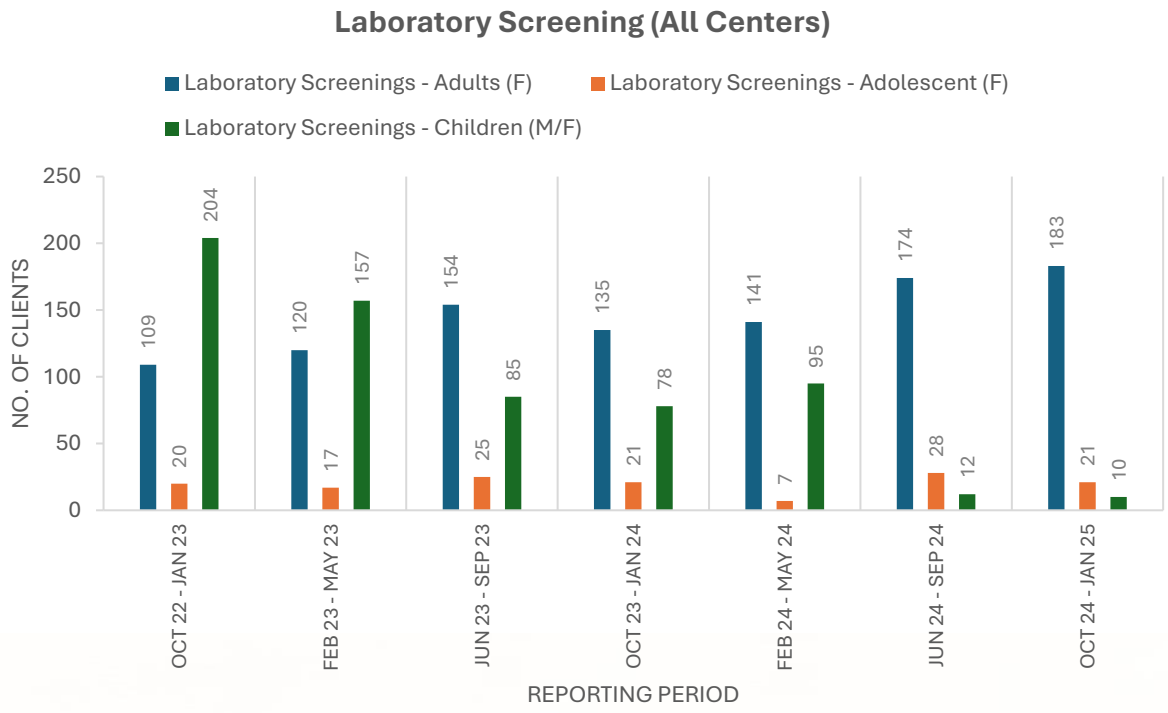

Figure 29: Laboratory screening done by all centres by demographics by 4-month reporting period

The data for laboratory screenings from October 2022 to January 2025 reveals varying trends across different demographic groups.

In the Oct 22 - Jan 23 period, there were 109 screenings for adult females, 20 for adolescent females, and 204 for children, reflecting a higher demand for screenings, particularly for children.

However, in Feb 23 - May 23, screenings for adult females increased to 120, while adolescent females saw a decline to 17, and children's screenings decreased to 157. This downward trend continued in Jun 23 - Sep 23, with adult female screenings reaching 154, adolescent females at 25, and children dropping significantly to 85.

In Oct 23 - Jan 24, adult female screenings further rose to 135, while adolescent females remained low at 21, and screenings for children decreased to 78.

The trend fluctuated slightly in Feb 24 - May 24, with adult females at 141, adolescent females dropping to 7, and children rising to 95.

In Jun 24 - Sep 24, adult female screenings peaked at 174, however, adolescent females and children continued to show minimal demand, with 28 and 12 screenings respectively.

Finally, in Oct 24 - Jan 25, the number of adult female screenings reached 183, while adolescent females and children had 21 and 10 screenings, respectively.

Overall, while laboratory screenings for adult females saw a steady rise, the numbers for children and adolescent females declined over time, indicating a shift in the medical needs and follow-up care for these groups.

Recovery Group Members:

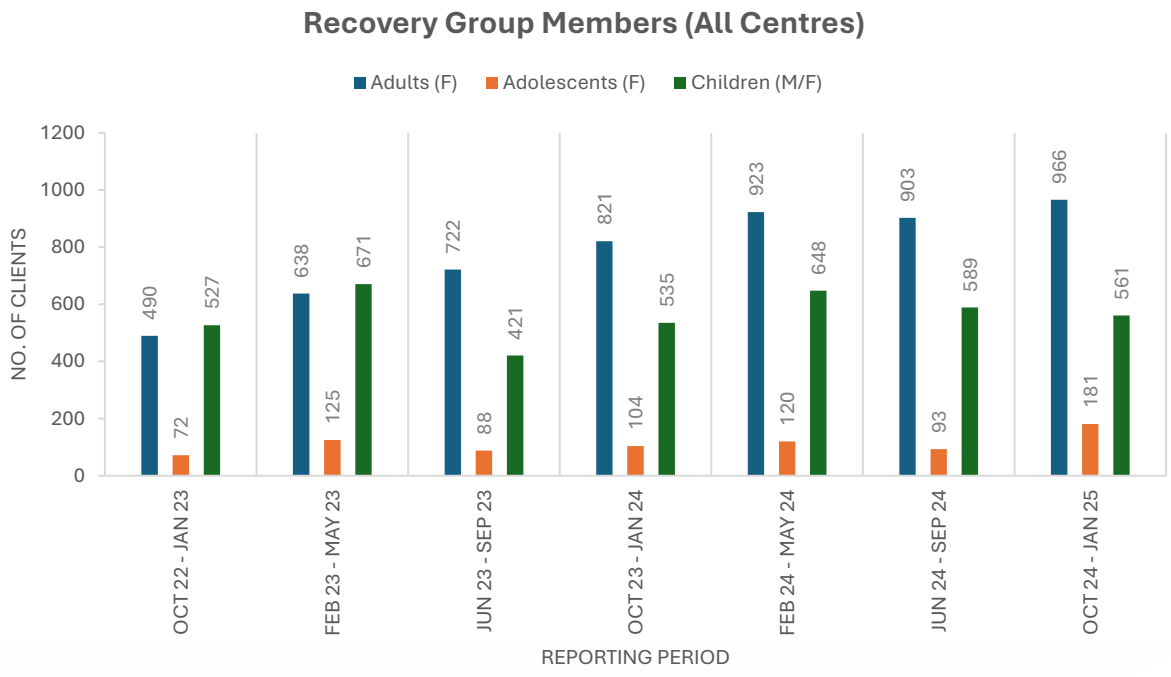

Figure 30: Recovery group members reported across all centres by demographics and by 4-month reporting period

The data for recovery group members from October 2022 to January 2025 shows a consistent increase in the number of participants across different demographic groups: Adults (Female), Adolescent Females, and Children (Male and Female).

In the Oct 22 - Jan 23 period, there were 490 adult female participants, 72 adolescent female participants, and 527 children in recovery groups. The numbers rose significantly in Feb 23 - May 23, with 638 adult females, 125 adolescent females, and 671 children involved, indicating growing participation.

In Jun 23 - Sep 23, the number of adult females in recovery groups increased further to 722, with 88 adolescent females and 421 children participating, reflecting the expanding reach of recovery programs. By Oct 23 - Jan 24, there was another increase, with 821 adult females, 104 adolescent females, and 535 children attending recovery groups.

The trend continued upwards in Feb 24 - May 24, with 923 adult females, 120 adolescent females, and 648 children participating, marking significant growth.

In Jun 24 - Sep 24, the number of participants remained high, with 903 adult females, 93 adolescent females, and 589 children involved.

Finally, in Oct 24 - Jan 25, the number of adult females in recovery groups peaked at 966, while adolescent female participation grew to 181 and children's participation remained significant at 561.

Overall, the data shows a positive and consistent trend in the growth of recovery group members across all groups, with adult females having the largest participation and children also being a key demographic in these recovery support groups. This growth suggests the increasing effectiveness and outreach of the recovery services offered.

Vocational Training:

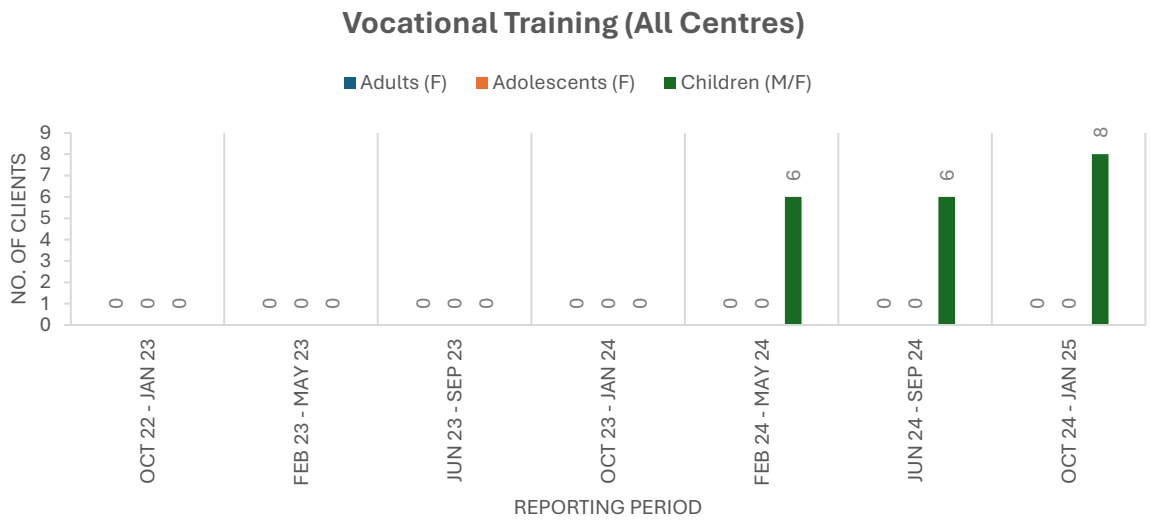

Figure 31: Vocational training offered by all centres by demographics and by 4-month reporting period

The data for vocational training from October 2022 to January 2025 shows limited participation across all demographic groups (Adults - Female, Adolescent Females, and Children - Male and Female).

Initially, there were no participants in vocational training during the Oct 22 - Jan 23, Feb 23 - May 23, Jun 23 - Sep 23, and Oct 23 - Jan 24 periods, as all groups had 0 participants.

However, in the Feb 24 - May 24 period, there was a small increase, with 6 participants in vocational training. This number remained consistent with 6 participants in Jun 24 - Sep 24. By Oct 24 - Jan 25, there was a slight rise, with 8 participants in vocational training.

This suggests that while vocational training services were introduced later in the program, they are slowly gaining traction, though participation remains relatively low.

6.6 OVERALL DTC DATA ANALYSIS AND FINDINGS

The data collected from October 2022 to January 2025 across residential, home-based, outpatient, and post-treatment services highlights several trends and areas of growth in the delivery of treatment and support services.

Residential Treatment Services

Residential admissions have steadily increased throughout the reporting periods, reflecting a growing need for inpatient treatment. The number of total residential admissions increased from 685 in Oct 22 - Jan 23 to 925 in Oct 24 - Jan 25, demonstrating rising demand. This increase is mostly driven by new admissions, which grew from 648 to 793 over the same period. The number of re-admissions, however, fluctuated, indicating that while many individuals are seeking treatment for the first time, there are also individuals returning for follow-up care. The rise in admissions, particularly new ones, shows an expansion of services and a higher acceptance of residential treatment as a viable recovery option.

Home-Based Services

Home-based services, which cater to individuals receiving treatment in their own environments, have also seen a gradual increase in both new admissions and home visits. New admissions grew from 50 in Oct 22 - Jan 23 to 85 in Oct 24 - Jan 25, demonstrating a sustained interest in home-based treatment models. Similarly, the number of home visits conducted increased from 221 in the initial period to 300 in the most recent period, suggesting that more clients are receiving ongoing support in their homes. This increase highlights the success of remote and flexible treatment options that cater to individuals who may prefer to stay in their communities.

Youth Outpatient Services

The youth outpatient services have shown fluctuations in the number of clients screened and assessed. Starting with 2,780 in Oct 22 - Jan 23, the number rose to 3,467 by Oct 24 - Jan 25, signalling growing engagement with youth treatment. Despite some ups and downs in the intermediate periods, the overall trend points toward increasing recognition of outpatient services as a necessary part of addressing youth addiction.

Post-Treatment Services

Post-treatment services, including hospital referrals, laboratory screenings, recovery group memberships, and vocational training, show a mix of consistent demand and emerging needs. Hospital referrals have steadily increased, especially for children, signalling a heightened need for medical attention after treatment. Laboratory screenings for adults have remained relatively steady, although they have seen a decline for children and adolescent females, indicating either a shift in care needs or decreased demand for medical follow-up.

The growth in recovery group memberships, particularly among adult females, reflects a positive trend in continued support and community-building post-treatment. However, vocational training remains limited, though it has shown slight growth.

Key Takeaways

- **Increased Demand**: There has been a consistent increase in demand for residential and youth outpatient services.

- **Steady Growth in Post-Treatment Engagement**: Recovery group participation is on the rise, suggesting positive outcomes in post-treatment support, though vocational training remains an area of slow expansion.

- **Challenges in Re-Admissions (Residential Treatment)**: While the number of new admissions has increased, re-admissions also remain significant, indicating the need for more effective long-term solutions or interventions to reduce relapse rates.

- **Need for More Comprehensive Services**: The relatively low uptake of vocational training and the fluctuating demand for laboratory screenings highlight areas where further service development and outreach might be needed.

Overall, the data from October 2022 to January 2025 shows positive growth in treatment services across all categories. While there is a rising demand for residential and outpatient care, the relatively low engagement with vocational training and the fluctuating need for medical follow-ups suggest areas for improvement. Further strengthening post-treatment services and increasing engagement in vocational and life skills training could enhance long-term recovery outcomes for individuals, particularly among adult female clients.

7. ONLINE CURRICULUM DEVELOPMENT

7.1 INTRODUCTION

The development and dissemination of evidence-based curricula is included in the project as one of the global strategies aiming at increasing access and becoming the pool of qualified practitioners in the DDR field. The UTC was developed to standardize and enhance the knowledge, skills, and competencies of addiction professionals globally. It promotes evidence-based practices and improve SUD treatment outcomes across diverse settings.

7.2 DESCRIPTION ON ONLINE CURRICULUM DEVELOPMENT UNDER 2022-AF-003

Emerging since the post COVID-19 pandemic, which significantly disrupted in-person training globally, the online version of the UTC was proposed to ensure the continuation of capacity development for SUD professionals during lockdowns and beyond. This model of capacity building was also promoted to provide more access for practitioners to improve their professionalization in DDR.

CPDAP has a long history of providing technical assistance to address the growing global concern on psychoactive substances. CPDAP conceptualized the initiative to develop the UTC curriculum into an online format providing learners with an independent style of learning, choosing when, where and the content they want to learn. This version complements the other trainings conducted in-person or scheduled online training or classroom which limited access of many practitioners due to travel, time and cost restrictions. Colombo Plan further identified the necessary partnerships for the program implementation and coordinated the development of courses.

7.3 SERVICE PROVIDERS TO DEVELOP ONLINE CURRICULUM DEVELOPMENT

Owing the wide expertise of online space, US-based firms were contracted to develop the online course. Banyan Communications developed the training scripts as well as content, graphics, audio, animation, and interactive elements necessary to translate the courses into interactive, Lecture-based, online training modules. Direct Consulting Firm was engaged to provide the content review of the developed online curricula to ensure consistency with the actual courses for fidelity of the training. Once completed, the online UTC courses are hosted at HealtheKnowledge.org Learning Management System of the University of Missouri.

