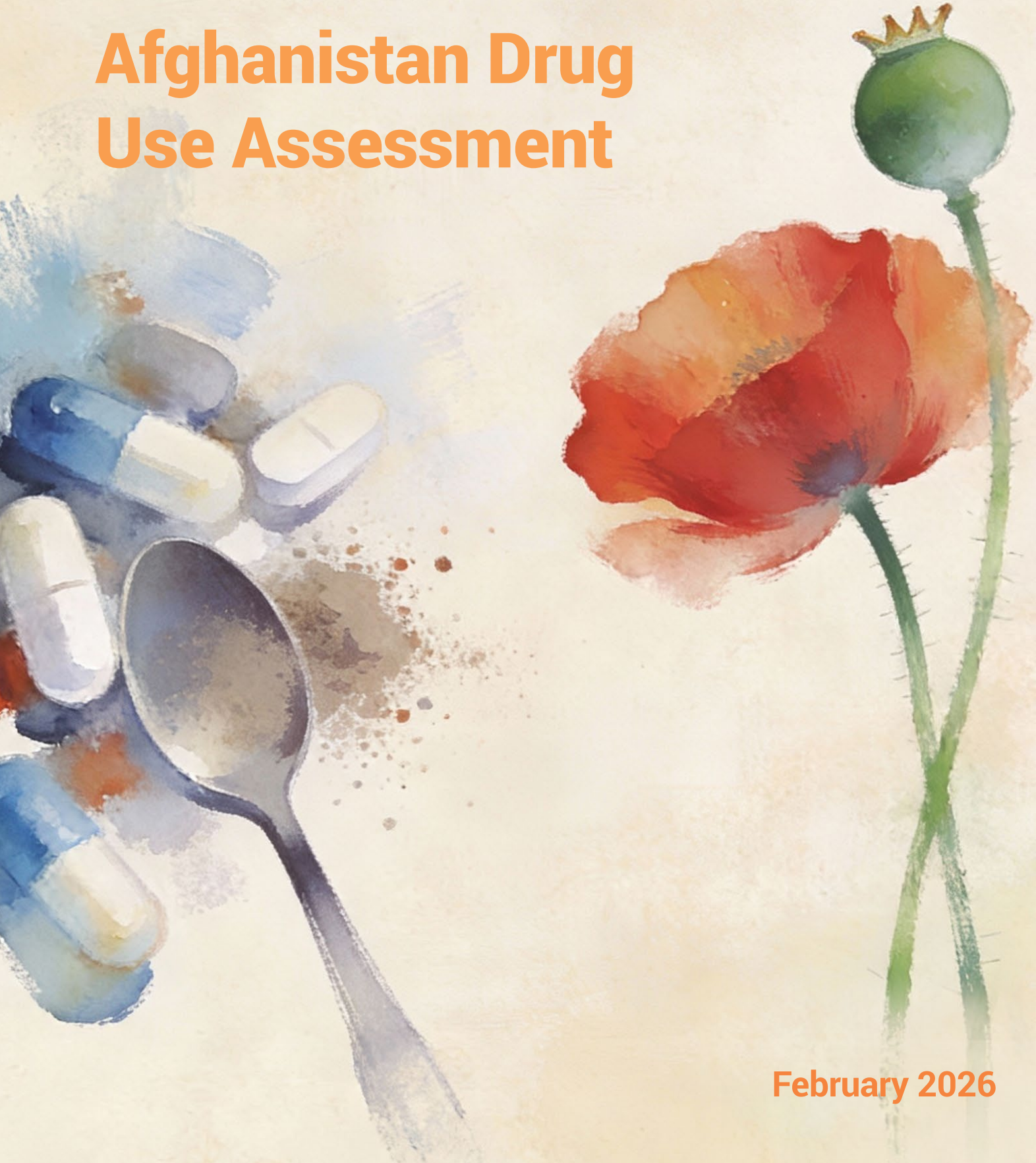
United Nations
Office on Drugs and Crime

Afghanistan Drug Use Assessment



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CONTENTS

KEY POINTS

- **Persistent data collection constraints and gaps in representativeness impede a fully comprehensive analysis.** Data collection in Afghanistan remains difficult, particularly in measuring stigmatized behaviours such as drug use. For this assessment, operational constraints and restrictions imposed by De Facto Authorities (DfA) limited proper sampling and data collection, affecting the geographical coverage and gender distribution. As a result, some regions, especially in the South and East, are underrepresented and data on women's drug use remain limited. These limitations have precluded any nationally representative estimates of drug use prevalence and hinder a complete understanding of drug use trends.
- **Drug use in Afghanistan is embedded socially yet disproportionally affects vulnerable men.** Men who report past-year drug use are typically married, live with family and are connected to work or are job seeking, yet they are younger, more often experience un- or underemployment, report lower levels of educational attainment, are more likely to have diagnosed health conditions, and are more likely to self-medicate than those who do not use drugs.
- **Cannabis dominates measures of use while opium - traditionally the primary substance of use documented by treatment admissions-, is now less frequently used in the last year than pharmaceutical products such as sedatives and opioid analgesics.** Cannabis is the most used drug among men, according to self-reports and perceptions of use among the community. Opium and heroin ranked second for lifetime use but were surpassed by pharmaceutical drugs for past-year use, indicating a possible shift in recent use patterns. This is presumably linked to the efforts by authorities to eliminate opium production starting in 2023, which could have reduced supply or access and thus nudged some consumers to substitutes that may still be available.
- **Provincial and urban patterns of perceived use differ.** Across provinces, cannabis and opium remain central concerns, but perceived patterns of use vary, with tobacco, Tablet K, methamphetamine and Pregabalin particularly prominent in some areas such as Kabul, highlighting distinct regional and urban drug market profiles. Further, there appears to be variations in the reported perceptions of use between methamphetamine and Tablet K, an illegally manufactured tablet that, among other substances, often contains methamphetamine. Tablet K appears to have a higher perception of use in eastern provinces, while methamphetamine's use is perceived to be higher in the west. It is possible that the regional perceptions of use between methamphetamine and Tablet K reflect different nomenclatures or use patterns of methamphetamine, as respondents could be referring to the same drug by different names or in different formulations.
- **Recent and poly-drug use focus on a small set of substances with high financial costs.** Among men who used drugs in the past 30 days, about half used cannabis and substantial shares used opium, codeine, Tablet K and methamphetamine. Nearly one in eight of those using drugs in the past 30 days reported poly-drug use. The amount paid for substances such as methamphetamine and opium is likely to account for a large share or exceed a day's wage for many workers. As a share of daily wage income, a use day for methamphetamine may cost 138% of a casual labourer's wages or 67% for a skilled labourer. In turn, poverty, lack of employment, and financial hardship were linked to continued drug use.
- **Harms and motivations regarding drug use reflect structural hardship.** Current drug use is mainly attributed to unemployment, economic hardship, pain and poor health, psychological distress, family problems and addiction, with men most often reporting health deterioration, family strain and poverty as key harms.

POLICY RECOMMENDATIONS

1. **Establish robust and routine monitoring, gender sensitive survey and data collection systems.** Institutionalize continuous data collection by public health authorities, such as light recurring surveillance and evaluation systems, possibly in conjunction with other health behaviour surveys, to monitor drug consumption trends (e.g. stimulant and injecting use), treatment outcomes, and service gaps for public health planning. Apply dedicated strategies embedded in respect for human rights to reach and safely include women to close critical evidence gaps.
2. **Expand and improve evidence-based treatment and service provision.** Scale up accessible, voluntary, and rights-based treatment and services for men and women, including psychosocial support and services for cannabis, opiates, pharmaceutical drugs and methamphetamine, while investing in training for health workers and minimum standards for facilities. Support a comprehensive continuum of care for substance use disorders, including outpatient and drop-in centres, to ensure that individuals receive appropriate services from early engagement to recovery support.
3. **Integrate drug use responses into social protection and health systems.** Link drug use interventions with employment support, social protection, and primary health care to address unemployment, poverty, pain, chronic illness and mental distress that respondents identify as key drivers of continued use, and to reduce reliance on self-medication.
4. **Tailor provincial responses to local drug markets.** Use provincial level patterns of perceived and self-reported use (e.g. cannabis dominance, local prominence of Tablet K, methamphetamine or Pregabalin) to design geographically differentiated prevention, treatment and enforcement strategies, with particular attention to urban centres.
5. **Mitigate the financial burden of drug dependence on households.** Recognize the high cost of regular drug use relative to daily wages and support interventions that reduce household vulnerability, including livelihood assistance for people in treatment, family centred services, and community awareness on the financial and health harms of sustained use.
6. **Expand and diversify evidence-based drug use prevention.** Develop and scale up culturally appropriate, gender-relevant, evidence-based prevention programmes that address root causes of drug use (poverty, lack of education, trauma, unemployment) and focus on early intervention in schools, communities, and families.

1. BACKGROUND

Afghanistan has historically been the world's leading source of illegally produced opium, supplying up to 80% of global opiates, particularly heroin destined for Europe and Asia.[1] This dominance was disrupted in 2023 when the De facto Authorities (DfA) enforced a nationwide narcotics ban, including opium poppy cultivation, leading to a 95% decline in opium production which fell from 6,200 tons to just 333 tons.[2] While figures on drug supply are regularly estimated and reported much less is known about drug use in Afghanistan as user surveys are sporadic.