7.4 CURRENT STATUS OF THE ONLINE CURRICULUM DEVELOPMENT

The complete UTC Basic Level courses 1-8 and Advanced Level UTC 16 and 22, are currently available for learners in both English and Spanish languages and are accessible through the International Society of Substance Use Professionals (ISSUP) website in a self-led manner:

https://www.issup.net/training/online-learning-hub/utc-self-led

It was initially anticipated that, with the availability of funding, the Basic UTC Courses 01–08 would be translated into Dari to enhance accessibility for DDR professionals in Afghanistan. These translated courses were to be uploaded onto the HealtheKnowledge (HeK) platform—an open-source Moodle-based learning management system allowing professionals to register and complete the courses at their own pace.

As part of the quality assurance process, it was planned to contract a technical reviewer to ensure linguistic and technical consistency across the entire training series. The reviewer would collaborate with the HeK team to review terminology, grammar, and structure directly within the platform, and return the annotated files to the translation agency for revision. This process also included reviewing and refining pre- and post-tests, quizzes, activity sheets, evaluation forms, and instructional content for 100 hours for each of the eight modules, totalling 800 hours of content to be translated and reviewed.

However, due to the official project termination, this component could not be implemented and remained incomplete. The inability to proceed with the translation and uploading of the Dari self-led UTC courses for expanded capacity-building in the local DDR workforce of Afghanistan.

8. PROJECT COORDINATION MECHANISM

8.1 PARTNERSHIPS AND COLLABORATION

The CPDAP built strong partnerships with local NGOs, and international organizations to implement DDR services and strengthen capacity in Afghanistan. With the support of implementing partners (WADAN, ARC, SSAWO, ASP, and OHSS), CPDAP operated 24 women's Drug Treatment Centres and one Data Centre, while maintaining regular coordination, monitoring, and technical support to ensure quality service delivery. Collaboration with organizations such as UNODC, WHO, UN Women, and the EU included Joint Monitoring Missions, application of quality assurance tools, and technical assistance, all of which contributed to enhancing programme effectiveness and sustainability.

8.2. COORDINATION WITH THE GOVERNMENT

Over the years, CPDAP established strong partnerships in the field of DDR with both national and international organizations. Following the fall of the republic regime in August 2021, the Colombo Plan ceased its engagement with the de facto authorities and ministries, as they lacked international recognition. This shift marked a significant change in the operational landscape, requiring CPDAP to focus more on partnerships with local NGOs and international organizations to continue supporting DDR initiatives in Afghanistan.

8.3 COORDINATION WITH NGOS

This extensive work in the DDR field would not have been possible without the dedication and support of local NGOs, which have been instrumental in implementing DDR projects in Afghanistan. CPDAP relied on the expertise and commitment of its implementing partners WADAN, ARC, SSAWO, ASP, and OHSS to deliver services directly to communities through the operation of 24 DTCs, and 1 Central Data Centre.

These centres provided essential treatment, care, and rehabilitation services for some of the most vulnerable groups, while also serving as platforms for data collection, monitoring, and evidence-based planning.

To ensure the effective and transparent delivery of services, CPDAP established regular coordination mechanisms, including structured meetings and reporting systems, which allowed for continuous oversight of both programmatic and financial matters. Beyond administrative coordination, CPDAP teams carried out frequent individual and joint monitoring (JMM) visits to DTC sites. These visits served multiple purposes:

- Identifying operational challenges
- Assessing service quality
- Providing technical and professional support
- Building the capacity of staff to deliver services more effectively.

Through this close collaboration, CPDAP not only strengthened the operational capacity of its implementing partners but also fostered a culture of accountability and continuous improvement.

The joint efforts contributed significantly to raising the quality-of-service delivery, expanding access to care, and ensuring that women had a safe and supportive environment for treatment and recovery.

This collaborative model demonstrates a best-practice approach for DDR initiatives in fragile contexts, highlighting how sustained partnerships with local and international stakeholders can enhance both program effectiveness and long-term impact.

8.4 ROLE OF INTERNATIONAL ORGANIZATIONS (IOS)

The collaborative approach extended to international organizations, including UNODC, WHO, UN Women, and the EU. These partnerships were contributed to ensuring the quality, accountability, and effectiveness of DDR services delivered through the DTCs operated by the Colombo Plan. Core activities included conducting JMMs, applying quality assurance tools, and providing mutual technical assistance to strengthen operational and programmatic standards. The role of each organization was clearly defined and coordinated through formal invitations for participation in specific JMMs.

For instance, UNODC and WHO were primarily invited to join monitoring missions and provide technical guidance on specialized areas such as clinical protocols, data management, and capacity-building initiatives. These collaborations not only enhanced the technical quality and consistency of services across the DTCs but also fostered knowledge exchange, reinforced best practices, strengthened international partners cooperation, and promoted a coordinated approach to DDR programming in Afghanistan.

8.5 STAKEHOLDER ENGAGEMENT

8.5.1 AT COMMUNITY LEVEL

During the project implementation phase, community stakeholders played an active and meaningful role. Influential figures and local leaders, including respected elders and community representatives, acted as key informants and facilitators. Their involvement was vital in creating an enabling environment where the project team could build trust, communicate openly, and adapt activities to reflect community priorities. By leveraging their influence and credibility, these stakeholders helped the project gain acceptance, reduce potential resistance, and ensure that interventions were culturally appropriate and relevant to local needs.

In addition, former clients were engaged as community guides, serving as a bridge between the project team and the wider community. Drawing on their personal experience with the program, they were able to share their knowledge, encourage others to participate, and help reduce stigma associated with accessing services. Their involvement not only strengthened outreach and participation but also highlighted the success of the program within the community. This combination of leadership support and peer involvement created a strong foundation for effective implementation of the project.

8.5.2 AT INTERNATIONAL LEVEL

The CPDAP has established a comprehensive coordination platform to engage stakeholders and strengthen collaboration across projects. International partners played a key role in this platform and have been invited to participate in every single meeting. This has fostered the dialogue, information sharing, and alignment on strategic priorities.

A key example of this coordination mechanism is the DDR Dialogue, held in Astana, Kazakhstan, from 6–8 May 2024. The DDR Dialogue served as a vital platform for project coordination, enabling comprehensive reviews of project status, progress, and operational challenges, while fostering collaborative solutions to enhance program outcomes.

Specifically, it provided an opportunity to evaluate CPDAP's ongoing Afghan DTC project, funded by the INL. The dialogue assessed achievements and challenges across six provinces in Afghanistan, facilitating in-depth discussions on key obstacles. These discussions led to the development of targeted recommendations to improve program effectiveness, optimize resource utilization, and ensure seamless implementation of project activities.

The dialogue was attended by representatives from international organizations, including UNODC, WHO, and DAWEO, with additional participation from UN Women, the European Union, and the Ministry of Healthcare of Kazakhstan.

Following the DDR Dialogue, CPDAP initiated coordination with UN Women to address shared priorities, particularly given CPDAP's support for Female, Female Adolescent, and Children DTCs. Discussions focused on navigating common challenges and enhancing gender-sensitive approaches in project implementation. However, progress was limited as only KFO staff were invited to a gender-based violence training, and further collaboration was halted due to a Stop-Work Order issued on 28 January 2025.

The DDR Dialogue exemplifies CPDAP's commitment to fostering meaningful stakeholder engagement, driving coordinated efforts, and delivering actionable insights to strengthen project implementation and impact.

9. PROJECT STOP-WORK ORDER AND TERMINATION

9.1 PROJECT STOP-WORK ORDER

Following the issuance of the Stop-Work Order on 28 January 2025, all five IPs were formally notified to cease all project-related activities and to refrain from incurring any additional expenses beyond this date. It was clearly communicated that CPDAP would not assume financial responsibility for any costs incurred after the stop-work order date. This directive was acknowledged and duly adhered to by all IPs without exception.

9.2 PROJECT TERMINATION

Following the official termination notice issued on 08 April 2025, the KFO initiated a structured closure process. This included the inventory and sale of all office assets, final reconciliation of dues with the landlord, and the formal handover of the premises. The entire process was conducted with transparency and in full compliance with administrative protocols, ensuring the proper conclusion of tenancy obligations.

In parallel, recognizing the sudden nature and scale of the project's termination, CPDAP implemented a comprehensive and culturally sensitive exit strategy. This strategy aimed to minimize disruption to services and to safeguard the dignity and well-being of clients undergoing treatment at CPDAP-supported DTCs. A core element of this exit strategy involved the safe and respectful reintegration of clients into their families. IPs engaged directly with clients' families, explaining the reasons for closure and supporting a smooth transition back to a supportive home environment.

In an exceptional display of commitment, several DTC staff voluntarily extended their service beyond the official closure date. During this period, they ensured:

- Closure and proper archiving of client files
- Verification and documentation of treatment records
- Handover of centre assets
- Coordination with families and relevant community stakeholders

Their dedication played a pivotal role in ensuring an orderly and compassionate transition, preventing confusion or emotional distress for clients and their communities. As operations concluded, most DTCs, operating from rented premises were returned to their landlords.

Despite this, in May 2025, KFO team successfully conducted a round of final DTC verification visits. These were led by experienced KFO Treatment Coordinators, deeply familiar with each facility and its operations. The visits were conducted in close coordination with CPDAP HQ, with technical teams providing real-time remote support, ensuring a standardized and credible verification process across all locations.

9.3 FINAL DTC VERIFICATION VISITS

Following the immediate Stop Work Order issued by the U.S. government on 28 January 2025, CPDAP took swift action to communicate this directive to all its implementing partners managing DTCs across six provinces in Afghanistan (Kabul, Balkh, Herat, Badakhshan, Farah, and Nangarhar).

The message highlighted the stopping of the support to all DTC operations, which is effectively bringing a wide-reaching and impactful public health initiative that has been serving thousands of individuals suffering from substance use disorders to an end.

To responsibly conclude its DTC operations across Afghanistan, the CPDAP conducted a series of verification visits to 24 DTCs across Afghanistan. These visits conducted between 19 – 31 May 2025 were led by designated treatment coordinators of KFO with the aim to assess the closure status of residential and outpatient DTCs across the six provinces in Afghanistan (Kabul, Balkh, Herat, Badakhshan, Farah, and Nangarhar).

The primary objectives were to verify the formal handover of facilities, document the condition and disposition of assets, and gather feedback from former clients, staff, and community members. These visits provided critical insights into the operations of the DTCs, the socio-economic impact of their closure, and the ongoing need for accessible addiction treatment services in Afghanistan.

Comprehensive reports were generated for each verification visit, documenting the condition of the facilities, status of program assets, and adherence to closure protocols. These reports were first reviewed by the KFO to ensure accuracy and completeness and subsequently forwarded to the CPDAP HQ for in-depth analysis and final approval. In parallel with the verification process, financial settlements were undertaken to reconcile outstanding obligations, including payments to landlords, vendors, and staff, as well as the final accounting of assets and budget allocations.

This coordinated effort between KFO and CPDAP HQ ensured a transparent, accountable, and orderly conclusion to the project's administrative and financial responsibilities.

Verification Checklist and Verification Summary Report are included in **Annex 04**, and **Annex 06** respectively.

Figure 32: Verification visit to WADAN Badakhshan OPTC

10. KABUL FIELD OFFICE CLOSURE

10.1 ASSETS SALE

Following the project termination notice, KFO initiated a systematic and transparent closure process. A key component of this process was the disposal of office assets, which was conducted through a competitive bidding process to ensure fairness and value for money under the supervision of the Programme Manager.

The KFO team identified and categorized all assets including electrical equipment, office fixtures, vehicles, and a generator for disposal. Local vendors were invited to submit bulk quotations for each category of asset. These quotations were reviewed and compiled by the KFO team and subsequently submitted to CPDAP HQ for evaluation.

Upon evaluation, the selected vendors were allocated the designated assets. The sale proceeds from this process were then partially utilized to settle outstanding operational dues, specifically pending payments to IPs for September 2022. However, the total revenue generated from the asset sales was insufficient to fully cover the remaining liabilities for that month.

Total revenue generated from the sale of assets is USD 25,010.00

It was distributed among DTCs as follows:

No	IP	Province	Treatment Centre	Amount Released (USD)
1	ARC	Herat	30-Bed women/children	1,882.63
2	ARC	Herat	50-Bed women/children	2,668.10
3	SSAWO	Balkh	70-Bed women/children	4,297.76
4	WADAN	Badakhshan	70-Bed women/children	3,654.37
5	WADAN	Badakhshan	Outpatient Centre	1,590.93
6	WADAN	Farah	35-Bed women/children	2,557.00
7	WADAN	Kabul	60-Bed women/children	3,402.06
8	WADAN	Kabul	Outpatient Centre	1,590.93
9	WADAN	Nangarhar	60-Bed women/children	3,366.22
			Total	**25,010.00**

Table 7: KFO Assets Sale Revenue

10.2 SCANNING AND DISCARDING OF OFFICE FILES

As part of the closure process of the KFO, all essential project files and documentation were scanned and digitized, with soft copies securely transferred to the Colombo Plan's OneDrive cloud storage system.

This ensured the preservation and accessibility of critical information for future reference, audit, or reporting needs. All remaining hard copy files and physical documents, deemed non-essential or already archived digitally, were securely destroyed. This was carried out through shredding and incineration, in compliance with data protection and confidentiality protocols. Following the completion of documentation disposal, the office premises were formally handed back to the landlord, and all financial settlements related to the lease and occupancy were fully reconciled and closed.

Figure 34: KFO Team Scanning Old and Archived Hard Copy Files 1

Figure 33: KFO Team Scanning Old and Archived Hard Copy Files 2

10.3 TERMINATION OF SUPPORT STAFF

The support staff of the KFO were formally released from duty effective 15 May 2025. As the building was vacated and no longer in use, their roles, primarily related to facility maintenance, office services, and staff transportation were no longer required. This decision was communicated in line with the overall closure plan and was implemented in accordance with relevant procedures and contractual obligations of CPDAP.

10.4 OFFICIAL HANDOVER

Although the lease agreement for the KFO officially ended on 28 March 2025, the landlord generously allowed additional time for KFO team to complete the office clearance and exit formalities.

The official handover of the building was completed on 27 April 2025. By that time, all equipment had been removed, and remaining fixtures were returned to the landlord in good condition. Electricity bills were fully paid, and minor building repairs were carried out to ensure a smooth and professional transition.

Figure 35: Group photo of the KFO staff on the last day, when the building was handed over to the landlord on 28th March 2025

From right to left: Dr. Aqa Stanikzai, Dr. Moh. Rahim Akbari, Mr. Naeem (Representative of the Landlord), Dr. Moh. Samin Stanikzai, Mr. Ali (Cook), Mirwais (Cleaner), and Abdul Rahim (Guard), seated on the ground.

10.5 BANK ACCOUNTS

All Colombo Plan bank accounts with Bank Alfalah in Kabul which were frozen due to the absence of the required authorized signatories required by the bank after August 2021. At the time of account frozen, three of the four individuals officially designated to operate these accounts had either left the organization or relocated abroad. Although the Chief of DDR – Afghanistan (Dr. Aqa Stanikzai) remained in Kabul, the bank's operating policy required a minimum of two authorized signatures to validate and process any financial transaction. With only one signatory available, the accounts could no longer be accessed or managed, effectively leading to their suspension.

This development created significant operational and financial challenges for the Colombo Plan in Afghanistan. The inability to access funds meant that payments to staff, vendors, and implementing partners were disrupted, affecting the continuity of project activities. It also hindered the settlement of outstanding commitments and obligations under DDR projects, leading to delays and uncertainties for both beneficiaries and partners. Moreover, the frozen accounts limited the Colombo Plan's flexibility in managing resources on the ground.

To address the challenge of frozen bank accounts, the Colombo Plan adapted to the situation by utilizing MSP channels for fund transfers to implementing partners and staff salary payments. This alternative mechanism ensured that essential project activities and obligations could continue despite the banking restrictions in line with international regulatory requirements and OFAC.

11. KEY CHALLENGES, LESSONS LEARNED AND RECOMMENDATIONS

11.1 KEY OPERATIONAL CHALLENGES

Despite DTCs operating within the health sector, female employment, social and political restrictions remained challenges and continued to affect the safe participation of women in project activities. Women professionals faced risks of harassment or inquiry, particularly in rural and conservative areas. Female staff had to be accompanied by a Mahram during travel and it created operational delays and financial implications. Also, the absence of formal banking channels significantly affected financial operations. With the freezing or inaccessibility of official project bank accounts, CPDAP had to rely on MSPs to process payments such as staff salaries, IPs operating costs, and procurements etc to Afghanistan. Moreover, this MSPs channel procedure incurred additional service charges of approximately 2.5% per transaction.

11.1.1 POLITICAL INSTABILITY IN AFGHANISTAN

The political shift in August 2021 created significant disruptions across all sectors. This situation remained at the time that the current project was started. Trained government personnel were replaced, and institutional knowledge was lost, particularly in the DDR sector. New appointees often lacked understanding of or commitment to evidence-based treatment protocols. As a result, core program standards such as treatment duration, patient screening, and monitoring practices were inconsistently applied across treatment centres.

11.1.2 TREATMENT CENTRE AND KFO STAFFING RETENTION ISSUES

Many skilled professionals, including doctors, psychologists, and social workers, left the country following the political transition, part of this is due to security reason. The KFO also experienced significant turnover, with staff leaving under humanitarian resettlement programs (P1/P2). This resulted in capacity gaps in treatment supervision, and monitoring efforts.

11.1.3 LOGISTICAL ACCESS

Although virtual monitoring was implemented during the COVID-19 pandemic, the in-person monitoring could be resumed later in 2023. However, logistical challenges (such as limited flights, fuel shortages, and local restrictions etc.) have been prevalent occasionally during monitoring visits.

11.1.4 EARLY PROJECT TERMINATION

The official stop-work order issued on 28 January 2025 required abrupt halting of all DTC services. Although KFO and IPs responded promptly, the lack of a long-term transition plan disrupted continuity of care for clients and caused distress for staff and families.

Considering the suddenness and scale of the closure, a comprehensive and culturally sensitive exit strategic approach was adopted to minimize disruption and uphold the dignity and safety of clients under treatment. The foundation of this approach was the safe reintegration of clients with their families. Implementing partners, initiating direct and respectful communication with families.

Each case involved informing families of the abrupt termination, explaining the circumstances surrounding the closure, and working to ensure that clients would be received back into a supportive environment. This process was especially delicate in more conservative or rural areas, where the stigma around addiction remains strong, and required patient, trust-building dialogue to ensure successful handovers.

11.1.5 SUSTAINABILITY OF DTCS IN AFGHANISTAN

The sudden closure of the DTCs posed a significant threat to the DDR landscape in Afghanistan. Without alternative funding or transition planning, these centres, many of which were operating successfully for years are now at risk of permanent closure.

11.2 LESSONS LEARNED

The implementation of this project provided several important lessons which could inform future programming. One of the most critical insights was the need for flexibility in both operations and planning. The ability to quickly shift from in-person to virtual monitoring during the COVID-19 pandemic and to adapt staffing and program modalities after the 2021 political transition proved essential for maintaining service delivery. It also became evident that female participation in DDR efforts requires structural and logistical support. Ensuring women could continue working safely and confidently under restrictive environments demands dedicated planning, and resources.

The experience also highlighted the importance of preparedness for sudden political shifts, projects should be designed with risk-mitigation strategies in place, particularly to address staff turnover and program continuity. Additionally, maintaining strong communication channels, remote supervision tools, and proactive coordination with implementing partners and donors was crucial in ensuring the uninterrupted delivery of services, especially during operational uncertainty.

Another key lesson was the fragility of institutional memory; when experienced staff leave, valuable knowledge and expertise was partially lost unavoidably. Investing thorough documentation, standardized protocols, and knowledge transfer mechanisms could help safeguard program continuity.

Finally, community involvement emerged as a critical factor in building resilience treatment centres with stronger local networks, including families, community elders, and religious leaders, were better able to navigate disruptions and sustain their services.

11.3 RECOMMENDATIONS FOR FUTURE PROGRAMMING

Based on the experience gained throughout the implementation of the project, several key recommendations emerge for future programming. First and foremost, sustainability should be prioritized from the outset, with a clear plan to transition DTC support to new donors. The INL and CPDAP are encouraged to facilitate connections between existing DTCs and potential funding agencies to preserve the infrastructure and retain trained personnel. Given the ongoing political and social situation in Afghanistan, future projects must also include contingency planning which addresses operational disruptions, including those related to female staff participation. This includes budgeting for Mahram when necessary and ensuring protective workplace policies for female professionals.

To overcome the limitations caused by the absence of formal banking channels, future initiatives must plan for alternative financial mechanisms such as MSPs, while factoring in their service fees (typically around 2.5% to 5%) into the project budgets. Capacity-building efforts should be continued with a strong emphasis on local ownership and leadership, while ensuring that staff turnover does not erode the quality-of-service delivery. Strengthening community engagement and creating local support networks around each centre can enhance resilience and acceptance, especially during times of instability. Ultimately, future DDR programming should strive for a balance between international standards and contextual adaptability, ensuring services remain accessible, inclusive, and sustainable in Afghanistan's evolving environment.

Figure 36: Image of a Group Counselling Services conducted at 0-Bed SSAWO DTC in Balkh

12. IMPACT: REFLECTIONS ON CHANGE

12.1 CLIENT SUCCESS STORIES

1- Success Story about high impact of the services provided through ARC related 25 beds women Drug Addiction Treatment Centre to vulnerable population in Herat city.

Drug abuse is a significant problem that can have far-reaching negative effects on drug addict, her family and on the whole community. Drug abuse is also associated with criminal activity, lost productivity, and economic costs. It can create difficulties for families and social relationships and can pose a risk to public safety. As such, it is important to address the problem of drug abuse through prevention, education, and treatment.

Incidence and prevalence rate of the SUDs are high in young age people and adversely affected health, economy and psychosocial wellbeing of them and their families.

Province: Herat

District: Guzara

Village: near Industrial Park

Health Facility Name: ARC 25 beds women DTC

Success Story:

On 7 Jan 2024 at 11:21 AM a 36-year-old patient was brought to ARC 25 beds women DTC from Guzara district by her family. Her surname was Fatima. She was one of thousands of helpless women who was addicted on psychoactive substances such as Heroin, nicotine and Sheesha (methamphetamine).

She was married and had 2 sons and 4 daughters. She had left her education in 7th class of middle school due to drug addiction. She was expelled by her husband and was living with her father. She was admitted in the DTC on the mentioned date, and she was in a very sever condition of withdrawal syndrome. On 13/Jan/ 2024, she was detoxified by the help of doctors and shifted to rehabilitation ward. Her case manager, Ms. Raihana made her a successful treatment plan and treat her accordingly in rehab stage. Now she was recovered and joined back with her husband. She and her family were very happy about her health and thankful of DTC staff and ARC Organization.

Note: client photos were not allowed due to confidentiality and client consent.

2- Success story:

My surname is Suhaila; I am 26 years old. I am a resident of 10th division of Kabul province. Almost ten years ago we were in very poor condition of economic life.

One day my father took me and my sister to my maternal uncle home who was a police officer and his wife was a school teacher, one day while my maternal uncle and his wife went to their duty, we were alone at their house along with the children, suddenly six armed people entered my uncle's house one of them came close to me and made me unconscious with the chemicals which he had with himself.

After several hours, when I came back to conscious, I observed that I was at a home in Kabul city, two other women were also with me, when I saw this situation, I started to cry, at this time a young boy entered the room, after 3 days they forcefully engaged me with the mentioned young boy.

After marriage, I had a better life than before, but I was not happy with my husband as I was alone in my life and so far from my family, after a short time I became pregnant, after seven months of our marriage my mother found the address of my house and came to my house, when my mother saw my life she suggested me to abort the child, leave your husband and let's go back home with me. I refused my mother's suggestion, after refusal of her suggestion my mother cut all her relations with me. My mother thought that I got married with my husband as per my choice, I really became fed up with such a life and I was always thinking with myself that when I will be free from these difficulties of life. Finally, I became friend with an addicted woman who was living in our neighbourhood.

After a short period of time, I also became a drug addict, after a while my husband also became a drug addict as he was living in the same house with me. We have used drugs for almost nine years. One day WADAN hospital workers came to the area in which, we were living, and they motivated me and my husband to stop the drug use and go to the drug treatment centre. We did so and came to the hospital with them, they treated me and my husband and provided us with the medicine. Now, we are really happy and thankful to Allah that we are clean or drug free and we are not drug addicts anymore, at the end, I am really thankful of all workers of WADAN hospital.

Note: client photos were not allowed.

Reference: WADAN 20 beds women DTC coordinator in Kabul.

12.2 AFGHAN DTC RESILIENCE AMIDST CRISIS

During the project implementation period, as resulted from the political transition in August 2021, Afghanistan's health and social service systems faced widespread disruption, including significant challenges within the drug treatment sector. Despite funding shortfalls, staff insecurity, and the loss of international technical support, the DTCs funded by CPDAP exhibited remarkable resilience. Their continued operation was crucial in preventing the collapse of essential addiction services at a time when demand remained high or even increased.

Core services such as detoxification, rehabilitation, psychosocial counselling, relapse prevention, and aftercare were maintained across 24 DTCs supported by CPDAP, despite severe operational restrictions. The centres increasingly emphasized community and family involvement, strengthening recovery outcomes and facilitating smoother reintegration for clients. Human resource resilience was evident as many committed technical staff remained in service, with experienced personnel mentoring and training new recruits despite the absence of formal refresher programs. These sustained efforts enabled hundreds of clients with substance use disorders to continue accessing vital treatment services amid the country's ongoing political and socio-economic challenges.

12.3 EVIDENCE OF SYSTEM SUSTAINABILITY OR RISK OF COLLAPSE

Since 2021, Afghanistan's drug treatment system has demonstrated a blend of resilience and vulnerability. On the one hand, the continued operation of 24 DTCs across six provinces under this project highlights a significant degree of system sustainability amidst challenging circumstances. These centres remained active as of 28 January 2025, collectively delivering essential treatment services to hundreds of clients annually. The retention of a qualified cadre of addiction professionals, including medical doctors, nurses, psychologists, counsellors, and social workers helped maintain the quality and consistency of care.

Additionally, the consistent use of standardized clinical protocols, such as UTC and UNODC screening tools, ensured continuity in treatment delivery and upheld clinical integrity across all centres. Stronger engagement of families and community members fostered enhanced social reintegration and increased acceptance of treatment at the grassroots level. Furthermore, robust monitoring systems, including joint quarterly visits and detailed reporting, enabled ongoing oversight and evaluation by KFO, contributing to program accountability and quality assurance. Despite these strengths, the system remains vulnerable due to funding uncertainties, staff attrition, and political instability, which continue to pose risks to long-term sustainability.

13. MAJOR RISKS AND MITIGATION MEASURES

13.1 RISK MITIGATION STRATEGY

Risk mitigation strategy used during project implementation is as follows:

No	Identified Risk	Involved Personnel	Risk Level	Action Plan
1	Taliban Interference with the project	IPs, KFO, CPDAP, INL	Medium	Maintain effective communication channels with IPs. In the event of interference, CPDAP will notify INL. Relevant DTC should inform respective IP, IP to inform KFO, KFO to inform CPDAP, and CPDAP to INL. If necessary, CPDAP and KFO to communicate with other NGOs and coordinate with other IOs in Afghanistan to engage with relevant ministries for the best possible approach.
2	Foreign Terrorist Organizations (FTOs) Interfering/Benefiting from the Program	IPs, KFO, CPDAP, INL	Medium	Implement strict vetting processes for all IPs (management and staff) using advanced screening tools (e.g., OFAC, UN sanction lists). Continuously monitor the security situation through KFO in-person missions.
3	MSP and Hawala system risk	IPs, KFO, CPDAP	Medium	Conduct thorough background checks (e.g., OFAC, UN sanction lists) and due diligence to verify MSPs' credentials and operations.
4	Taliban Restrictions on Women	KFO female staff, DTC female staff	High	Enable DTC work environment to allow female staff have a Mahram and have segregated male and female workspaces with curtains. Allocate funds to cover Mahram travel expenses for female staff on monitoring missions.
5	Natural Disasters (e.g., earthquakes, floods)	IP staff, KFO	Low	Establish partnerships with local disaster response agencies and other IOs operating in Afghanistan to facilitate a coordinated and effective response in times of crisis with necessary resources.

Table 8: Risk mitigation strategy used during project implementation

13.2 SANCTIONS COMPLIANCE

Some measures were taken to ensure that the project accomplished sanctions compliance during its implementation period.

13.2.1 OFAC SEARCH

Sanctions compliance was rigorously maintained through regular and systematic checks in accordance with the Office of Foreign Assets Control (OFAC) guidelines. An OFAC search was conducted every six months for all DTC staff paid by project funds, as well as for the management teams of the DTCs and IPs. These checks ensured that no personnel involved in project implementation appeared on any sanction lists, helping to mitigate financial and reputational risks.

Additionally, prior to any fund transfers to Afghanistan, especially those processed through selected MSPs, an OFAC screening was performed on the receiving organization (entity) and its management.

The OFAC search process involved verifying identities using official documents such as passports and Tazkiras (national ID cards). The proactive application of OFAC checks ensured ongoing compliance with international sanctions laws and minimized the risk of inadvertently funding prohibited entities or individuals using project funds.

13.2.2 SECURITY QUESTIONNAIRE

To receive real-time security updates, the Colombo Plan initially contracted with two international security service providers in Afghanistan, GardaWorld and Intelyse. However, after the fall of the republic regime, the reliability of these services was significantly affected, and obtaining accurate and timely information became increasingly challenging. This created a gap in the ability to monitor risks effectively, particularly in areas where the Colombo Plan operated its DTCs.

To mitigate this issue, the CPDAP, in consultation with INL, developed a localized system to collect security related information, with a focus on the six provinces where DTCs were operational (Kabul, Balkh, Badakhshan, Nangarhar, Herat, and Farah).

A comprehensive security checklist was designed in consultation with INL, consisting of 21 questions across seven categories: 1) General Security Situation, 2) Threat Assessment, 3) Humanitarian and Civilian Safety, 4) Infrastructure and Logistics, 5) Economic and Social Impact, 6) Environmental and Seasonal Factors, and 7) Future Outlook. **Security Questionnaire Checklist is included in Annex 05**.

For accessibility in the field, the checklist was translated into Pashto and Dari. Though the mechanism was reviewed and approved by INL, however, this activity has not been implemented due to the immediate Stop Work Order issued by the U.S. Government on 28 January 2025.

13.3 INTELYSE LLC SUBSCRIPTION

Prior to August 2021, security services under previous Afghan DTC projects have been provided by GradaWorld Consulting Middle East Limited (from June 2019 to August 2021). From August 2021 onwards, Intelyse LLC took over the role of providing computer-based insight platform services, focusing on delivering essential intelligence and security information related to Afghanistan. The services were formally contracted, with payments made using project funds from 24 October 2022 to 02 May 2023.