Most recently, UNODC has conducted a mapping of drug treatment facilities in Afghanistan and assessed high-risk drug use in the country.[3,4] These surveys found that opiates have been the most common drug involved in treatment admissions as well as in high-risk drug using populations. That said, the use of stimulants, principally methamphetamine, has also been a growing concern and cannabis use is very common among drug-using populations.

A study from 2018 by UNODC estimated drug use prevalence in school-aged populations (ages 15-18), finding that 12% of students had used a drug, including alcohol and pharmaceutical drugs, at least once in the past 12 months.[5] The most prevalent drug was cannabis, at 5.6% of students using in the last year. Opium and heroin were estimated to be used at least once in 2% and 1.3% of the student population, respectively. Methamphetamine and Tablet K[6] were used at least once in the last year by 1.3% and 1.8% of the student population, respectively. The report also noted pronounced gender differences in drug use, with boys reporting much higher prevalence rates. Though for non-medical use of opioid analgesics and sedatives the past year prevalence was at similar levels among boys and girls.

An earlier study from 2015 conducted by the previous Afghan authorities, in partnership with the United States Government, estimated rates of drug use across households in Afghanistan through confirmatory analysis of hair, urine, and saliva of randomly selected households. Although the approach and estimates are not comparable to more traditional surveys that assess self-reported drug use,[7] the 2015 survey found that 11% of the population tested positive for exposure to drugs, with variations across urban and rural populations and by drug. Opioids were the most frequently detected substances in the samples collected, with 7.4% of the population testing positive, followed by cannabis at 3.4%; amphetamine-positive results were 0.3% of the population. [8]

1 United Nations Office on Drugs and Crime. (2022). Opium Cultivation in Afghanistan. Latest findings and emerging threats. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Opium_cultivation_Afghanistan_2022.pdf

2 United Nations Office on Drugs and Crime. (2023). Afghanistan opium survey 2023. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_opium_survey_2023.pdf
United Nations Office on Drugs and Crime. (2024). Afghanistan Drug Insights Volume 2 2024 Opium Production and Rural Development.. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V2.pdf
United Nations Office on Drugs and Crime. (2025). Afghanistan opium survey 2025. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Opium_Survey_2025.pdf

3 UNODC (2025) Afghanistan Drug Insights Volume 5: High-Risk Drug Use in Afghanistan. Accessed at: https://www.unodc.org/coafg/uploads/documents/Afghanistan_Drug_Insights_Volume_5.pdf

4 United Nations Office on Drugs and Crime. (2024). Afghanistan Drug Insights Volume 3 Mapping Facilities for Treatment of Substance Use Disorders: Addressing Service Provision Challenges in a Humanitarian Crisis.. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V3.pdf
United Nations Office on Drugs and Crime. (2025). Afghanistan Drug Insights Volume 5 High-Risk Drug Use in Afghanistan. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V5.pdf

5 United Nations Office on Drugs and Crime. (2018). Study on substance use and health among youth in Afghanistan. https://www.unodc.org/documents/data-and-analysis/statistics/Drugs/Drug%20use/Study_on_substance_use_and_health_among_youth_in_Afghanistan_2018.pdf

6 Tablet K is the street name for a variety of synthetic drugs sold in tablet form in Afghanistan. They can come in a wide variety of colours, shapes, and logos. Contents vary by producer and batch and typically include just methamphetamine, but some tablets may also include methamphetamine combined with opioids like heroin or tramadol; others may include MDMA along with caffeine or antidepressants depending on availability. More information can be found here: https://www.unodc.org/LSS/announcement/Details/66069555-1009-4f55-8a33-f992ea49fbc4

7 An individual may not be positive on such a screening but could have consumed a drug in the last month or year.

8 United Nations Office on Drugs and Crime. (2018). Study on substance use and health among youth in Afghanistan. https://www.unodc.org/documents/data-and-analysis/statistics/Drugs/Drug%20use/Study_on_substance_use_and_health_among_youth_in_Afghanistan_2018.pdf

There are many challenges to estimating drug use prevalence in Afghanistan, including hard-to-reach populations, stigma associated with drug use, limited access to resources, inadequate institutional capacity and collaboration, and gender sensitivities. Because of these and other reasons, regular surveys are not carried out and estimates are sporadic, at best. To update estimates of drug use prevalence, between November 2024 and January 2025 a survey aimed at asking about self-reported drug use, among other measures, in the Afghan population was carried out.

Information gleaned from assessments of self-reported drug use suggests that drug use remains a social and public health challenge and that there are variations in user behaviours across drugs and parts of the country.

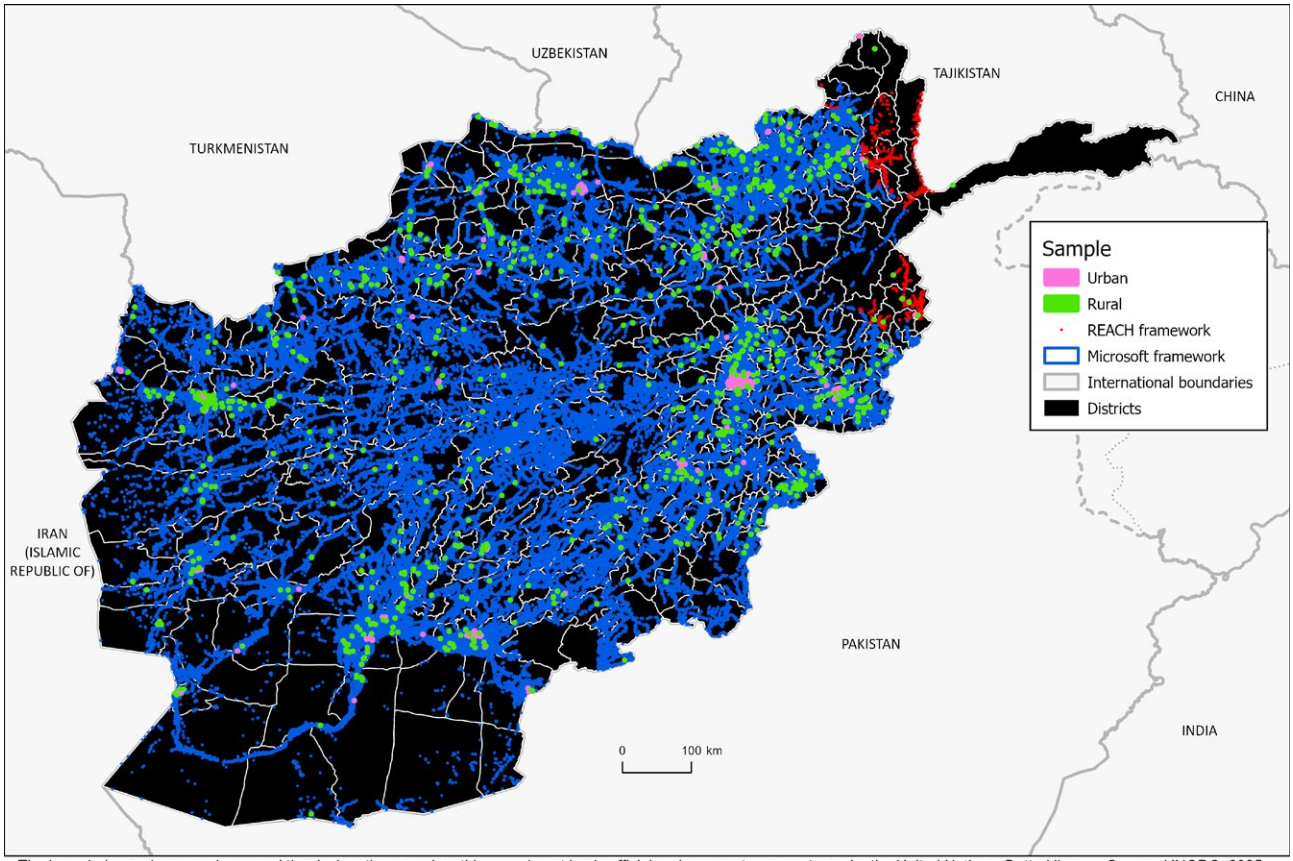
2. ASSESSMENT DESIGN AND IMPLEMENTATION

The Drug Use Assessment of Afghanistan was conceived as a national household assessment to estimate drug use and related indicators with statistically valid inference. A Probability Proportional to Size (PPS) cluster sampling strategy was adopted to enhance representativeness over simple random sampling by allocating higher selection probability to more populous units.

Because Afghanistan lacks a complete, official, and current population frame, a synthetic population surface was constructed by combining Microsoft Building Footprints[9] (6+ million structures) and REACH[10] village data to close gaps in remote areas after manual verification. Assuming 6.5 inhabitants per building yielded an estimated reference population of approximately 42.5 million, enabling PPS and cluster allocation across the country's settlement fabric. This method relies on the premise that areas with more buildings correspond to higher population density, overcoming the limitations of coarser models that are not suited for household surveys.

As no consolidated village list exists, a 1,200-meter grid (1.44 km²) was generated across the country, yielding about 60,000 candidate clusters containing at least 25 buildings. From these, 1,100 clusters were selected (341 urban, 759 rural). Within each cluster, 25 buildings were sampled, with enumerators instructed to complete 15 household interviews, targeting around 26,900 interviews. If a selected building could not be surveyed, the next available sampled unit was used to maintain feasibility in hard-to-reach areas.

Figure 1: Original sampling framework and sample areas by type



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Source: UNODC, 2025
REACH, 2024
Microsoft, 2022

9 Microsoft. (2022). Worldwide building footprints derived from satellite imagery (Global ML Building Footprints) [Data set]. GitHub. https://github.com/microsoft/GlobalMLBuildingFootprints/

10 https://www.impact-initiatives.org/what-we-do/reach/

2.1. Field realities and protocol deviation

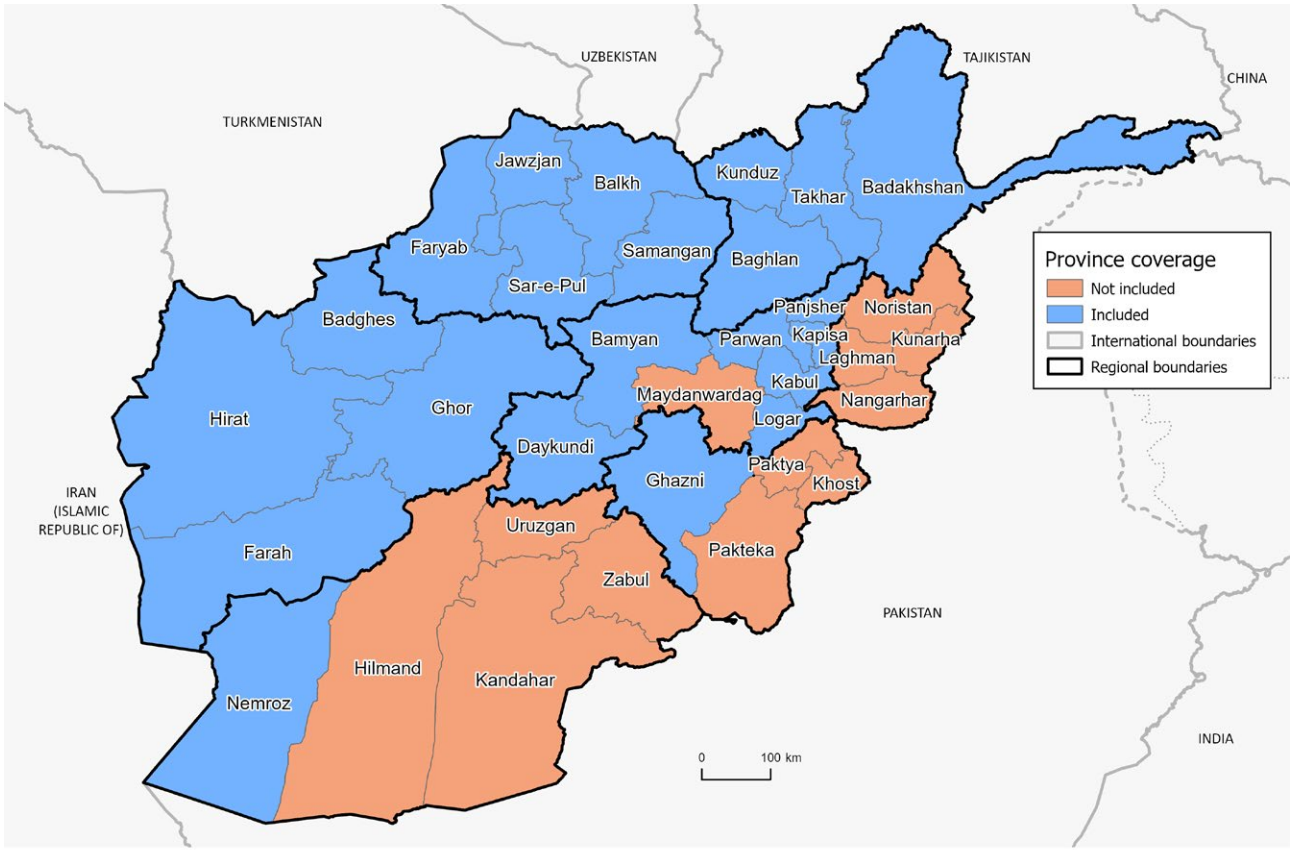
The field data acquisition process took place between November 2024 and early January 2025, but extensive constraints undermined adherence to the agreed data collection protocol. In many provinces it was not possible to carry out the survey at household level as field enumerators were directed by the DfA to recruit respondents after Friday prayers, via mosque loudspeakers, and through local religious and political authorities - practices incompatible with household-based random selection. Interview venues frequently departed from domiciles to government offices, mosques, police stations, treatment centres, or transport hubs, all of which can introduce selection and response biases. DfA or security observers were sometimes present, potentially suppressing truthful disclosure. In aggregate, over half of collected cases did not follow the intended protocol, producing severe demographic distortions (notably the near absence of women, urban overrepresentation, and atypical age profiles). The most pressing issue was the survey, as fielded, was unable to obtain a sufficient number of observations on women. In many instances, authorities prohibited enumerators from talking to women, despite efforts by the survey design to accommodate gender sensitivities by using women interviewers and phone interviews. Under these conditions the PPS design became analytically inapplicable and necessitated a pivot to post-collection quality assurance and corrective modelling.

2.2. Data cleaning, quality assurance and representativeness

The data cleaning strategy prioritized internal consistency checks, enumerator-level diagnostics, speed-of-interview filters, and the removal of implausible reports, iteratively strengthening the analytic subset. Given persistent field constraints and a very significant demographic skew, women were excluded from the primary analyses to avoid extreme weight inflation and instability; hence results for women are reported separately and without many details. This multi-stage process reduced the working dataset by over 50%, from 21,319 responses to a 9,279 men-only analytic sample after all responses presenting data quality concerns were discarded.

The level of deviation from the established data collection process was not homogeneous across the country. Data quality was markedly weaker in the south and east compared with the north. While fieldwork was conducted in all of these provinces, data quality could not always be fully ensured due to factors such as enumerator constraints, difficulties in conducting the assessment freely, and inconsistencies in the collected data. As a result, data from several provinces were excluded from the final analysis to uphold methodological rigor and ensure the reliability of reported findings. Consequently, the results presented in this assessment cover a substantial portion of the country but are not fully representative of Afghanistan as a whole. Reliable measures from provinces highlighted in blue below represent approximately 70% of the national population. Additionally, women accounted for only a very small portion of the sample, further limiting the generalizability of findings (see dedicated box).

Figure 2: Provinces included as part of the drug use assessment



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Source: UNODC, 2025

2.3. Weighting for demographic alignment and adjustments

Given the opportunistic and uneven realized sample, post-stratification weights were applied to align the sample to the target population distribution across key dimensions known to influence drug use prevalence: region, urban-rural residence, and age group. Again, responses from women were set aside for separate treatment. For each post-strata cell, the weight was computed as the ratio of the cell's population proportion to the sample proportion and applied to individual respondents. This approach restores alignment to most of the underlying demographic characteristics despite the non-probability character of the realized data.

Sensitive and stigmatized behaviours are vulnerable to misreporting, especially under coercive or supervised conditions.[11] In essence, most respondents are likely to underreport their drug use or the use of drugs by others when in the presence of authorities or others[12,13]. To partially correct for systematic underreporting, two established multiplicative adjustments were adopted from Maghsoudi et al. (2014) for Iran[14], a neighbouring country with a demographically comparable context:

11 Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. Psychological Bulletin, 133(5), 859–883.

12 Zeger, S. L., & Thomas, D. (1996). Reporting bias and correcting for it in HIV behavioural surveillance surveys: A case study from Brazil. AIDS, 10(8), 1061–1066.

13 Anglewicz, P., & Slaymaker, E. (2012). Underreporting of sexual risk behaviours in low-income countries: Implications for HIV/AIDS modelling and survey methods. International Journal of Epidemiology, 41(3), 1050–1057.

14 Maghsoudi, A., Baneshi, M. R., Neydavoodi, M., & Haghdoost, A. (2014). Network scale-up correction factors for population size estimation of people who inject drugs and female sex workers in Iran. PLOS ONE, 9(11), e110917. https://doi.org/10.1371/journal.pone.0110917

- Transmission factor: Compensates for downward bias where respondents are more likely to conceal stigmatized behaviour when asked directly.
- Popularity ratio: Applied only to proxy (acquaintance) measures to correct for incomplete knowledge of peers' drug use; many respondents are unaware that contacts use substances, especially in conservative settings.

Challenges in Measuring Drug Use Among Women

Women represented only 9.8% of the survey respondents, reflecting persistent barriers to female participation in public research activities in Afghanistan, where women's mobility and visibility in social and economic life remain heavily constrained.

That said, data collected by the assessment note that women respondents were younger than data from men, with a median age of 33 years, and most (72.2%) were married -indicating the limited participation of unmarried women due to social restrictions. Widows accounted for nearly 6% of the female sample, a much higher proportion than among men, consistent with elevated male mortality associated with prolonged conflict. Despite systemic educational disadvantage, women who did report having had a formal education displayed higher rates of tertiary attainment. This could have been due to selection bias, as educated women may feel more comfortable taking part in such activities and therefore more likely engaging and giving their views publicly. However, 36.5% of women had no formal education, underscoring enduring gender disparities in schooling and literacy that continue to restrict economic and civic opportunities.