Intelyse's platform was a vital tool for monitoring and assessing the security landscape in Afghanistan, providing real-time information to help maintain situational awareness to KFO and CPDAP management. The key features of the platform included:

- Automatically generated 24/7, real-time incident spot reports, offering immediate updates on security incidents.
- Their comprehensive insight platform provided access to a variety of threat analysis tools, and a full historical incident database. And up-to date situational awareness across Afghanistan's 34 provinces.
- Regular daily and weekly email updates had been delivered with country updates and threat assessments specific to Afghanistan.
- On request and in coordination with Intelyse, the platform also offered the capability to conduct in-depth security reviews.

Subscriptions were provided for 5 computers, ensuring the necessary access for key personnel.

However, on 03 April 2023, Intelyse issued a "Termination Notice" with a 30-day termination period to CPDAP, marking the end of their service provision under the project This decision was driven by Intelyse's internal restructuring, as the financial cost of delivering their services was no longer viable in comparison to the prevailing market value of the output.

14. FINANCIAL SUMMARY

2022-AF-003: Continued NGO Assistance to Training and Specialized Substance Use Disorders Treatment Facilities

LOA FAIN: SILLEC22LA0388

Period of Performance: 23 September 2022 - 28 January 2025

14.1 SUMMARY FINANCIAL TABLE

Budget Category	Approved Budget (USD)	Actual Expenditure (USD)	Variance (USD)	Spent %
Personnel	1,046,575.46	693,900.83	352,674.63	66.30%
Fringe Benefits	157,108.14	80,921.42	76,186.72	51.51%
Travel	770,842.11	75,876.38	694,965.73	9.84%
Equipment	0.00	0.00	0.00	--
Supplies	62,032.50	7,269.18	54,763.32	11.72%
Contractual	9,044,544.49	4,511,097.18	4,533,447.31	49.88%
Construction	0.00	0.00	0.00	--
Other Direct Costs	851,262.07	213,760.68	637,501.39	25.11%
Total Direct Costs	11,932,364.77	5,582,825.67	6,349,539.10	46.79%
Indirect Costs (Admin fees)	1,670,531.07	772,304.92	898,226.15	46.23%
Total	**13,602,895.84**	**6,355,130.59**	**7,247,765.25**	**46.72%**

Table 9: Summary Financial Table

14.2 BUDGET VS. ACTUAL NARRATIVE

On 28 January 2025, CPDAP received official notification of an **Immediate Stop-Work-Order** issued by the current U.S. administration. This order suspended all initiatives funded by the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the U.S. Department of State. Subsequently, on 07 April 2025, CPDAP received the **"Termination Notice"** for the Letter of Agreement (LOA), SILLEC22LA0388, under which the project was operating.

Due to the stop-work-order and termination of the project, the planned activities could not be conducted, resulting in underutilization across many budget lines.

14.3 FUNDS STATUS SUMMARY

Description	Amount (USD)
Total Federal Funds Authorized	13,602,895.84
Total Federal Funds Disbursed	13,602,895.84
Total Expenditures Incurred	6,355,130.59
Unexpended Balance	7,247,765.25
Program Income (if any)	-
Amount to be Returned	**7,247,765.25**

Table 10: Fund Status Summary

15. ANNEXES

ANNEX 01: PROJECT STOP-WORK ORDER, AND PROJECT TERMINATION NOTICES

United States Department of State
Bureau for International Narcotics
And Law Enforcement Affairs

Washington, D.C. 20520

April 8, 2025

NOTICE OF TERMINATION

Dr. Benjamin Reyes
Secretary General
The Colombo Plan
Colombo, Sri Lanka

Dear Dr. Reyes:

The purpose of this letter is to inform you that the U.S. Department of State has determined to terminate the Letters of Agreement for the projects listed below between the Government of the United States of America, through the U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL), and the Colombo Plan. The Department has reviewed the projects supported by these agreements and determined that they no longer effectuate agency priorities. In accordance with the terms of these agreements, we are exercising our right to terminate the agreements. This letter serves as your notice that the awards are terminated as of April 7, 2025. This notice is intended to be implemented consistent with the terms and conditions of the Letters of Agreement.

- **SINLEC22LA0033 Philippines - Drug Use Prevention in Classrooms**
- **SINLEC22LA0388 Continued NGO Assistance to Training and Specialized Substance Use Disorders Treatment Facilities**

The Colombo Plan was issued a Notice of Suspension for these Letters of Agreement on January 28, 2025. Legitimate costs incurred or committed in good faith prior to the issuance of the Notice of Suspension may be reimbursed. Additionally, legitimate costs incurred or committed in good faith to comply with the Notice of Suspension may also be reimbursed. Future financial commitments entered into by the Colombo Plan for these Letters of Agreement prior to receipt of the Notice of Suspension may also be covered by the funds provided by the

United States for these projects, including the costs to the Colombo Plan resulting from the early termination of these agreements, but any such future financial commitments should be terminated immediately.

The Colombo Plan is requested to work with INL to return the remaining funds associated with these projects to the U.S. government. All required closeout documentation should be submitted to INL in accordance with the annex to the Letters of Agreement. Per the annex to the Letters of Agreement, should there be any disputes, they are to be resolved through negotiation between representatives of the United States and the Colombo Plan.

INL extends its appreciation to the Colombo Plan for its work on these projects on behalf of the U.S. Department of State.

Sincerely,

F. Cartwright Weiland
Senior Bureau Official

THE COLOMBO PLAN

For Co-operative Economic and Social Development in Asia and the Pacific

THE COLOMBO PLAN

Our Ref: CP/DAP/GEN-2025/08 29 January 2025

Subject : Immediate Stop Work Order

Recipients : CP Consultants/Advisors/Partner Organizations/Service Providers/ Contractors/Trainers

The Colombo Plan hereby notifies the Recipient that the CP contract or activity with you/your agency is immediately suspended as of January 28, 2025 in compliance with the stop-work order issued by the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the US Department of State (the Funder) in accordance with the US President's Executive Order on Reevaluating and Realigning United States Foreign Aid.

Effective immediately upon receipt of this Notice of Suspension, the Recipient must stop all work on the program and not incur any new costs after the effective date cited above. Only expenses incurred prior to this date and with valid supporting documents will be reimbursed. Advance payments made to the Recipient for future periods and activities are not to be expended.

Sincerely,

Dr. Benjamin P.Reyes
Secretary–General

5th Floor, M2M, Verandah Offices, No. 34, W.A.D Ramanayake Mawatha
Colombo 02, Sri Lanka Tel.: +94-11-257 6322 Fax: +94-11-257 6311
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ANNEX 02: 2022-AF-003 PROJECT IMPLEMENTATION SELF-ASSESSMENT REPORT

Introduction

This Final Self-Assessment Report evaluates the implementation of Project 2022-AF-003, which aimed to sustain drug treatment and rehabilitation services in Afghanistan amid a volatile post-August 2021 context. The project supported 24 DTCs and 1 Data Centre operated by five NGO partners: Welfare Association for the Development of Afghanistan (WADAN), Afghan Supporting Point (ASP), Organization for Health and Social Services (OHSS), Social Service for Afghan Women Organization (SSAWO), and Afghan Relief Committee (ARC).

General Project Objective:

To maintain the operation and service delivery of residential, home-based, and outpatient treatment and rehabilitation facilities for drug dependents in Afghanistan.

Specific Project Objectives:

1. Continue service delivery of INL/CP-supported NGO-run residential, home-based, and outpatient DTCs.
2. Provide access to treatment and rehabilitation services for adult, adolescent, and child drug dependents, involving families.
3. Support national joint monitoring visits to all INL/CP-funded treatment centres.
4. Provide a platform for annual review of DDR programs by national and international stakeholders.
5. Preserve trained human resources in addiction treatment, especially post-August 2021 closures of government-run centres.
6. Develop self-guided UTC and translation into Dari.

The self-assessment draws from project monitoring reports, financial records, performance data, and final verification visits. It assesses performance against objectives, highlights achievements and challenges, and provides lessons learned and recommendations. The project was suspended on 28 January 2025 and formally terminated on 08 April 2025.

Methodology

This self-assessment is based on a mixed-methods approach:

- **Quantitative Data:** Analysis of performance indicators from the Performance Management Plan (PMP), including beneficiary numbers (e.g., 5,530 residential admissions, 21,310 screenings), financial utilization, and findings from monitoring visits.
- **Qualitative Data:** Insights from joint monitoring reports, stakeholder meetings (e.g., Afghan DDR Dialogue in Astana, Kazakhstan, May 2024), client success stories, and final DTC verification visits (May 2025).
- **Sources:** Internal reports (monthly/quarterly progress, financial summaries), external audits (Kudos/Grant Thornton), sanctions compliance checks (OFAC vetting), and annexes (e.g., monitoring summaries, visibility materials).
- **Scope:** Covers the full implementation period, focusing on outputs, outcomes, efficiency, effectiveness, and sustainability.
- **Limitations:** Early termination truncated some activities (e.g., Self-led UTC Dari translation).

Performance is rated as:

- **Achieved:** Fully met or exceeded targets.
- **Partially Achieved:** Met with limitations.
- **Not Achieved:** Unmet due to external factors.

Key Achievements and Performance Against Objectives

The project demonstrated resilience in a challenging environment, delivering services despite political instability, banking restrictions, and COVID-19 impacts.

Overall achievement rate: 75-80% of planned targets, adjusted for early termination.

Objective 1: Continue Service Delivery of NGO-Run DTCs

- **Status: Achieved.**
  Supported 24 DTCs (19 residential, 5 outpatient) and 1 Data Centre until stop-work order.
  Key Outputs: 5,530 residential admissions, 486 home-based admissions; 21,310 youth screenings/assessments; 13,648 received aftercare supports.
  Bed Capacity: 425 beds maintained; annual discharges ~3,020.

  Trends: Admissions increased over time (e.g., residential from 685 in Oct 2022-Jan 2023 to 925 in Oct 2024-Jan 2025).

  Impact: Reduced relapse rates, improved physical/mental health, and enhanced family reintegration.

Objective 2: Provide Access to Treatment with Family Involvement

- **Status: Achieved.**
  Beneficiaries: 2,649 adult females, 626 female adolescents, 1,962 children.

  Services: Residential (45-90 days), home-based (402-472 annual admissions), outpatient (5,445 referrals).

  Family Engagement: Counselling sessions integrated; success stories highlight reintegration.

Objective 3: Support Joint Monitoring Visits

- **Status: Achieved.**
  Conducted quarterly: Virtual until 2023; in-person from March 2024 (e.g., March 2024, September 2024, January 2025).
  Partners: UNODC, WHO, national DDR experts.
  Final Verification: May 2025 visits confirmed orderly closures.

Objective 4: Platform for Stakeholder Review

- **Status: Achieved.**
  Afghan DDR Dialogue (6-8 May 2024, Astana): Attended by representatives from IPs, UNODC, WHO, UN Women, EU, CPDAP/KFO staff.

  Outcomes: Shared lessons on DDR challenges; hybrid format enhanced accessibility.

Objective 5: Preserve Human Resources

- **Status: Partially Achieved.**
  Challenges: Staff turnover post-2021; many relocated via P1/P2 programs.

  Efforts: Renewed contracts, 3 new treatment coordinators joined KFO in March 2024.

Objective 6: Develop Self-Guided UTC Courses

- **Status: Partially Achieved.**
  Completed UTC Basic (1-8) and Advanced (16, 22) in English/Spanish; hosted on HeK and ISSUP Hub.

  Dari Translation: Planned, however, not implemented due to termination.

Challenges and Risks

Operational Challenges:

- Political Instability: Post-2021 restrictions on women (e.g., Mahram requirements) delayed activities; no engagement with de facto authorities.
- Banking Constraints: Relied on MSPs (2.5% fees), bank accounts frozen.
- Staff Retention: High turnover, security risks.
- Logistics: Earthquakes (Herat 2023), COVID-19 shifts to virtual monitoring.
- Early Termination: Disrupted services; unpaid dues, client transitions.

Risks and Mitigation:

- Sanctions Compliance: Regular OFAC vetting (every 6 months): no issues identified.
- Security: Questionnaires and checklists used, joint missions were conducted with other IOs UNODC/WHO.
- Financial: Kudos audits ensured expenditure verification, MSPs for fund transfers.

Financial Summary

- **Total Funding:** USD 13,602,895.84
- **Utilization:** 46.72%
- **Closeout:** Final settlements by October 2025; all obligations cleared.

Lessons Learned

- Community Engagement Builds Resilience: Involving elders/families reduced stigma and supported reintegration across DTCs.
- Human Resource Fragility: Sudden staff lose capacity; need for knowledge transfer procedures.
- Gender Considerations: Structural support (e.g., Mahram expenses) is required for female participation.
- Monitoring Strengthens Accountability: Joint visits with other Ios such as UNODC and WHO ensured quality of the monitoring visits.
- Adaptability is Key: Conduct virtual monitoring if in-person visits are not possible and MSPs enabled fund transfer continuity amid crises.

Recommendations

- Sustainability: If possible, link DTCs to new donors.
- Financial Mechanisms: Budget for MSP fees and provisions to cover additional expenses such as Mahram expenses.
- Monitoring and Evaluation: Adopt hybrid (virtual/in-person) models; use digital tracking for follow-ups.
- Stakeholder Collaboration: Annual dialogues with project partners and donors helps to align DDR efforts.
- Risk Management: Build contingency plans for political shifts; strengthen sanctions compliance tools.

Conclusion

Project 2022-AF-003 successfully sustained essential DDR services in a high-risk environment, achieving most objectives and benefiting thousands despite early termination. It exemplified adaptability, impacting client recovery, community awareness, and professional retention. However, sustainability remains a concern without continued support to DTCs. This self-assessment underscores the project's value as a model for crisis-context programming, with recommendations to guide future initiatives in Afghanistan's DDR landscape.

ANNEX 03: MONITORING REPORTS SUMMARY

Analytical Report Based on the Joint Monitoring Findings and Checklist from 24 DTC/OPTCs

Period: 23 September 2022 – 28 January 2025

Provinces: Kabul, Nangarhar, Herat, Farah, Balkh, and Badakhshan

Public Awareness Activities

Annual Target: 23,800 individuals

Over the reporting period, a total of 56,345 individuals were reached through public awareness activities conducted by the outreach teams of DTCs and OPTCs—achieving 97.9% of the cumulative pro-rated target of 57500.

Performance improved progressively each year:

- 2022–2023: 18,300 (76.89% of annual target)
- 2023–2024: 22,650 (95.16%)
- Aug 2024 – Jan 2025: 15,359 (129.067% of pro-rated target)

Kabul and Herat led in outreach coverage, reaching 15,270 and 14,930 individuals respectively, due to urban access and strong coordination. Farah showed steady progress, while Nangarhar underperformed due to security and access issues. Badakhshan and Balkh maintained consistent efforts despite logistical challenges.

Key achievements include widespread dissemination of drug prevention messages, strengthened referral systems, and reduced stigma. Challenges such as security instability, remote geography, and limited resources affected outreach in some provinces.

Recommendations include targeted support for low-performing areas, increased community involvement, ongoing staff capacity building, and strengthened monitoring systems to enhance future outreach impact.