Women's economic profile reveals profound exclusion from the labour market, with 76.4% unemployed compared to less than a quarter of men. Those employed were largely confined to locally acceptable, low-income occupations such as teaching, tailoring, and cleaning, while smaller proportions worked in private business or health. Limited mobility, childcare responsibilities, and cultural stigma around women's employment further restrict their participation in the economic life. Health outcomes also highlight structural inequities: women reported poorer self-assessed health and a higher incidence of chronic symptoms, compounded by barriers to accessing care due to the scarcity of female healthcare providers and societal restrictions on receiving treatment from men. Reproductive and maternal health concerns -including childbirth complications and gynaecological conditions- were notably prevalent.

Given these contextual and methodological constraints, the survey captured only a limited number of women who reported drug use. Drug use by women in Afghanistan is widely underreported due to entrenched stigma, social sanctions, and legal risks associated with substance use, compounded by the restricted visibility and mobility of women in public life. Cultural norms, privacy concerns, and the limitations in how participants could be recruited further hinder women from disclosing sensitive behaviours during data collection. Consequently, the low proportion of women identified in the survey should not be interpreted as an absence of prevalence but rather as evidence of significant underrepresentation driven by structural, cultural, and methodological barriers. This limitation underscores the continued challenges of obtaining accurate gender-disaggregated data on substance use in highly restrictive environments. Overall, the number of women reporting drug use was too limited to allow for statistically robust analysis or in-depth interpretation of female substance use patterns.

3. RESULTS

A total of 10,286 respondents, 9,279 men (90.2%) and 1,007 women (9.8%) aged 15–64 years, were included in the assessment analysis. The 9:1 ratio of men to women reflects constraints of data collection and fieldwork, particularly the limited access to women in areas where women's mobility and participation is restricted such as Afghanistan. Most of the results below pertain to men unless noted otherwise. Further, results are not valid for the entire Afghan population, but only for men and the provinces for which data were available.

Estimates of adjusted self-reported drug use are presented below to offer insight into the perceived extent of drug use across some categories of drugs. In addition, perceptions of drug use in a respondent's community were also asked. These measures on perception allow for ranking of drugs that are of greatest concern to respondents and presented as the proportion of respondents at both overall sample level and provincial levels. To provide further context, self-reported behaviours of those who used drugs in the past month, which is often an indicator of more regular use, are presented to compare use patterns across different drug types and to enrich the overall understanding of the drug use landscape in Afghanistan. However, these figures should not be interpreted as traditional prevalence rates representing the entire country, due to the aforementioned limitations in the dataset.

3.1. Demography of men who use drugs

The demographic characteristics of men who reported drug use in the past 12 months[15] are broadly similar to the assessment's working-age population of men in being predominantly married, rurally rooted, and active in agriculture and informal work, but they skew slightly younger, have lower rates of formal educational attainment, show more casual and unemployed labour status, rely more on self-medication- and private health facilities, and present more frequent mentions of asthma and chronic pain alongside intermittent contact with 'addiction' services.

Overall, 83.6% of the men in the sample were married and 38% had either primary or secondary-school levels of education. Employment among men in the sample demonstrates relatively diversified labour market participation: 40.4% engage in full-time work, 22.8% face unemployment, 15.9% pursue casual informal work, and 15.1% undertake part-time employment. Self-reported health status shows men in the sample to be optimistic about their health: 86.6% rate their health as good or very good, comprising 46.8% "good" and 39.8% "very good". Only 2% report bad health, and 11.3% cite moderate status. Conversely, 30.2% report at least one diagnosed condition despite self-assessing their health as good. Nonetheless, only 20.2% of men in the sample with diagnosed conditions indicated receiving some medical treatment.

In short, men in the sample are socially embedded but face limited access to healthcare that typically raises risk and lowers continuity of care in Afghanistan's strained health and treatment system. When taken together, the subset of men who self-reports drug use is not socially marginal but more health and economically exposed. Table 1 below compares demographic measures for men who self-report past-year drug use or report abstinence.

On average, those who self-report past-year drug use are two years younger than abstainers (37 vs 39 years). Men who self-report using drugs are less likely to be employed compared to those that self-report abstinence (59% vs 72%), they are less likely to have a formal education (54% vs 63%), they are more likely to be diagnosed with some other health condition (43% vs 29%); and they are more likely to self-medicate in the last year (i.e., use medications without physician supervision or guidance) (47% vs 33%).

15 The number of responses for women participants in the survey who had recently consumed drugs was not large enough for comparability with the total sample. Findings throughout this report are for men, unless stated otherwise.

Table 1: Comparing measures across men who self-report past-year drug use and those who report abstinence

Measure[16]	Self-reported use Mean (SD)	Self-reported abstinence Mean (SD)	P-value
Age	36.92 (11.15)	38.65 (12.33)	**0.0013**
Urban	0.3 (0.46)	0.34 (0.474)	**0.071**
Any formal education	0.54 (0.5)	0.63 (0.48)	**<0.001**
In a relationship	0.87 (0.34)	0.85 (0.35)	**0.392**
Employed (full or partial)	0.59 (0.49)	0.72 (0.45)	**<0.001**
Health	0.98 (0.15)	0.98 (0.15)	**0.998**
Diagnosed medical condition	0.43 (0.5)	0.29 (0.46)	**<0.001**
Self-medicate in the last year	0.47 (0.5)	0.33 (0.469)	**<0.001**

P-values calculated using Wilcoxon Rank Test; values in bold indicate significant differences at the 0.05 level. Data weighted via post-stratification.

Within the subset of men who used drugs in the past year, ages concentrate in the 20s–30s with cases ranging from late teens to the 60s, and the most frequent status as married, indicating ongoing family responsibilities. This profile aligns with evidence that Afghan men who report using drugs commonly fall in young to mid-adult-brackets and are often married[17], placing substance use risks directly within working-age households.

Educational attainment among men who self-report past-year drug use is limited, often including no formal education or lower tiers (primary, lower secondary) with many madrasa pathways noted. This is consistent with previous literature showing low levels of educational attainment among Afghan men who use drugs[18]. This lower educational attainment fits with informal work or unemployment, where barriers to diversified formal employment can heighten exposure to stressors and reduce access to structured treatment.

Care-seeking mixes government and private hospitals with primary care, pharmacies, and frequent self-medication. Some report having been taken to treatment facilities without seeking treatment themselves, often on a non-voluntary basis or against their will. Overall, those that self-report past-year drug use are more likely to self-medicate than non-users.

16 Measures are defined as follows: Age refers to the reported age of the respondent. Urban is coded as 0 for rural and 1 for urban residence. Any formal education is coded 0 if the respondent has no formal education and 1 if they have any formal education. In a relationship is coded 0 if not married or engaged and 1 if married or engaged. Employed is coded 0 for those without full- or part-time employment and 1 for those employed. Health status is coded 0 for respondents reporting very bad or bad health and 1 for those reporting good or very good health. Diagnosed medical condition is coded 0 for no diagnosis and 1 for yes. Self-medication in the last year is coded 0 for no and 1 for yes.

17 United Nations Office on Drugs and Crime. (2025). Afghanistan Drug Insights Volume 5. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V5.pdf

18 Haidary, Abdul Shukoor. "Socioeconomic factors associated with opioid drug use among the youth in Kabul, Afghanistan." RCAPS 34 (2016): 80-92. https://www.apu.ac.jp/rcaps/uploads/fckeditor/publications/journal/RJAPS34_9_Haidary.pdf

3.2. Ranking self-reported use

Responses from men reporting lifetime or past-year use of a variety of drugs revealed the rank order of the shares of common drug categories. Overall, cannabis was the most common drug reportedly used, placing it first among lifetime and past year use. Opium and heroin, some of the most common opiates found in Afghanistan, ranked second for lifetime use but third for past-year use. Pharmaceutical drugs (mostly hypnotic sedatives, tranquillizers, and other opioid analgesics) were the third most ranked class of substances used ever but second for past-year use, switching with opiates. This switch between opium/heroin and pharmaceutical drugs between lifetime and past-year use may reflect recent efforts by the DfA to eliminate opium production since 2023, which could have reduced supply or access and thus nudged some consumers to substitutes that may still be found in the country. This is one possibility given that, traditionally, opiates, such as opium and heroin, have been the primary drug class reported in treatment admissions and have a long history of use and production in the country. Other tablets of non-pharmaceutical origin and other drugs less commonly used ranked the same between lifetime and past-year use.

Table 2: Self-reported use ranking among men

Drug	Lifetime Use Rank	Past-year Use Rank
Cannabis	1	1
Opium/Heroin	2	3
Pharmaceutical drugs (e.g., barbiturates, benzodiazepines, etc)	3	2
Tablets of non-pharmaceutical origin (Tablet K, MDMA, etc)	4	4
Other	5	5

Data weighted via post-stratification.

3.3. Perceptions of the most used drug by men overall and by province

Respondents were asked to gauge their perceptions of the most used drugs where they lived.[19] Although perceived drug use is not the same as measured use, the inclusion of perceptions can provide some additional information about the scope of drug use in the country.