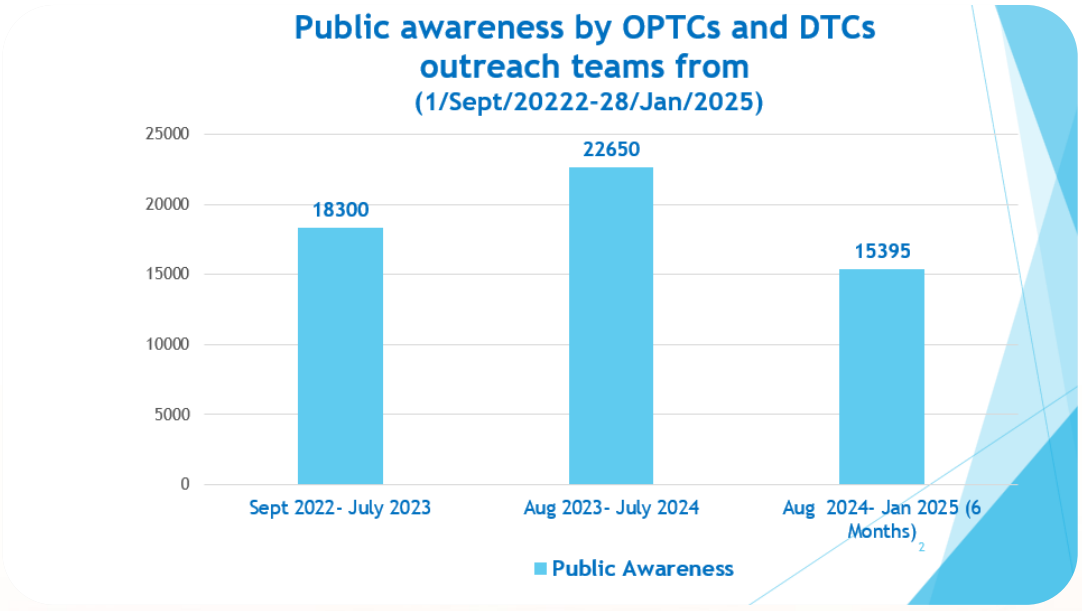


Figure 37: Public Awareness by OPTCs and DTCs Outreach Teams

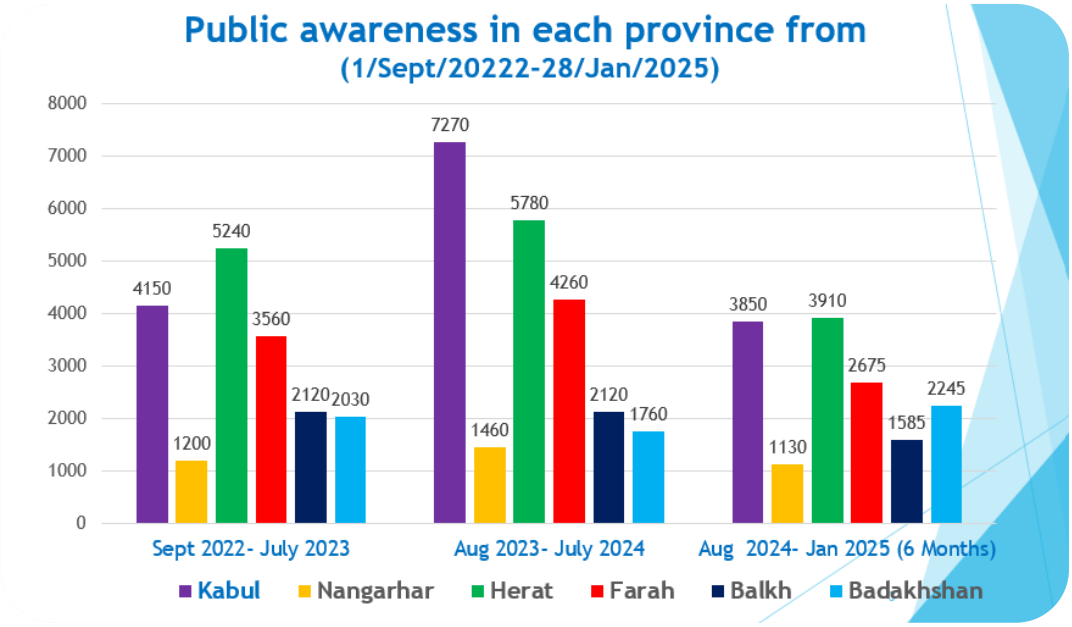


Figure 38: Public Awareness in each province

Case Detection in each Province

During the reporting period, case detection of SUD showed a consistent upward trend across all six provinces. Herat recorded the highest figures throughout, peaking at 893 cases in 2023–2024 and maintaining 488 cases in just six months of the final period—demonstrating strong outreach and referral capacity.

Kabul maintained steady performance (455–470 cases), indicating consistent urban outreach impact. Farah and Badakhshan showed significant improvements, reflecting increased community engagement and operational maturity. Nangarhar and Balkh, while starting lower, exhibited positive growth in each period.

The second year (Aug 2023 – July 2024) marked the highest detection across nearly all provinces. Notably, the last six-month period achieved nearly equivalent performance to full-year figures, highlighting improved efficiency in detection mechanisms.

In summary, the data indicates effective scaling of outreach efforts, with strong performance in Herat, Kabul, and Farah, and meaningful progress in historically lower-performing provinces.

Patient Referrals through OPTCs

Over the reporting period, a total of 5,445 patients were referred from Outpatient Treatment centres (OPTCs) to appropriate treatment services. Referral volumes remained strong and consistent, reflecting the effectiveness of outreach and screening services at the community level.

- Sept 2022 – July 2023: 2,120 referrals
- Aug 2023 – July 2024: 2,018 referrals
- Aug 2024 – Jan 2025 (6 months): 1,307 referrals

Although the number of referrals slightly declined in the second full year, the six-month period (Aug 2024 – Jan 2025) achieved over 65% of the previous full year's referrals, indicating enhanced efficiency and improved service linkage in a shorter timeframe.

The data highlights the increasing functionality and responsiveness of OPTCs in identifying and referring individuals with substance use disorders to treatment. Continued coordination between OPTCs, outreach teams, and DTCs is vital to sustaining this momentum and expanding access to care across all provinces.

Substance Use Among Referred Patients by OPTCs

The data provides critical insights into evolving drug use patterns in the community.

1. Heroin Remains the Predominant Substance

Heroin was the most commonly used substance among referred patients in all three periods:

- 909 cases (2022–2023)
- 679 cases (2023–2024)
- 438 cases (Aug 2024–Jan 2025)

Though numbers slightly declined, heroin use continues to dominate, requiring targeted interventions.

2. Methamphetamine and Poly-Drug Use are Rising

Methamphetamine cases rose from 275 to 327, indicating a growing trend.

Meth + Heroin (poly-drug use) showed consistent usage: 265 → 270 → 234 (in just 6 months), suggesting an alarming shift toward dual-substance dependency.

3. Opium Use Remains Steady

Opium use fluctuated slightly but remained around 290–356 cases annually, with 191 in the final six months.

4. Increase in "Other Substances"

Use of other substances (e.g., prescription drugs, unknown substances) grew in the final period to 136 cases, suggesting a diversification in substance abuse trends.

The data shows heroin as the leading drug among referred patients, but a notable rise in methamphetamine and poly-drug use highlights a shifting drug landscape. This shift necessitates tailored treatment protocols and expands capacity to address co-occurring substance use disorders. Continuous monitoring and adaptive harm reduction strategies are essential to effectively respond to these evolving patterns.

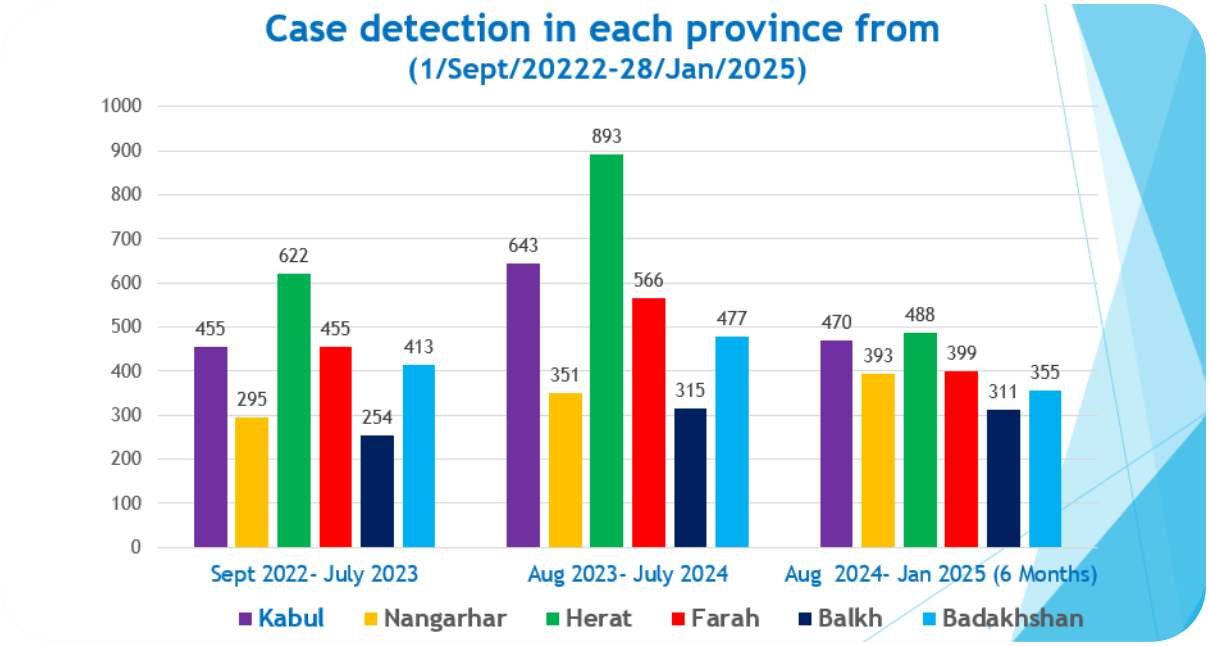


Figure 39: Case detection in each province

Residential Treated Patients by Gender through DTCs (1 Sept 2022 – 28 Jan 2025)

Between 1 September 2022 and 28 January 2025, the Drug Treatment centres (DTCs) across six provinces treated 5237 patients. Over the course of 2 years and 5 months (approx. 29 months), the total cumulative target was 7,330 patients.

Actual Performance:

- Female Adults Treated: 2,649
- Children Treated: 1,962
- Female Adolescents Treated: 626
- Total Treated: 5,237 patients

Gender & Age Group Breakdown:

Female Adults: Comprising the majority (50.6%) of treated patients, indicating high demand or accessibility for adult women.

Children: Accounted for 37.5%, reflecting significant service coverage among minors, likely influenced by family-based interventions.

Female Adolescents: Represented the lowest proportion (11.9%), suggesting a potential gap in adolescent-specific services or outreach challenges for this vulnerable group.

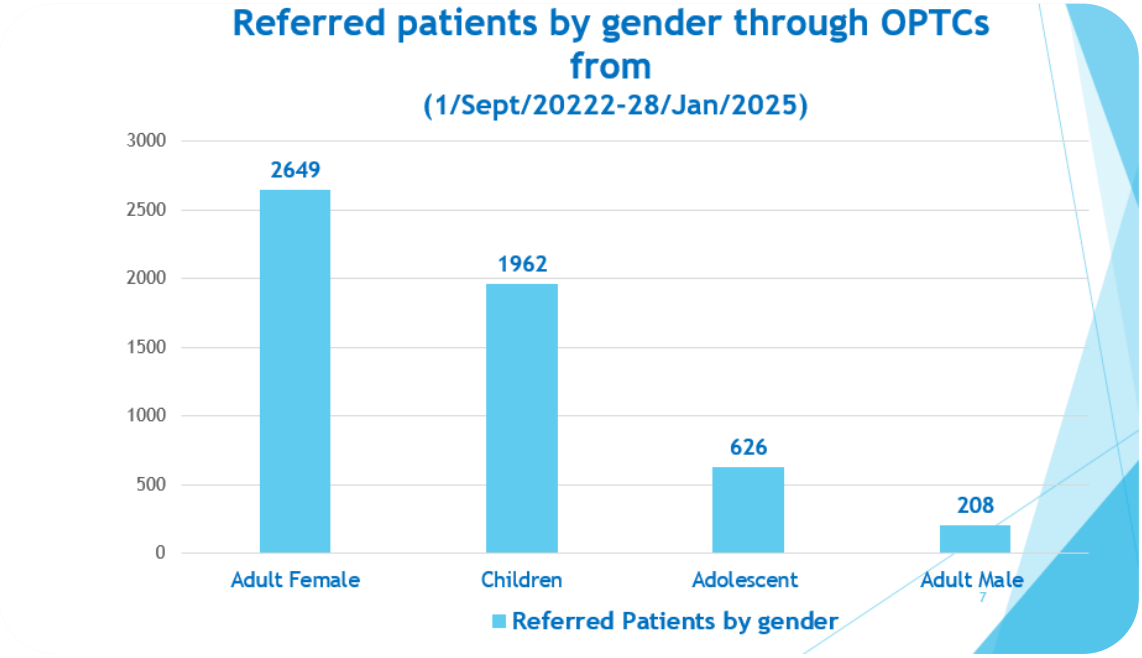


Figure 40: Referred patients by gender through OPTCs

Observations:

While remarkable progress was made in reaching adult and child populations, the lower registration of female adolescents highlights the need for targeted strategies such as gender-sensitive programming, adolescent outreach, and integration with schools or youth services.

Overall underachievement (27.3% shortfall) could be attributed to challenges such as insecurity of the coverage area, cultural barriers, or resource restrictions.

Recommendation:

Intensify outreach and case identification, particularly for adolescent females, and evaluate center-specific bottlenecks to improve overall performance and close the gap towards annual targets.

Home-Based Treated Patients by DTCs

Target: 983 patients per 29 months across 6 provincial DTCs (Total Target 870 for around 29 months)

Actual Performance:

- Sep 2022 – July 2023: 402 patients
- Aug 2023 – July 2024: 472 patients
- Aug 2024 – Jan 2025: 109 patients
- Total Treated: 983 patients

Analysis:

- Overall Achievement Rate: 983 out of 870 = 112.98 % of the target achieved.
- Year 1 (2022–2023): Achieved 46.20% of the annual target.
- Year 2 (2023–2024): Achieved 54.25%, showing improved coverage and outreach.
- Year 3 (partial, 2024– 29/Jan/2025): Achieved 12.52 % of the prorated target (109 out of 250 in 6 months), indicating potential to meet or exceed the annual goal if the trend continues.

Observations:

There was a positive growth trend in the second year, reflecting enhanced implementation capacity.

The third period shows slower progress, likely due to its partial duration, but remains on track proportionally.

Sustained efforts are needed to fully meet annual targets, particularly during shorter implementation cycles.

Recommendation:

Sustain and intensify outreach efforts and service delivery. It was advisable to utilize rapid assessment tools to promptly identify and register untreated patients, with a focus on provinces or areas showing lower performance.

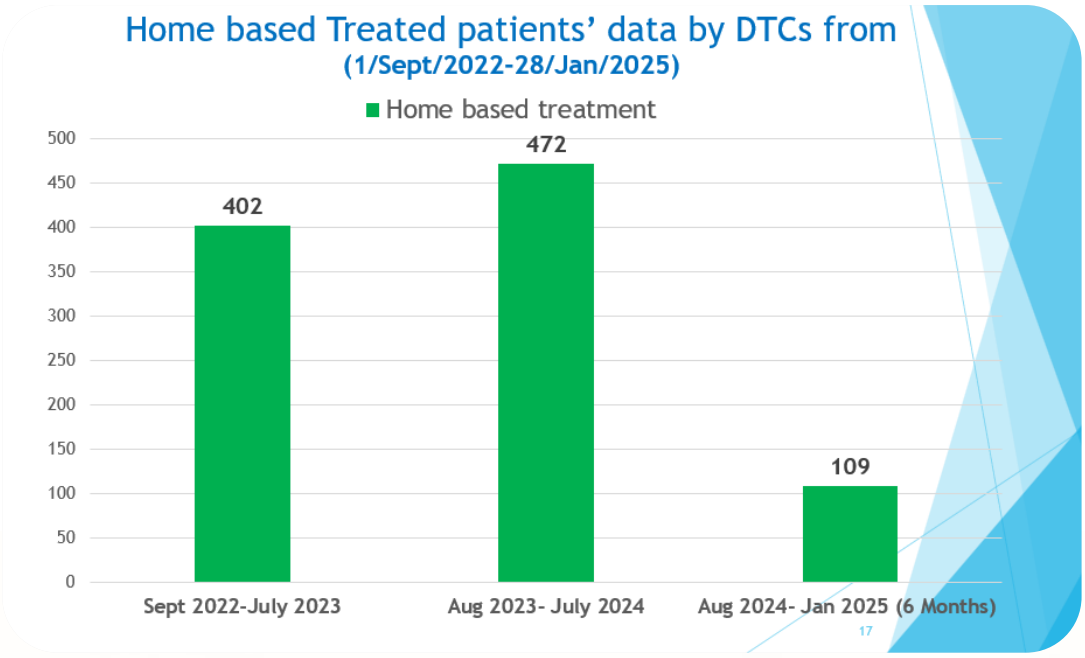


Figure 41: Home-based treated patient data

Follow-Up of Treated Patients by DTCs and OPTCs

Follow-Up Data Overview:

- Sep 2022 – July 2023: 3,051 patients
- Aug 2023 – July 2024: 2,434 patients
- Aug 2024 – Jan 2025: 735 patients

Total Follow-Ups Conducted: 6,220 patients

Analysis:

A steady follow-up mechanism was in place throughout the implementation period, with the highest number of follow-ups (49%) conducted in the first year.

A 20% decline in follow-up numbers is noted from Year 1 to Year 2, potentially due to operational or contextual challenges such as staffing, mobility, or resource constraints.

The final five-month period shows a proportionally lower figure (735 patients), which, if projected annually, would estimate around 1,764 follow-ups—indicating a slight recovery from the previous year's decline.

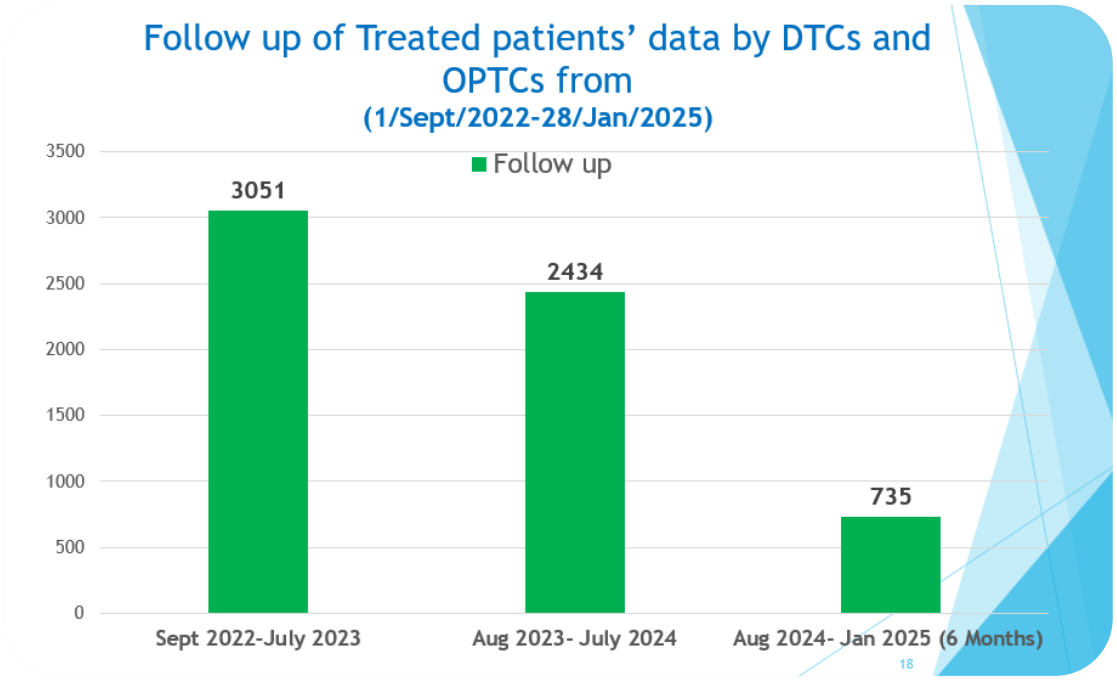


Figure 42: Follow-up of treated patient by DTCs

Observations:

Consistent follow-up activities reflect commitment to ensuring continuity of care and monitoring of post-treatment recovery.

However, the descending trend in follow-up numbers warrants further assessment to identify gaps in outreach, tracking systems, or patient availability.

Recommendation:

Strengthen coordination between DTCs and OPTCs to ensure systematic and timely follow-ups. Introduce digital patient-tracking tools and improve community-based support mechanisms to enhance retention in post-treatment monitoring. Prioritize follow-up in provinces with steep drop-offs to ensure relapse prevention and long-term recovery outcomes.

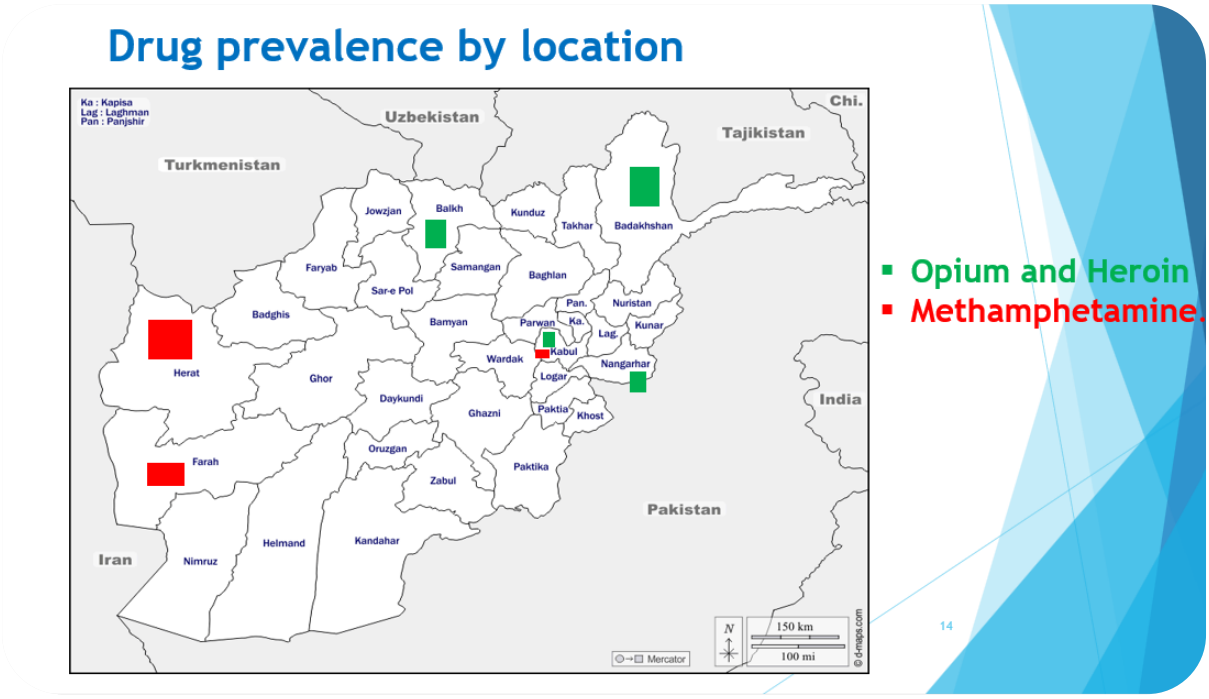


Figure 43: Map showing drug prevalence by location

THE COLOMBO PLAN

AFGHANISTAN DTC PROJECT TERMINATION
VERIFICATION VISIT CHECKLIST

1	**Date of Verification Visit**			
2	Treatment Coordination Name			
3	Province			
4	Name of Implementing Partner (IP)			
5	Name of DTC/OPTC			
6	GPS coordinates:			
7	Location:			
8	Current status	Open:	Closed:	Other details:
9	**If closed**			
9.1	Has the Building been handed over?	Yes:	No:	
9.1.1	If yes, take a copy of the handed-over items' list as supporting and submit it along with your verification report			
9.2	Has the Assets been handed over?	Yes	No	
9.2.1	If yes, take a copy of the list of handover items as supporting and submit it along with your verification report	Available:	Unavailable:	To whom was It handed over?

9.2.2	If the Assets have not been handed over - Provide reasons			
10	**If the DTC is still operational**			
10.1	What are the reasons?			
10.2	Funding source	NGO:	Community:	DfA:
10.3	Number of patients	Waiting list:	Detox:	Rehab:
10.4	Number of staff	Technical:	Supportive:	
10.5	Type of services	DTC:	OPTC:	Other: Specify the type of service

Additional Comments and Remarks:

- **Client Interviews (if applicable):**
- **Staff interviews (if applicable):**
- **Community:**
- **General observations – narrative description of what did you see inside the DTC?**
- **Photos – include some photos from the most recent situation of the DTCs during your verification visit.**
- **Video – a short video of the DTC during the verification visit (upload in OneDrive and provide a link here).**

Signature:

ANNEX 05: SECURITY QUESTIONNAIRE CHECKLIST

GATHERING SECURITY RELATED INFORMATION FROM 24 – DTC OPERATED BY THE COLOMBO PLAN DRUG ADVISORY PROGRAMME (CPDAP) IN AFGHANISTAN

This checklist is comprising of 21 security related questions and helps to assess various dimensions of the security situation in certain provinces of Afghanistan, from current threats to the response and future projections.

CHECKLIST

PROVINCE	
DTC NAME and TYPE	
DATE	
INFO GATHERED BY	

SN.	QUESTION	RESPONSE	REMARKS
1. GENERAL SECURITY SITUATION			
1.1	What is the current overall security level in your district?		
1.2	Have there been any security incidents (e.g., petty crime, theft, robbery, kidnappings) in the past week/month?		
1.3	What is the current status of influence (or implementation)? of Promotion of Virtue and Prevention of Vice (PVPV) Law by the Taliban in the key areas of your province?		
1.4	If any Taliban decrees affect the work of the DTCs? Which ones, how does it impact? What is the solution to be done?		
1.5	How is the DfA ability to maintain order and respond to security incidents (if any)?		
2. THREAT ASSESSMENT			
2.1	Are there any known terrorist groups or insurgent activities operating in specific districts/province?		
2.2	What is the likelihood of civil unrest or demonstrations occurring in your district?		

2.3	Are there any specific threats targeting nationals, internationals and DTC personnel?		
3. HUMANITARIAN AND CIVILIAN SAFETY			
3.1	How safe is it for civilians to travel between districts, and from one province to another?		
3.2	Have there been any incidents or reports of civilian casualties or human rights violations?		
3.3	What is the status of refugees, returnees, or displaced populations (IDPs) due to poverty or natural disasters (in this community/ district)?		
3.4	Are humanitarian organizations able to operate freely, or they are facing restrictions and security risks (in this community/ district?		
4. INFRASTRUCTURE AND LOGISTICS			
4.1	Are major roads and highways safe for transportation, or are they targeted by insurgents/robberies?		
4.2	Have there been any incidents of Road Traffic Accidents (RTAs) in your area that have prevented mobility to the DTC? (Cars, motorcycles, three wheelers, etc.?		
5. ECONOMIC AND SOCIAL IMPACT			
5.1	How is the local economy affected by currency, inflation, market disruptions, lack of access to essential services, etc.?		
5.2	Has any incident occurred recently that impacted schools, hospitals, or other public services?		
5.3	What is the impact of unemployment and returnees in your area/province?		

5.4	Are there any significant black-market activities or trafficking operations happening in your area that you are aware of (e.g., arms, drugs)?		
6. ENVIRONMENTAL AND SEASONAL FACTORS			
6.1	Are there any seasonal weather patterns (e.g., harsh winters) affecting mobility to the DTC in your province?		
6.2	How are environmental conditions (e.g., floods, landslides) influencing the vulnerability of regions to instability?		
7. FUTURE OUTLOOK			
7.1	What are the anticipated changes in security based on current trends and situation in your province?		

THE COLOMBO PLAN AFGHANISTAN DRUG TREATMENT CENTERS (DTC)
PROJECT TERMINATION VERIFICATION VISITS TO DTCs
MAY 2025

EXECUTIVE SUMMARY

Following the immediate stop work order issued by the U.S. government on 28 January 2025, the Colombo Plan took swift action to communicate this directive to all its implementing partners managing DTCs across six provinces in Afghanistan (Kabul, Balkh, Herat, Badakhshan, Farah, and Nangarhar). The message highlighted the stopping of the support to all DTC operations, which is effectively bringing a wide-reaching and impactful public health initiative that has been serving thousands of individuals suffering from substance use disorders to an end.

Considering the suddenness and scale of the closure, a comprehensive and culturally sensitive exit strategic approach was adopted to minimize disruption and uphold the dignity and safety of clients under treatment. The foundation of this approach was the safe reintegration of clients with their families. Implementing partners, initiating direct and respectful communication with families. Each case involved informing families of the abrupt termination, explaining the circumstances surrounding the closure, and working to ensure that clients would be received back into a supportive environment. This process was especially delicate in more conservative or rural areas, where the stigma around addiction remains strong, and required patient, trust-building dialogue to ensure successful handovers.

Demonstrating exceptional professionalism and commitment, staff at several DTCs voluntarily extended their involvement beyond the formal shutdown period, remaining in their posts until 12 February 2025. Their continued presence was crucial in finalizing critical administrative work such as the proper closure of client files, verification of treatment records, handover of program assets, and coordination with families and local authorities. Their dedication significantly contributed to the orderly wind-down of the program, mitigating potential confusion or distress for clients and their communities.

As operations came to an end, many of the physical spaces used by the DTCs—largely rented facilities—were returned to landlords. In many cases, these premises were quickly re-rented to new tenants, which presented unforeseen challenges during the verification phase. The verification visits, conducted in May 2025 was conducted by experienced KFO Treatment Coordinators with longstanding familiarity with the drug treatment programs and operation of the DTCs. The process was supported through close coordination with CPDAP HQ, whose technical teams maintained real-time contact with field teams to troubleshoot issues and ensure consistency in the approach.

In one or two incidents, the verification team encountered resistance when attempting to access former treatment sites. Challenges ranged from cultural sensitivities and privacy concerns of new tenants to unfamiliarity of the tenants with the verification personnel.

These obstacles were successfully addressed with the assistance of former centre coordinators, who helped meditate access and explain the purpose of the visit. Verification teams were able to collect comprehensive visual documentation (photos and videos) of nearly all centres. However, one DTC remained inaccessible due to a locked facility and the unavailability of any responsible contacts.

In addition to program closure and site verification, efforts were also made to safeguard remaining assets. Recognizing the uncertainty around future funding, some implementing partners pre-emptively moved valuable equipment and supplies into secure storage locations with the hope that treatment services might resume if support is reestablished.

Importantly, feedback received from clients and community members underscores the substantial value the DTCs held for those impacted by substance use. Clients expressed distress and concern over the closure, highlighting that the centres had provided not only medical and psychological treatment but also a sense of hope, structure, and meaning in their lives. They emphasized that the absence of these free and accessible services leaves a serious gap in care, particularly as private treatment options remain financially out of reach for most Afghan families. The sudden termination, therefore, represents a profound loss for vulnerable individuals and communities already struggling with addiction amidst complex social and economic challenges.

In conclusion, the closure of the DTCs supported by the project, while executed with professionalism and compassion, has a significant impact on beneficiaries and implementing partners. The drug treatment process was managed in an organized, ethical, and culturally respectful manner, but the absence of these services highlights an urgent need for renewed investment in public health responses to drug use in Afghanistan.