Overall, 32.4% of men said they knew someone who used drugs (other than tobacco or alcohol). Respondents could pick more than one drug, so frequencies do not amount to 100%. Given that the sample includes mostly men, figures below report data on the perceptions of men; responses of women are presented further down. Among men, about half -46%- perceived that cannabis was the most widely consumed drug. This was followed by opium, which was chosen by about one out of every five respondents. Together, these two drugs had the highest perceptions of use across Afghanistan. The third drug named by respondents was Tablet K, which often contains methamphetamine among other substances, at 11% of responses. Methamphetamine and heroin were less frequently perceived as common drugs of use, at 7 and 5%, respectively.

19 The question that participants answered to was: "Could you please tell me what drugs are most often used in your area now?" This was an open question and some participants included alcohol and tobacco among their responses. Although these products are not under international control, the sale and consumption of alcohol is banned in the country, while tobacco -in all its forms- was considered as a drug by some respondents. The word "drug" in this report refers to substances controlled under the international drug control conventions, and their non-medical use. Measures involving alcohol and tobacco are included for comparison.

Table 3: Perceptions of most used drugs according to men in the sample

Substance	Percentage
Cannabis (Hashish)	46.2
Opium	19.1
Tobacco (Snuff, Naswar)	14.9
Tablet K	11.2
Methamphetamine (crystal)	7.2
Pregabalin (zeegap)	6.1
Heroin	5.0
Tramadol	0.3
Alcohol	0.1
Don't know, no drugs	32.4

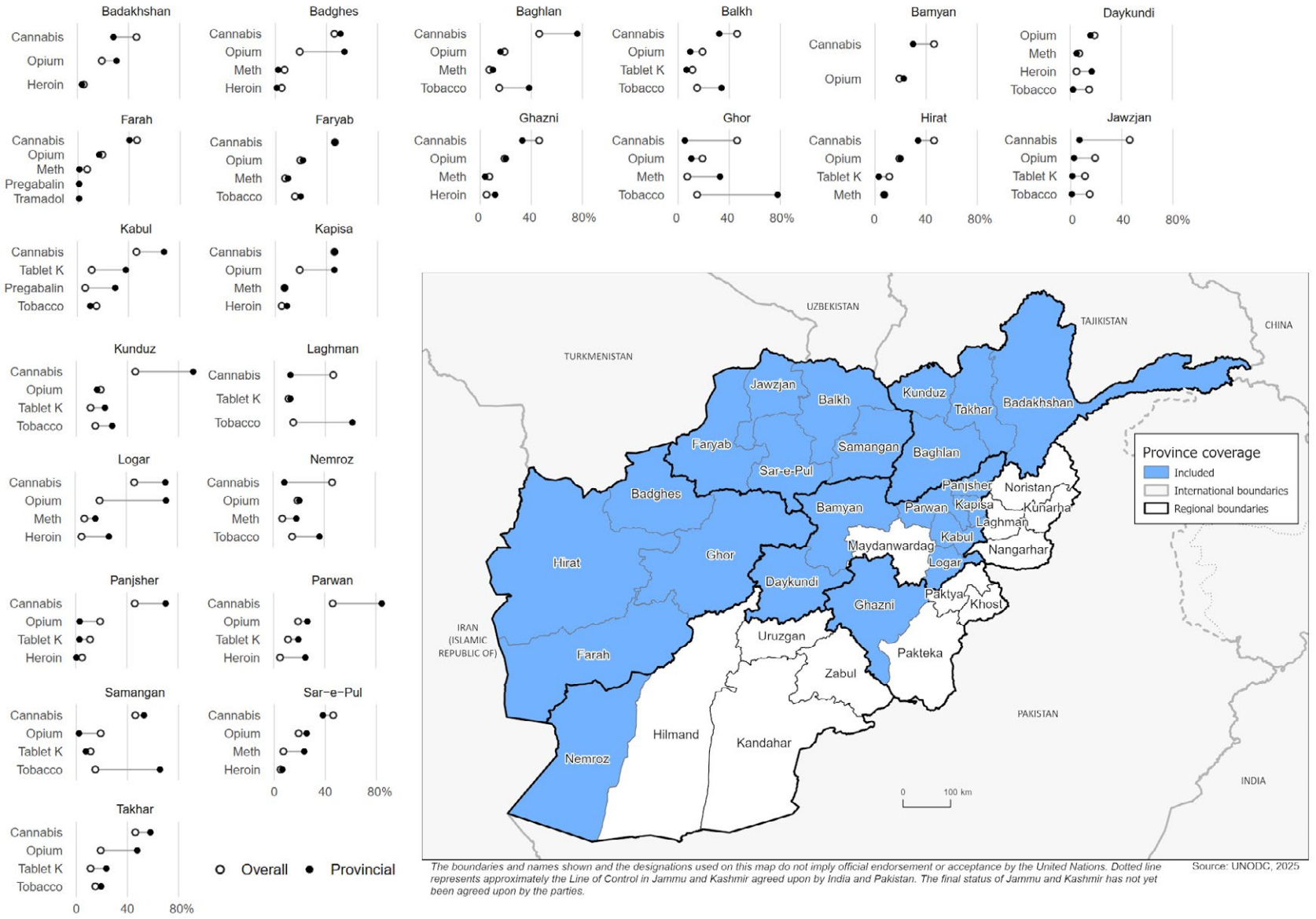
These results refer to the provinces for which reliable data were available, see figure 2. A comparison of perceptions between men and women is presented in figure 5. Data weighted via post-stratification.

In several provinces variations from the overall sample averages were observed. When examining drugs currently perceived to be most used across different provinces it was clear that cannabis dominated responses. Across almost all provinces, except for Badakhshan, Badghis, Balkh, Daykundi, Ghor, Laghman, Logar, Nimroz, and Samangan, cannabis was the drug most often perceived of highest use. However, in most of these instances, tobacco edged out cannabis as the most ranked drug of perceived use. Only in Daykundi cannabis was not listed.

Apart from cannabis (and tobacco), opium was the second most perceived used drug across regions, according to men. Tablet K was reported in several provinces, but only in Kunduz (22%), Takhar (24%) and Kabul (38%) was its perceived use appreciably high and well beyond the sample average. Likewise, Kabul stands out for the perceived use of Pregabalin as it was cited as the third most used drug as 30% of respondents mentioned it. This suggests that the urban market of Kabul is distinctly different from other provinces of Afghanistan.

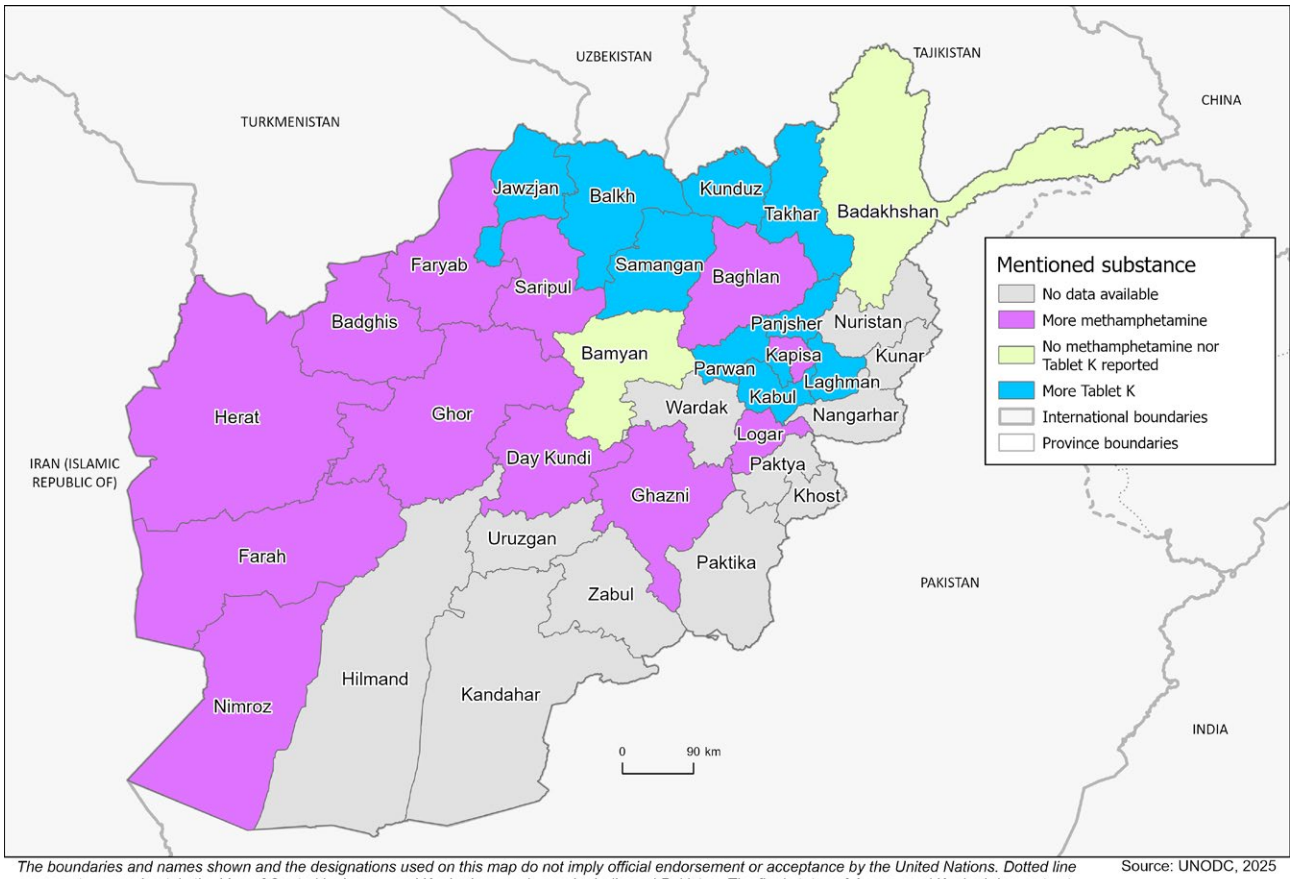
When compared to the overall average, several provinces reported higher perceived use for some drugs. Measures of perceived use of cannabis were higher than the overall average in Badghis, Baghlan, Kabul, Kapisa, Kunduz, Logar, Panjsher, Parwan, and Takhar. The provinces of Daykundi, Ghazni, Logar, and Parwan reported much higher perceived use for heroin compared with the overall average. For methamphetamine, Ghor, Nimroz, and Sar-e-Pul stand out for having higher perceived measures of use. Given the variety of substances that can appear in Tablet K, including methamphetamine, provincial responses suggest that respondents may understand Tablet K to be methamphetamine as seldomly do both appear as the top four drugs of perceived use. It could be that there are regional variations in how the drug is sold or used, with tabletted methamphetamine more common in some places while non-tabletted methamphetamine crystal more common in others.

Figure 3: Overall vs provincial perceptions of most used substances by men



Only the top four substances per province are shown. Overall averages reflect the sample -see figure 2- not the entire country. Data weighted via post-stratification.

Figure 4: Most common mention of methamphetamine vs Tablet K in Afghanistan



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Source: UNODC, 2025

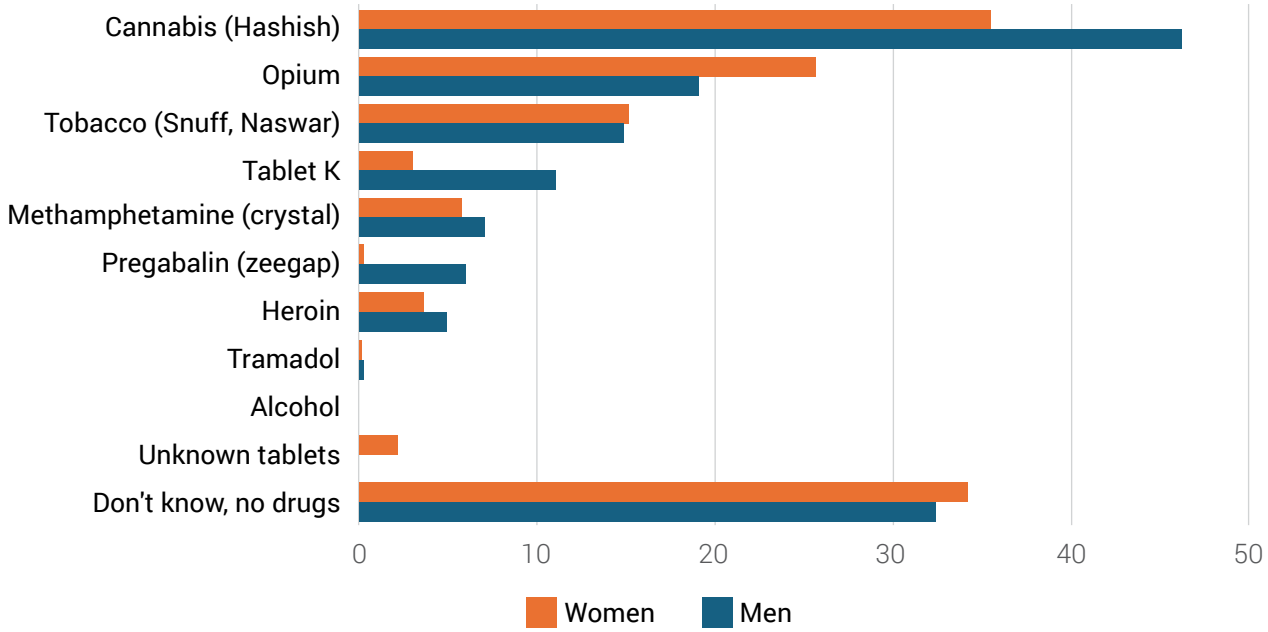
Perceptions of the most commonly used drugs align with other Afghan high-risk drug use surveys, which indicate lifetime use rates of 64% for cannabis and 62% for opium.[20] However, for past-month use, the drug most commonly used by high-risk drug using populations was methamphetamine or amphetamine at 48%, followed by heroin at 43%, then cannabis at 33%.

3.4. Perceptions of the most used drug by men and women

When breaking down the responses to perceived use among the respondent's neighbourhood between men and women, it was found that, broadly, the ranking across drugs was similar. Cannabis was the most reported drug of perceived use in the neighbourhood, followed by opium. However, men reported slightly larger shares for cannabis and Tablet K, while women reported higher perceived use for opium than men.

20 United Nations Office on Drugs and Crime. (2025). Afghanistan drug insights, volume 5: High-risk drug use in Afghanistan (Afghanistan Drug Insights Series, Vol. 5). United Nations. https://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghanistan_Drug_Insights_V5.pdf

Figure 5: Perceived most used drug by substance and reporting gender



Data weighted via post-stratification.

3.5. Prevalence estimates for men representing 21 provinces

UNODC took efforts to carefully clean responses and adjust them to reflect the underlying demographic measures for men, grouping self-reported responses for lifetime and past-year drug use for the most reported categories of substances to overcome the limitations in data quality and coverage from the challenges in data collection and reporting.

These estimates are available for men in a subset of provinces from the north, centre, and west of the country, as shown in Figure 2 above (provinces that are orange do not have reliable data). The situation in the country made it impossible to collect enough responses from women to construct prevalence estimates. **Therefore, the presented estimates are not valid for the entire Afghan population, but only for men and the provinces for which data were available.**

The table below shows that lifetime and past-year use of cannabis by the men who were interviewed stands at 13.6% and 4.8%, respectively. These were the highest reported rates for use for both lifetime and past-year use. As discussed above in rankings, opium/heroin saw higher rates of lifetime use but much smaller rates for past-year use at 6.5% and 1.5% in men, respectively. In contrast, the misuse of pharmaceutical drugs (most commonly sedatives, tranquillizers, and opioid analgesics) was reported by 6% and 2.4% of the men in their life or past year, respectively. The disparity between opium/heroin and pharmaceutical drug misuse may reflect reduced availability of opium and heroin since the enforcement of the drugs ban, which took effect in 2023. Other tablets of non-pharmaceutical origin, including Tablet K, MDMA, etc. were reported less commonly (3.2% for lifetime use and 1.5% for past-year use) as were other drugs like solvents and cocaine.

Table 4: Prevalence estimates of use of drug for men in Afghanistan representing 21 provinces

Substance	Lifetime (%)	Past year (%)
Cannabis	13.6	4.8
Opium/heroin	6.5	1.5
Pharmaceutical drugs (barbiturates, benzodiazepines, codeine, pharma opioids)	6.0	2.4
Tablets of non-pharmaceutical origin (Tablet K, MDMA, etc)	3.2	1.5
Other	0.2	0.1

These are not fully representative of all of Afghanistan but only of those provinces for which data were available, see figure 2. Estimates also exclude women due to sampling limitations. Data weighted via post-stratification. Transmission factor applied (Maghsoudi et al, 2014).

3.6. Self-reported use of drugs in the past month by men

Focusing on recent and frequent drug use, as indicated by those who used at least once in the past 30 days, provides additional insights into men currently using drugs in Afghanistan. Table 5 below shows the percentages of use of various drugs for those reporting past-month use. Overall, half of men in Afghanistan who self-reported using drugs in the past month have consumed cannabis. This was followed by alcohol and tobacco (16.6%), then codeine (13.2%), then opium (10.5%). Tablet K and methamphetamine were used around 8% of those who reported past-month use. Heroin was reportedly used by 5.4% of men who used drugs in the past month. In general, these past month use rates are ordered similarly to perceived use in the community. Cannabis prevalence is highest, followed by opiates and pharmaceutical drugs (after excluding alcohol and tobacco)[21].