ANNEX 07: VISIBILITY MATERIALS

Figure 44: ARC 50-Bed Herat Adult Female and Children Residential DTC

Figure 45: WADAN 35-Bed Adult Female Centre

Figure 46: WADAN Kabul OPTC Awareness Session

Figure 47: SSAWO 70-Bed DTC in Balkh Outreach Team conducting community focused activities

Figure 49: WADAN Child DTC in Kabul - Education Session

Figure 48: WADAN Child DTC in Nangarhar - Recreational Activity

Figure 50: SSAWO 70-Bed Balkh - Group Counselling Session

Figure 51: During Monitoring Visit to ASP OPTC in Kabul

Figure 52: During Monitoring Visit to OHSS OPTC in Kabul

Figure 53: During Monitoring Visit to WADAN DTC and OPTC in Kabul Centre Staff

Figure 54: During Monitoring Visit to WADAN DTC in Nangarhar

ANNEX 08: PROJECT STAFF

The project was initially managed under the Programme Manager for Afghanistan with the support from a Programme Officer from the DAP Headquarters with regard to all project implementation activities, and through the KFO team led by the Chief of DDR, based in Kabul. Kabul based team included Chief of DDR Kabul office, 3 treatment coordinators, a finance officer, and support staff.

Three new treatment coordinators from Afghanistan were recruited in March 2024 to replace former treatment coordinators who relocated to the third countries due to the political unrest or to the United States under the P1 and P2 programmes. The new recruitment of treatment coordinators on site in order to facilitate the physical monitoring mission to the 24 DTCs as part of the project implementation.

Below are the details of all staff who contributed to this project from DAP HQ and KFO:

DAP HQ Project Staff

Figure 55: Picture of Dr. Ahmad Khalid Humayuni

Dr. Ahmad Khalid Humayuni (Programme Manager)

Dr. Ahmad Khalid Humayuni served as Programme Manager for Afghanistan at the CPDAP HQ, as assigned by the CP Management to manage DTC project operations, including MoUs with partners, fund transfers, in person DTC monitoring, verification visits, reviewing quarterly technical and financial reports, development of the proposals and supervision and technical oversight to the team in Kabul, and report to the INL and CP Management. Following the U.S. Government's Immediate Stop Work Order in January 2025, he supported the transition of DTC programs and worked with implementing partners to ensure professional and ethical client reunifications. He previously served as Programme Manager for Asia-Pacific training dissemination, Executive Committee member for the Global Recovery Network (GRN), and worked in Afghanistan as INL Advisor and Colombo Plan Consultant for Ministries of Counter Narcotics and Public Health, contributing to DDR policies, NDCS, and NDAP. Earlier, he served as team lead and deputy program coordinator for HealthNet TPO's mental health program in Afghanistan. As an internationally certified addiction professional and master trainer for UTC and UPC, he holds an MD from Nangarhar University and an MBA from London Metropolitan University.

Figure 56: Picture of Mr. Muhammad Ayub

Mr. Muhammad Ayub (Senior Treatment Advisor)

Mr. Ayub was previously assigned as a project lead in drafting project proposals in consultation with INL and developing the first MoUs between DAP and project implementing partners (NGOs). A key part of his job was to review monthly reports submitted by these partners and preparing monthly PMP reports and quarterly progress reports. Additionally, quarterly financial reports were initially reviewed by him and Kabul finance team, in order to prepare quarterly fund transfer documents. His role also entailed supervising the treatment centre monitoring work organized by KFO treatment coordinators, who work alongside joint monitoring teams including overseeing the work related to treatment centre operations. Later, he was assigned to prepare paperwork in responding to queries, questions, and information requests from donors and third-party auditors (such as SIGAR) related to Afghanistan treatment and training projects which is also a crucial aspect of the role. Mr. Ayub has ended his employment contract with the CP in March 2025.

Figure 57: Picture of Ms. Yasasi Kalutarage

Ms. Yasasi Kalutarage (Senior Programme Officer)

Ms. Kalutarage has been supporting the project since its inception in September 2022. From the beginning, she is the key person assisting the Programme Manager in various aspects of project implementation. Her initial contributions focused primarily on, monthly DTC progress data analysis, M&E, and reporting on key indicators of DTCs, including staff numbers, residential treatment, home-based treatment, outpatient services, and aftercare. She has also played a major role in preparing quarterly reports, drafting project proposals and budgets, reviewing monthly financial reports, processing payments, managing project budget variances, and handling all related project documentation and procurement sourcing.

KFO Project Staff

KFO Technical Staff

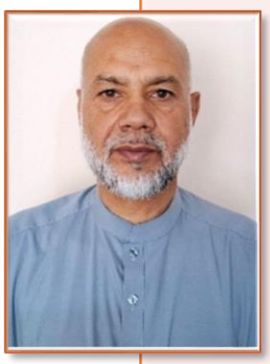


Figure 58: Picture of Dr. Mohammad Aqa Stanikzai

Dr. Mohammad Aqa Stanikzai
(Chief of DDR – Kabul Office, Afghanistan)

Dr. Mohammad Aqa Stanikzai began his career as a Programme Manager at NEJAT Drug Rehabilitation Center from October 2002 to April 2004. He then worked as a Project Officer with UNODC from April 2004 to July 2007. Following this, Dr. Stanikzai, with his background as a Medical Degree (MD) from Shikhzaid University, served as an HIV Advisor at the Ministry of Public Health between August 2007 and September 2008. He worked as a Technical Expert with the Sanaye Development Organization from October 2008 to February 2009, and then as Deputy Director at Khatiz Organization for Rehabilitation (KOR) from July 2009 to August 2010. From September 2010 to May 2019, he was the Executive Director at OHSS. Since June 2019 until July 2025, Dr. Stanikzai has served as the Chief of DDR at KFO. Dr. Stanikzai holds a Master of Public Health degree from the University of Central Nicaragua, obtained in 2018, and earned international certification in drug addiction in 2016. He also holds various certifications related to drugs and HIV from several countries, with certificates available upon request. With over 22 years of experience in drug demand reduction and HIV/AIDS programmes, Dr. Stanikzai has primarily overseen the operations of KFO and overseen the joint monitoring missions.

Figure 59: Picture of Ms. Hosai Alizai

Ms. Hosai Alizai (Finance Officer)

Ms. Alizai, with a specialization in Banking and Finance and with a Post Graduate Diploma in Business Management (PGDBM) from the India School of Business Management (ISBM), Pune, specializing in Human Resource Management, began her career working as an accountant for two years before joining the Colombo Plan as a Finance Assistant supporting both CPDAP and the CP Gender Affairs Programme. She was subsequently promoted and served as a Finance Officer for both programmes.

Figure 60: Picture of Dr. Mohammad Rahim Akbari

Dr. Mohammad Rahim Akbari
(Treatment Coordinator- Afghanistan)

Dr. Akbari graduated from Kabul Medical University in 2003 and has accumulated over 15 years of experience in the health sector, particularly in DDR in Afghanistan. He began his DDR career in 2011 as the Capacity Building Manager at the Ministry of Public Health (MoPH), where he played a key role in enhancing technical expertise in addiction treatment. Dr. Akbari holds the International Certified Addiction Professional (ICAP) certification and is officially recognized as a National Master Trainer for UTC in Afghanistan. Since March 2024, he has served as the Treatment Coordinator at KFO, overseeing and coordinating drug treatment activities across DTCs nationwide. His responsibilities include providing technical support, conducting clinical supervision and monitoring, and strengthening systems to ensure effective service delivery. He has completed Training of Trainers (ToT) certifications for both Basic and several Advanced UTC modules and has participated in international training programmes. Dr. Akbari has contributed to the development of national treatment protocols, standard operating procedures (SOPs), and guidelines. Additionally, he organized and led the creation of a national training database and has actively facilitated Echo trainings for treatment centre staff.

Figure 61: Picture of Dr. Khalida Sharifi

Dr. Khalida Sharifi (Treatment Coordinator - Afghanistan)

Dr. Khalida Sharifi is a medical doctor who graduated from Nangarhar Medical Faculty and has over 16 years of professional experience in DDR in Afghanistan. She has worked extensively in treatment centres serving women, children, and adolescents, including two years as a Coordinator in Nangarhar and 14 years with WADAN in Kabul. Dr. Sharifi holds the International Certified Addiction Professional (ICAP I) credential and has contributed as a trainer in numerous national training programmes. In March 2024, she joined the KFO as a Treatment Coordinator, where she continued to support and strengthen treatment services and training efforts in the substance use field.

Throughout her career, Dr. Sharifi has been dedicated to improving access to effective, compassionate, and gender-responsive treatment services for women and children affected by substance use in Afghanistan.

Figure 62: Picture of Dr. Samin Stanikzai

Dr. Samin Stanikzai (Treatment Coordinator - Afghanistan)

Dr. Mohammad Samin Stanikzai completed high school in 1991 and subsequently enrolled at Nangarhar Medical Faculty, Nangarhar University, graduating in 1998. Following graduation, he worked as a Basic Health Center (BHC) officer in Surkhroad District. Between 2003 and 2006, he served as a national trainer for the Integrated Management of Childhood Illnesses (IMCI) programme under the Ministry of Public Health, Afghanistan. In December 2006, Dr. Stanikzai joined the Nangarhar 170 Beds Drug Addict Treatment Hospital as a medical doctor and worked there until 2016. From 2016 to 2024, he served as the provincial coordinator for the hospital. In March 2024, he began working as a Treatment Coordinator with the KFO until July 2025. Dr. Stanikzai is the author of four books in Pashto: Narcotic Drugs, Narcotic Drugs and Related Diseases, Medical Management of Certain Drug Addictions, and Intoxication or Overdose Management of Some Drugs and Psychoactive Substances. He has also translated several modules of the UTC and UPC from English to Pashto. He passed the International Certified Addiction Professional (ICAP-1) exam in 2017 and has been a national trainer with the Colombo Plan since that year.

Figure 63: Picture of Ms. Latifa Ahmadi

Ms. Latifa Ahmadi
(Senior Treatment Coordinator - Afghanistan)

Ms. Ahmadi performed her role as a Senior Treatment Coordinator KFO from November 2015 to February 2024, Ms. Ahmadi provided technical support to DTCs by planning and implementing monitoring missions to ensure high-quality service delivery aligned with international standards and the UTC, which she delivered alongside national trainers. She also collaborated closely with government partners until August 2021 (prior to the collapse) and continued working with national and international organizations thereafter. Her contributions supported informed decision-making through evidence-based reporting and advocacy, strengthening DDR efforts across Afghanistan.

Figure 64: Picture of Dr. Enayatullah Moserrat

Dr. Enayatullah Moserrat
(Senior Treatment and Training Coordinator - Afghanistan)

From November 2015 to February 2024, Dr. Moserrat served as the Senior Treatment and Training Coordinator, responsible for delivering UTC training to clinical staff at DTCs. His duties included training management and budgeting, preparing training materials, conducting training sessions as a trainer, and fulfilling all other training-related requirements aligned with the project's goals and targets. In addition, he conducted regular monitoring visits to treatment centres to ensure that service delivery met project standards and that training topics were effectively applied in practice according to the training curricula. .

Figure 65: Picture of Mr. Saida Gul Stanikzai

Mr. Saida Gul Stanikzai
(Treatment Coordinator - Afghanistan)

Mr. Stanikzai served as a treatment coordinator at KFO for 8 years until February 2024. During his tenure, he worked and visited most of the DTCs to provide technical and professional guidance for further improvement. Furthermore, to assist in building and capacity of DTC staff.

Mr. Jamil Hotak (Support Staff)

Mr. Hotak worked as a driver for KFO from January 2012 to April 2025. He is fluent in three languages: Dari, Pashto, and English.

Figure 66:
Picture of Mr. Jamil Hotak

Mr. Mohammad Ali Khorami (Support Staff)

Mr. Khorami served as a cook at KFO from October 2012 until March 2025. He studied culinary arts in 1996 at Mr. Mac's Restaurant and Fast Food in Karachi, Pakistan. He is fluent in four languages: Dari, English, Pashto, and Urdu.

Figure 67:
Picture of Mr. Mohammad Ali Khorami

Mr. Muhammad Mirwaise (Support Staff)

From 2012 to 2024 Mr. Mirwaise worked as a cleaner at KFO.

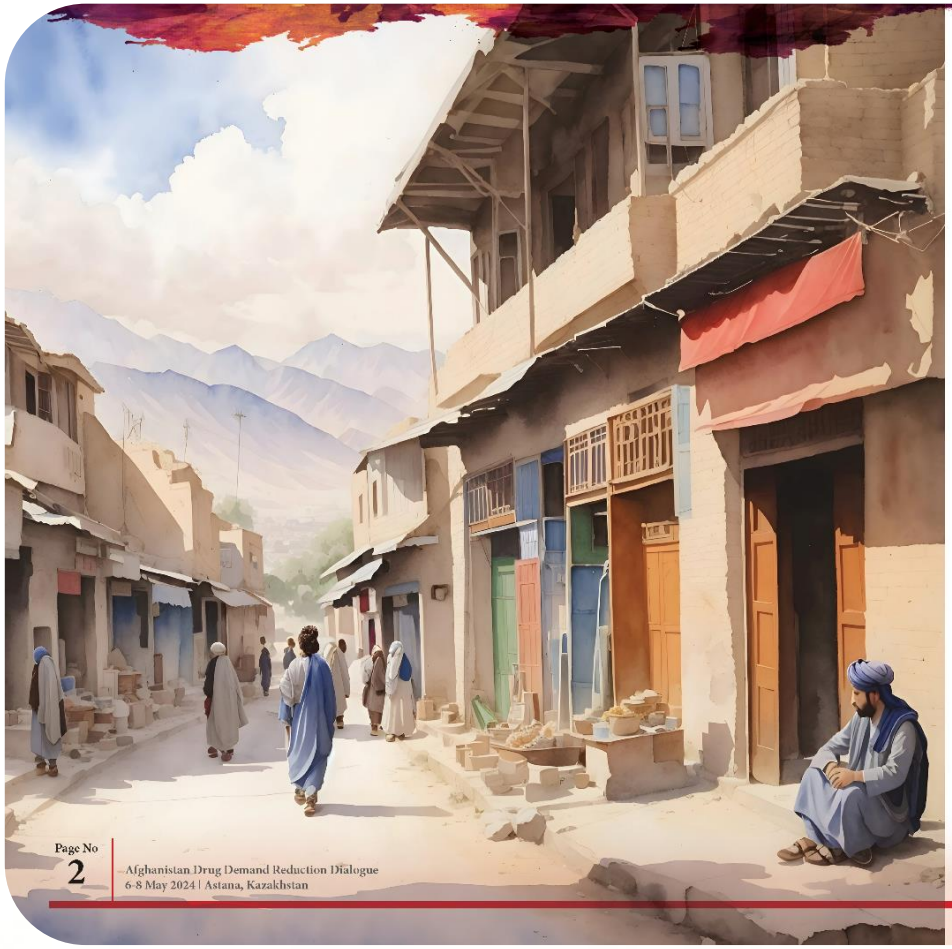
Figure 68:
Picture of Mr. Muhammad Mirwaise

SUMMARY REPORT

AFGHANISTAN DRUG DEMAND REDUCTION DIALOGUE

6 – 8 MAY 2024 | ASTANA, KAZAKHSTAN

THE COLOMBO PLAN | DAP Drug Advisory Programme



INTRODUCTION

1. The Afghanistan Drug Demand Reduction (DDR) dialog was convened from 6th – 8th May 2024 at Hilton Astana Hotel, Astana, Kazakhstan. This meeting aimed at exploring the latest drug situation and trends in Afghanistan, exchange information of the ongoing initiatives, re-assessing the collaborative mission of the Colombo Plan Drug Advisory Programme (CPDAP) and their Implementing Partners (IPs), and identifying ways forward for more collaboration with all stakeholders.