Table 5: Drugs of use for those men who had consumed during the last 30 days

Substance	Use in the last 30 days %
Cannabis	49.6
Others (alcohol and tobacco)	16.6
Codeine	13.2
Opium	10.5
Tablet K	8.3
Methamphetamine	8.1
Barbiturates	5.5
Heroin	5.4
Benzodiazepines	1.8
Solvents	0.7
Opioid analgesics	0.4

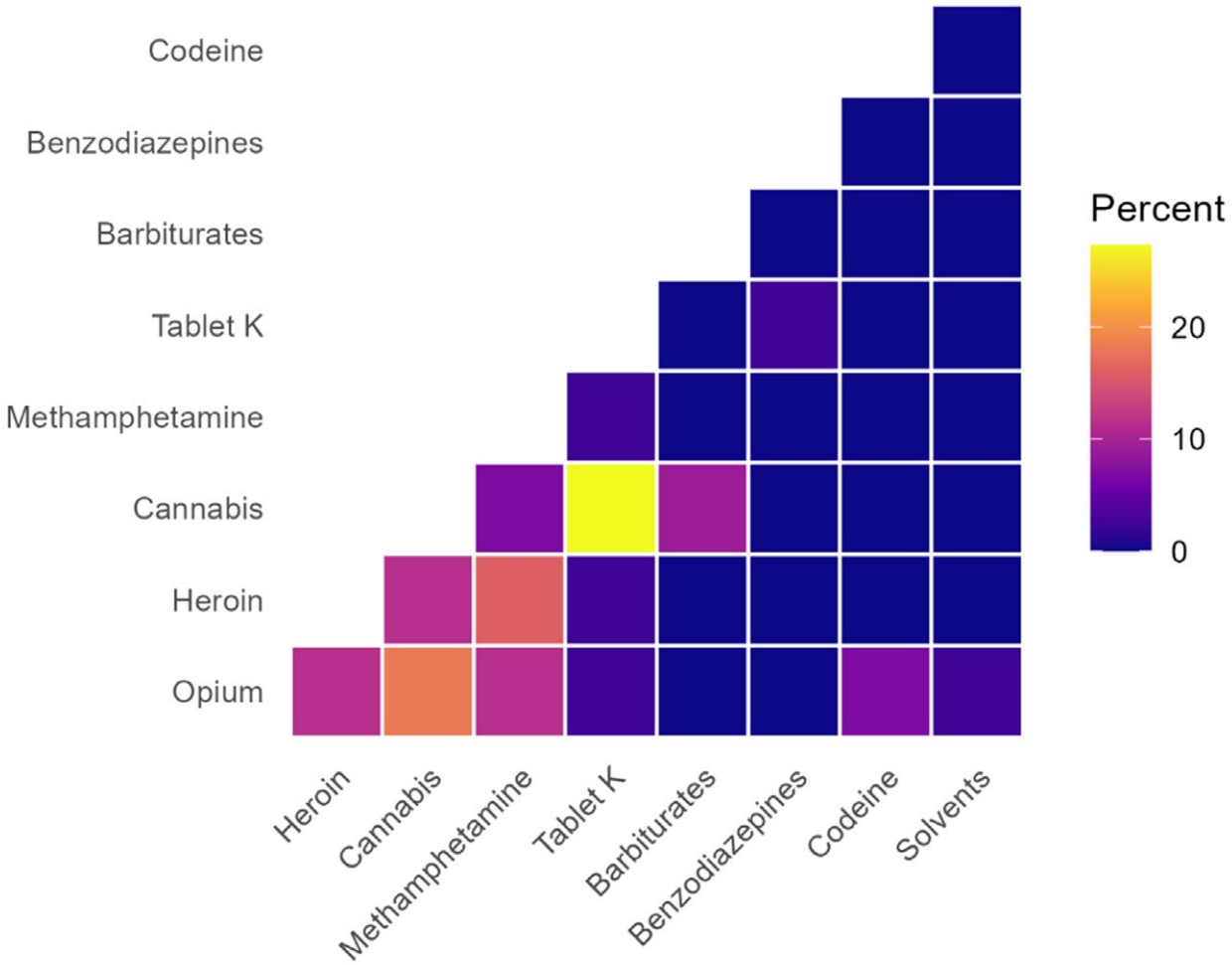
Data weighted via post-stratification.

21 Participants were asked to mention any other drug they had consumed during the last 30 days. This was an open-ended question, and some participants included alcohol and tobacco among their responses, with more considering alcohol as a drug than tobacco. Although these products are not under international control, the sale and consumption of alcohol is banned in the country, while tobacco -in all its forms- was considered as a drug by some respondents. The word "drug" in this report refers to substances controlled under the international drug control conventions, and their non-medical use.

3.7. Poly-substance use

Among men who reported using drugs in the past-month, approximately 12% had used more than one drug (excluding alcohol and tobacco). The types of poly-drug combinations varied, but there was a general overlap, with most respondents reporting cannabis use alongside some other drug. In the figure below, warmer colours indicate higher percentages of poly-drug use between the two substances listed in rows and columns. Overall, several patterns of different types of poly-drug use were noted with some self-reporting a variety of similar drugs (opioids, depressants, stimulants), suggesting substitution for a drug of similar effect or perhaps desired effects of different drugs. However, there was general overlap in poly-drug use for opium, heroin, cannabis, and methamphetamine, which were reported with the highest shares (i.e., warmer colours below).

Figure 6: Poly-drug use by those self-reporting past-month use



Data weighted via post-stratification.

3.8. First drug used and order of initiation

Across drugs, cannabis was reported to be used at the earliest age while benzodiazepines and solvents were reported at much later ages. Table 6 reports the ranking of the age of drug of first use reported by men who self-reported past month use. Higher ranks indicate younger ages of initiation.

Just over half of men reporting past-month use indicated that cannabis was the first drug of use. This was followed by opium at 18%, codeine at 15%, Tablet K at almost 4% and methamphetamine at 1.3%. All other drugs were reportedly the drug of first use in less than 1% of men who used drugs in the past month.

Table 6: Rank of age of first use by drug and percentage of respondents indicating drug of first use among past-month men who use drugs

Substance	Rank of age of first use	First drug of use (%) of responses
Cannabis	1	50.9
Tablet K	2	3.6
Heroin	3	0.2
Barbiturates	4	2.0
Opium	5	17.8
Methamphetamine	6	1.3
Codeine	7	15.4
Benzos	8	0.8
Solvents	9	0.5

Rank of age of first use is ordering of average age (higher rank is younger age). Data weighted via post-stratification.

3.9. Monthly consumption frequency and expenditures

For men who used drugs in the past month, the average number of days of use for several drugs were also calculated with the estimates reproduced below. As shown in Table 7 those who reported methamphetamine use were estimated, on average, to use 9.3 days out of the past 30. This was followed by cannabis at 8 days, then Tablet K by 6.6 and barbiturates at 6.3 days. Opium and codeine, both opiates, were used for just under 6 days on average. For other drugs, the number of responses were too low to report.

Table 7: Average number of days per month each substance is consumed for men self-reporting past month use

Substance	Average number of days consumed in the past month
Methamphetamine	9.3
Cannabis	8
Tablet K	6.6
Barbiturates	6.3
Opium	5.8
Codeine	5.6

The assessment also asked respondents who used in the past month to self-report how much they spent in a month, in local currency, on their drugs. As shown, methamphetamine use was associated with the highest expenditures at nearly 4,000 Afghanis a month[22]. This was followed by opium at 1,868 Afghanis and cannabis at 1,333 Afghanis. When factoring the average number of use days, the average amount spent per use day remains highest for methamphetamine at 432 Afghanis, followed by opium at 325 Afghanis, and then cannabis at 166 Afghanis.

Table 8: Afghanis spent on drugs and share of average daily income for men self-reporting use in the last 30 days

Substance	Total Spent Past Month (AFG)	Average Spent per Use Day (AFG)	Share of daily income Casual Labourer	Share of daily income Skilled Labourer
Methamphetamine	3,994	432	138%	67%
Opium	1,868	325	104%	50%
Cannabis	1,333	166	53%	26%
Barbiturates	500	80	26%	12%
Codeine	357	63	20%	10%
Others	556	NA	NA	NA

The national average of expected daily income for full-time casual labourers was estimated in April 2024 to be 313 Afghanis and for skilled labourers that figure increases to 648 Afghanis.[23] As a share of daily wage income, a use day for methamphetamine may cost 138% of a casual labourer's wages or 67% for a skilled labourer. This suggests that past month drug purchases are not insignificant for past-month users, even if one assumes 22 full-time working days in the last month. If those that use drugs report greater rates of un- or underemployment, then their drug use habits are likely to create substantial financial strains to them and their families because they are spending a larger portion of their disposable income on drugs instead of other outcomes.

22 For reference, in April 2024 one USD was approximately worth between 71 and 72 Afghanis.

23 Afghanistan: Monthly market report: Issue 47, April 2024 – WFP. https://reliefweb.int/report/afghanistan/afghanistan-monthly-market-report-issue-47-april-2024

3.10. Most reported mode of administration of drugs

In terms of modes of administration for drugs, men reporting past-month use indicated that smoking was the most common form of administration for opium, heroin, cannabis, and methamphetamine. Opium was also reported to be consumed as a tea, perhaps in more traditional settings. Heroin was reportedly injected by some respondents, and this was the only drug for which injecting was reported. Tabletted drugs, including Tablet K and other pharmaceuticals, were orally ingested while solvents were inhaled.

Overall, injection drug use was not very common in the sample. In the overall sample, injection drug use was estimated to occur in 0.6% of the population. Of those that ever-used drugs, the estimate for injecting drugs was 3.9%. When asked why individuals did not inject drugs, the most common reason was because of a general fear of injecting, without disclosing the specific reason (73%). Injecting drugs is culturally stigmatized which could be a strong motivation against the practice, as the respondents often cited that they did not want to resemble those injecting drugs (36%). Avoiding infectious diseases like HIV and hepatitis were cited in 17% and 7% of the responses.