2. The three-day meeting had attendees both in-person and virtual. The meeting was attended by representatives from five Implementing partners; ARC, ASP, OHSS, SSAWO, and WADAN. In addition, representatives from UNODC, WHO, DAWEO joined the meeting. The meeting also had the participation of CPDAP staff in Colombo and Kabul Office in Afghanistan. Representatives from UN Women, EU, and Ministry of Healthcare Kazakhstan joined virtually. The List of Participants appears as ANNEX 1.

AGENDA ITEM 1:

OPENING REMARKS BY DAP AND INL

3. The opening remarks was given by Ms. Oranooch Sungkhawanna, Director of the Colombo Plan Drug Advisory Programme, Mr. Bruno Bui, Foreign Affairs Officer and Ms. Amanda Pascal, Foreign Affairs Officer of the INL, U.S. Department of State. Ms. Sungkhawanna welcomed all the attendees to the meeting and highlighted the meeting objectives. The objective of the meeting revolves around exploring current drug use and trends in Afghanistan, identifying gaps in substance use, and sharing DDR experiences with the larger group. The meeting was informed about the emphasis of the importance of collaborative efforts in combating drug-related challenges in Afghanistan. The Meeting was also informed of the Programme Agenda, which appears as ANNEX 2.

AGENDA ITEM 2:

INTRODUCTION OF ATTENDEES

4. The meeting was chaired by the DAP Director and co-chaired by INL representatives; Mr. Bruno Bui and Ms. Amanda Pascal. The chairperson and co-chairpersons introduced themselves, followed by a round of introduction of the representatives of International Organizations, participants both in person and virtual, and Implementing Partners (IPs) of Colombo Plan.

AGENDA ITEM 3:

OVERVIEW OF INL DDR INITIATIVES IN AFGHANISTAN

5. Ms. Amanda M. Pascal, Foreign Affairs Officer from the INL, U.S. Department of State delivered a comprehensive presentation on INL Programmes in Afghanistan, shedding light on their focus pre- and post-2021. Emphasizing stakeholder collaboration, she emphasized the pivotal role of partnerships with the Colombo Plan and key international organizations like UNODC and UN Women. Together, they've made significant strides, serving over 5,000 patients with a holistic family-centered approach, catering to diverse needs including children. Notably, INL's support extends to Drug Treatment Centers via the Colombo Plan Drug Advisory Programme, complemented by UNODC's staff training initiatives and UN Women's vital contributions towards addressing gender-based violence within these centers. She also mentioned about the budgetary allocation of the INL to Afghan initiatives. Her presentation appears as ANNEX 3.

AGENDA ITEM 4:

DAP'S SUPPORT EXTENDED GLOBALLY AND DAP PROGRAMME IN AFGHANISTAN

6. Ms. Oranooch Sungkhawanna, Director of the Colombo Plan Drug Advisory Programme (CPDAP) and Dr. Khalid Humayuni, Programme Manager of the CPDAP delivered a presentation an overview of the CPDAP, areas of work, current project activities and the capacity building support provided to 80 countries including 28 member states through the CPDAP Universal Curricula. The presentation highlighted DAP's areas of focus e.g. trainings, professionalizing and expansion of services. The meeting was also informed about the evidence-based curricula developed on prevention, treatment, and recovery (UPC, UTC and URC) its curriculum development process.

The second part of the presentation focused on Afghanistan's drug use scenario and CPDAP's support extended to Afghanistan in DDR strategies. The capacity building program was highlighted through CPDAP trained 850 SUD professionals in clinical settings and offered them with credentialing support. DAP has trained a cadre of 35 National Trainers in UTC and 4 Global Master Trainers in UPC Practitioners Series (School, Workplace, Environment, Media, and Community). The translation of evidence-based curricula in local languages (UTC, UPC, CHILD, Rural Based model) was also highlighted, the latest online version is published in the year 2024. More focus paid on the existing support with funding from INL for 24 women and children Drug Treatment Centers (DTCs) through 5 Implementing Partners (IPs). The meeting was also informed some data on number of admissions in residential and homebased centres, number of people that are screened and assessed by the outpatient centers and quarterly data on Performance Management Plan (PMP) during the year 2023 along with the challenges and recommendations. Their presentation appears as ANNEX 4.

AGENDA ITEM 5:

UNODC'S CAPACITY BUILDING AND SERVICE DELIVERY IN AFGHANISTAN

7. The UNODC presentation was done by Ms. Melody Lalmuanpuii, Head of Health Section, UNODC, Kabul, Afghanistan and Ms. Anja Busse, Programme Officer, UNODC, PTRS. The presentation highlighted the country context in Afghanistan, Drug Use Prevention by highlighting the changes of technical assistance before and after 2021, Drug Use Disorder Treatment and Care before and after 2021, and ways of moving forward. The presentation highlighted the importance of prevention strategies in addressing drug use in Afghanistan. Initiatives such as the

implementation of prevention activities, including the Strong Families programme were emphasized. The presentation outlined plans for further implementation of the Strong Families programme, translations for trauma recovery interventions, remote training sessions, and the dissemination of caregiver tools to various organizations. In terms of support for treatment and care for drug use disorders the focus was on strengthening the capacity of treatment centers, addressing operational challenges, and enhancing services to ensure effective reintegration of individuals into society. Additionally, the presentation emphasized the importance of training programs to enhance the skills of service providers and stakeholders in delivering quality drug treatment and support services. Their presentation appears as ANNEX 5.

AGENDA ITEM 6:

KAZAKHSTAN'S UPDATE ON THE IN-COUNTRY DDR SYSTEMS

8. The presentation on the in-country DDR systems of Kazakhstan was made by Dr. Valeriya, Republican Center for Mental Health, Ministry of Healthcare. Her presentation covered the drug policy in the healthcare system of Kazakhstan and outlined epidemiological research findings pertaining to drug use among young population and New Psycho active substances. She further outlined the clinical protocols of diagnosis and treatment and highlighted on the Kazakhstan's medical and social rehabilitation programme. Dr.Valeriya also gave insights to the national budgetary allocations and explained the Kazakhstan's comprehensive plan to combat drug trafficking with the support of the international organizations in the years 2024-2025. Her presentation appears as ANNEX 6.

AGENDA ITEM 7:

UN WOMEN GBV PROGRAMME AND SUPPORT EXTENDED IN AFGHANISTAN

9. Ms. Irene Ramatala presented on UN Women's efforts to address Gender-Based Violence (GBV) in Afghanistan, emphasizing the support from the International Narcotics and Law Enforcement Affairs (INL) for capacity building and essential services provision. UN Women's extensive work in Afghanistan, particularly in delivering family support services, was highlighted. Challenges such as discrimination against women in NGO/INGO engagement, CSO registration/reporting, and partner capacity were highlighted, prompting a need for intervention re-focusing. Ms. Ramatala also noted the stigma faced by Afghan women accessing drug treatment facilities, leading to UN Women's collaboration with Drug Treatment Centers (DTCs) to offer additional services like psychosocial support (PSS) and livelihood opportunities. Her presentation appears in ANNEX 7.

AGENDA ITEM 8:

WHO AND EU SUPPORT TO DRUG TREATMENT CENTRES

10. The presentation was jointly conducted by Dr. Alireza Noroozi, Technical Officer of Mental Health and Substance Abuse, WHO – Afghanistan and was intervened by E.U. Ms. Karolina Lagiewka, Project Officer, E.U. Delegation, Kabul, Afghanistan. The presentation discussed various aspects related to drug use disorders and health issues in Afghanistan. The impact of natural disasters and decades of war on the population was also mentioned, resulting in a fragile healthcare system.

Afghanistan has a high prevalence of drug use, with opiates being the most commonly used drugs with the extremely rising trend of Methamphetamine consumption. Reducing drug supply alone is not sufficient to address the opioid crisis, and public health measures are necessary to reduce demand for opioids. The cultivation and production of drugs in Afghanistan were also discussed, with a possible transition in the drug market from opiates to stimulants. This shift poses new challenges that need to be addressed to effectively combat drug use disorders. The presentation also provided statistics on HIV and HCV prevalence among people who inject drugs (PWID). However, the availability of drug treatment centers was found to be limited, highlighting the need for improved infrastructure and resources.

Ms. Karolina highlighted that E.U remains as one of the leading donors for drug use disorder and mental health services in Afghanistan. Other than the DTCs, the presentation also highlighted their opioid substitution treatment (OST) clinics which will be operating on either on-site or as satellite clinics. Furthermore,

details were outlined on the Mental Health and Psychosocial Support (MHPSS) activities under the E.U. Project, and the capacity building efforts of Drug Addiction Treatment Center (DATC)/OST clinic staff. To address common challenges, the presentation emphasized the need for a paradigm shift in drug treatment policies, focusing on integrated health services. Collaboration with national and international stakeholders was seen as crucial, with a focus on developing guidelines and protocols for treatment and rehabilitation. It also highlights that current drug treatment services focus on inpatient detoxification but lack community-based aftercare, which is crucial for long-term recovery. Their presentation appears as ANNEX 8.

AGENDA ITEM 9:

PRESENTATION BY IPs

11. Mr. Mohammed Nasib, representing WADAN, delivered a comprehensive presentation on the founding and achievements (1991 to 2023) of CHATAR, a coalition of seven NGOs. Notable accomplishments include providing treatment to both genders, conducting follow-up sessions, and implementing drug awareness programs, alongside research publications and re-establishing the Afghan ISSUP chapter. Emphasizing evidence-based treatment and prevention programs, particularly the Strong Families Program, Mr. Nasib underscored CHATAR's commitment to accessibility for female staff and clients, as well as grassroots support. Despite acknowledging challenges like inadequate funding, rooted in poverty, lack of hope, and associated Post Traumatic Stress Disorder (PTSD) and psychosocial disorders, Mr. Nasib proposed collaboration with UN Women and UNODC for vocational training and urged all stakeholders in drug control to unite, empower local NGOs, expand CHATAR, raise funds, and enhance DDR services at various community levels. Suggestions included increasing the number of Drug Treatment Centers (DTCs), implementing evidence-based prevention programs, credentialing, and establishing a comprehensive drug control board. Additionally, recommendations were made to WHO to establish a DDR sub-cluster under the health cluster. His presentation appears as ANNEX 9.

AGENDA ITEM 10:

IN PERSON JOINT MONITORING MISSIONS TO CP-FUNDED DTCs IN AFGHANISTAN

12. The presentation was done by Dr. Khalid Humayuni (CPDAP, HQ), Dr. Aqa Stanikzai, and Dr. Rahim Akbari from CPDAP, Kabul Office. The presentation identified that Joint Monitoring Missions was one of DAP's initiative for several years where technical teams from Ministry of Counter Narcotics (MCN), Ministry of Public Health (MoPH), UNODC and DAP used to jointly monitor DTCs in several province of Afghanistan. It was highlighted that CPDAP has established a useful mechanism to monitor DTCs and developed comprehensive tools to monitor every aspect of service delivery in DTCs (monitoring checklist, scoring sheets, and reporting template).

DAP team from HQs and Kabul shared the findings of the recent in-person monitoring missions carried out between January – April 2024 and talked about the strengths, points to be improved, challenges and recommendations for the betterment of services. It was highlighted that the plan for the next phase will be from May – September 2024 and DAP will do the necessary coordination among the partners e.g. UNODC, WHO and freelancers. To avoid delays, it was suggested to continue with the missions if neither of the involved parties are not available for certain planned missions. All Joint Monitoring Missions will be carried out on unannounced bases. Their presentation appears as ANNEX 10.

AGENDA ITEM 11:

THE STUDY VISIT TO THE ASTANA CITY MENTAL HEALTH CENTER

13. On the 6th May 2024 at 2.00PM, the participants had a chance to enjoy the study visit to the Astana City Mental Health Center Drug Treatment Unit at the Astana Mayor's office. The high-level officials from the Astana City Mental Health Center graced a warm welcome to all participants and provided a briefing of the treatment services of the center to give a firsthand look at the actual work being done by the Kazakhstan government. After the briefing, participants walked through the residential wards and services, and observed the facilities of the center. The study visit contributed to the lively discussions on the practical challenges and opportunities faced on the ground during the meeting.

AGENDA ITEM 12:

OPEN DISCUSSION

14. Following the presentations by all stakeholders, participants were encouraged to have an open discussion, based on Chatham House's rules, on challenges and interactions with the Taliban government in Afghanistan, particularly in relation to their drug treatment centers and the involvement of international organizations (IOs) and non-governmental organizations (NGOs), challenges faced by Drug Treatment Centers (DTCs), particularly focusing on the recruitment of beneficiaries and the importance of proper record-keeping, training of substance use disorder (SUD) professionals in Afghanistan including the way forward for DDR Programs in Afghanistan. The discussion was done actively and fruitfully from all participants both in-person and virtual. Key points of discussion on each topic are as follows:

1. Challenges and interactions with the Taliban government in Afghanistan, particularly in relation to their drug treatment centers and the involvement of international organizations (IOs) and non-governmental organizations (NGOs) 9.

Proposed recommendations included:

1. Engage grassroots communities to foster trust and mobilize support for DDR strategies. Encouraging them to advocate for services from local authorities.
2. Maintain confidentiality by refraining from sharing sensitive information or activities of service recipients.
3. Prioritize advocacy efforts at the local level, while reserving indirect advocacy for higher government or de facto authorities. Consider cultural sensitivities throughout the advocacy process.
4. Enhance analysis by utilizing existing data collection methods.
5. Forge connections with other sectors such as the economy and community involvement to empower individuals in various stages of recovery.
6. Promote volunteer-based treatment approaches and ensure all eligible individuals receive necessary care.
7. Provide robust support for outpatient community-level treatment services.
8. Continuum of care is critical for the recovery of clients and should be addressed adequately.

2. Challenges faced by Drug Treatment 2. Centers (DTCs), particularly focusing on the recruitment of beneficiaries and the importance of proper record-keeping.

Proposed recommendations included:

1. Implementing an improved coordination and referral system that ensures the entire family of the beneficiary is effectively connected to necessary treatments and support services.
2. Define, plan, implement, and evaluate community treatment models, including outpatient treatment models.
3. Information sharing and coordination at the level of the DDR taskforce (under the umbrella of the MHPSS/health cluster), and coordination with other platforms at the local level.
4. Secure sharing of information/data between donor supported centers to keep confidentiality.

3. Training of substance use disorder (SUD) professionals in Afghanistan.

Proposed recommendations included:

1. Virtually connect Afghan trainers/expert professionals who have left the country to provide training for Afghan nationals currently residing in the country.
2. Conduct a comprehensive training needs assessment to tailor community-based programmes, enhancing their relevance and effectiveness.
3. Establish robust staff retention mechanisms link to performance appraisals to ensure continuity, such as monetary incentives, and capacity building opportunities.
4. Ensure alignment and complementarity with other training courses (other than CPDAP courses) conducted within the Afghan context for Addiction Professionals.
5. Respective indicators for training need to be developed based on the National and international guidelines.

4. The way forward for DDR Programs in Afghanistan

Proposed recommendations included:

1. Engage in collective advocacy efforts to raise funds and ensure effective management of resources within the DDR sector.
2. Joint advocacy initiatives at the country level to support homeless people with SUDs through adequate social and health services.
3. Incorporate grassroots-level NGOs into discussion forums to provide insights into ground-level issues and facilitate inclusive strategic decision-making processes.
4. Expand outreach efforts to engage more donors and foster greater collaboration with other international organizations (IOs) within their relevant mandates to enhance support for initiatives.
5. A proactive strategic plan among concerned stakeholders should be considered to ensure the smooth transition process.
6. Enhance the quality of existing drug treatment centers and strive for excellence in their services.
7. Explore the expansion of services to rural communities to ensure equitable access to essential resources and support.
8. Enhance coordination mechanisms involving all relevant sectors to ensure comprehensive collaboration.

Figure 69: Group Photo of the Afghanistan DDR Dialogue held in Astana, Kazakhstan from 6 - 8 May 2024

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