3.11. Reasons behind continued use of drugs

Men who had used drugs in the past-month were asked about the reasons behind their continued drug use after initiation. Responses are shown below by share for each mutually exclusive answer. The most common responses were generally those that indicated some negative motivation, such as unemployment, pain, personal problems, addiction, etc. Availability and affordability of drugs ranked near the bottom as did influence. Overall, in most instances these reasons largely mirror the demographic breakdown above showing that men who use drugs report greater rates of unemployment, higher rates of diagnosed medical conditions, and higher rates of self-medication compared to those that do not self-report drug use.

Table 9: Reasons for why men continuing to use drugs, self-reported

Reason	Share (%)
Unemployment and Economic Hardship	13
Health, Pain, and Self-Medication	13
Seeking Pleasure, Escape, or Happiness	11
Lack of Awareness, Boredom, or Ignorance	11
Family and Personal Problems	10
Peer Influence and Social Circles	10
Addiction and Habit	10
External Pressures and Environmental Factors	10
Availability and Affordability	6
Influence or Recommendation	6

Data weighted via post-stratification.

Unemployment and Economic Hardship (13%):
Many individuals highlighted "unemployment" and "weak economy" as central causes for ongoing drug use. Responses repeatedly mentioned losing jobs, lacking sources of income, or experiencing general poverty and not having economic opportunities. Some simply said "I was jobless", or "because I was unemployed", emphasizing the link between economic insecurity and persistent drug use.

Health, Pain, and Self-Medication (13%):
Some continued to self-medicate due to "sickness", "being in pain", or needing "relief from pain." Others specified seasonal illnesses ("coughs related to the season"), emotional or psychological distress ("depression, stress, or anxiety"), or using drugs "to relax", "to calm the nerves", "to relieve depression", or "to feel better".

Seeking Pleasure, Escape, or Happiness (11%):
People also continued for psychological reasons such as "excitement", "seeking happiness", "for enjoyment", "to feel good", or "to pass time happily." Others used drugs to "escape loneliness", "reduce the pain of life", "relieve depression", or "to experience joy and relaxation".

3.12. Problems reported by men who self-reported past month use

Men who reported past-month use were asked about a variety of individual and social problems associated with their continued drug use. Overall, 85% respondents noted direct health harms to themselves. About a quarter noted problems with their family, either parents, wives, siblings, children, or others due to their continued drug use. Poverty was noted by about one in five respondents as being connected to continued drug use. Problems with friends were cited by 12%. Arrest, problems with employment, violence, legal troubles, or imprisonment were cited less than 10% of the respondents. Overall, the main negative consequences of continued drug use were worsening health, worsening social and familial relationships, and impoverishment.

Grouped responses to the question: What kind of problems were caused by substance you mentioned?

- Health problems were overwhelmingly the most frequently mentioned in approximately 85.4% of all responses.
- Problems with relationship to parents were cited in 27.2% of responses, often referenced as affected or involved in the problems caused by substance use.
- Family problems appeared in 26.8% of responses.
- Poverty was cited in 18.2% of responses as a consequence of drug use or connected issue.
- Problems with relationships to friends were mentioned in 12.2% of responses, either as affected or involved.
- Arrest linked to drugs was reported in 6.1% of responses.
- Employment was affected in 5.5% of responses.
- Education was associated with problems in 5.4% of responses.
- Violence was mentioned as a problem in 5.3% of responses.
- Legal issues (distinct from arrest) appeared in 4.9% of responses.
- Imprisonment was named in 2.7% of responses.
- Other specific or descriptive problems (not fitting these main categories) were reported in 0.3% of responses.

4. CONCLUSIONS

Understanding the drug use situation in Afghanistan remains challenging for a variety of reasons. First and foremost, unbiased and representative data collection and measurements are hard to obtain. The lack of regular household surveys and the inability to collect data from randomized samples make it difficult to assess patterns of drug use and emerging trends, especially in light of the current enforced ban on all drugs, which went into effect in 2023. At that time, the De-facto Authorities began several campaigns to encourage or coerce individuals into a variety of treatment services and abstinence-based programs. However, it is hard to accurately assess the effects of these efforts without reliable measures. Further, without reliable data on drug use by women, the issue of drug use in up to half of the country's population remains a critical gap, woefully hindering the health and wellbeing of women and girls.

Further, while the De facto Authorities report efforts in the treatment of thousands of people who use drugs, the availability of quality and evidence-informed treatment services remains limited. As noted by UNODC assessments of drug treatment in Afghanistan[24], many facilities face obstacles in providing effective treatment, including shortages of qualified professionals and insufficient infrastructure and necessities. More problematic is the gender disparity in accessing treatment.

Nonetheless, with the data available it can be shown that demographics of men who use drugs vary across the country when comparing those who self-report abstinence. Men who self-report drug use in the past year are socially embedded in many of the same ways as those who self-report abstinence; however, they are slightly younger, significantly different when it comes to having less steady employment, having had some formal education, and are more likely to have a diagnosable medical health condition and self-medicate drugs for that condition.

Overall, cannabis is the drug self-reported and perceived to have the highest rates of use both for lifetime and in the past year. Across other measure, cannabis is the drug most often associated with first use and has the earliest age of onset in the sample. Opium and heroin, which have long been of concern in Afghanistan, are reported to be of the second highest perceived use across the country. In terms of self-reported use, opium and heroin are estimated to have the second highest lifetime use, but estimated rates of past-year use are lower than misuse of pharmaceutical drugs, such as sedatives and opioid analgesics. It is therefore possible that efforts by the DfA to constrain the supply of opium-and other drugs may have affected recent drug use patterns.

When it comes to self-reported past-month use by men, it becomes clear that frequent drug use is an expensive habit in Afghanistan when compared to average daily wages. Compounding this is the fact that men who self-report using drugs indicate higher rates of un or underemployment. It is likely that regular users of expensive drugs, like opium and methamphetamine, could keep them and their families in cycles of poverty. Similarly, poverty and underemployment were a leading reason for why respondents that self-report past-month use continue to take drugs.

It is safe to say that the drug situation in Afghanistan remains a challenge. The lack of reliable data does not make this problem any less apparent and instead only hinders the ability of authorities and communities to properly and effectively address it.

24 United Nations Office on Drugs and Crime. (2025). Afghanistan Drug Insights Volume 5. https://www.unodc.org/documents/cropmonitoring/Afghanistan/Afghanistan_Drug_Insights_V5.pdf

ANNEX

Islamic Emirate of Afghanistan Ministry of Interior Affairs Deputy Ministry Of Counter Narcotics
Vice Deputy Ministry on Civil Affairs Directorate for Survey and Analysis of Narcotics

Views of the Directorate for Survey and Analysis of Narcotics on the "Household Assessment on Drug Use" survey report - 2025

As a first step, we express our appreciation to the respected UNODC office for their efforts in conducting this survey and sharing its report with the Deputy Ministry Of Counter Narcotics aimed at building mutual trust.

This report, which has been prepared based on field data from 10,286 respondents including 9,279 men (90.2%) and 1,007 women (9.8%) at the country level, is technically a good analytical report. However, due to certain field limitations, there are some points which need to be mentioned as below:

Points worth mentioning:

1. On page seven of the report, it is mentioned *"The level of deviation to the established data collection process was not homogenous across the country. Data quality was markedly weaker in the south and east compared with the north.*
   The view of the Directorate for Survey and Analysis of Narcotics is that field issues and problems during the survey should have been shared with the officials. If it is assumed that the information is incomplete, then this report cannot reflect the actual situation and statistical figures of drug users at the country's level.
2. On page 22 of the report, lack of access to quality treatment services has been mentioned.

In regard to point four, the esteemed UNODC office should obtain the opinion of the Directorate of Drug Demand Reduction.

On page five of the report, it is stated that *"Afghanistan also lacks an up-to-date unique village list, Somewhere else in the report, country's population mentioned as 41 million."*

In regard to point five the Afghanistan National Statistics and Information Authority, as well as the GIS section of the Survey and Analysis Directorate, should provide their opinion regarding the updated villages lists.

Agreed points :

3. Page 11 of this report shows that among drug users, the number of users of cannabis (hashish) ranked first at 46% followed by opium and heroin ranked second from the perspective of long-term use; however, in terms of use during the past year, they ranked third. This means that after the ban, easy access to opium and heroin has been restricted, the use of opiate substances has been replaced by cheaper narcotics such as non-medicinal tablets and pain-relief medications.

View of the Directorate for Survey and Analysis of Narcotics
This is an accurate analysis, because after the issuance of the decree by the Taliban Supreme Leader and as a result of the successful combat against opium poppy cultivation and production, cheap opiates and easy access to opiate substances no longer exist. For this reason, the price of opiate drugs rose sharply at the beginning of the ban. Later, after drug users turned to synthetic drugs and were rounded up from the cities, the prices of opium and heroin declined again, but not to the level they were before the ban. The consumption of cannabis (hashish)), from long-term, one year and one month ago use perspective ranked first. These statistics correspond with the figures from the "Survey of Public Satisfaction with Police Performance 2022 – Counter-

Narcotics Directorate," which was conducted in 22 districts of Kabul city, where the proportion of hashish users ranked first at 37%. One of the factors that led to addiction to other narcotic substances was also that initial use often began with cannabis (hashish).

4. On page 17 of this report shows that 12% of men have used more than one type of narcotic substance within one month. This estimate is also correct and, in most cases, applies to the wealthier class of society.
5. On page 19 of this report, the financial pressure of drug use on families has been mentioned, stating that it exceeds the daily income of an unskilled laborer and amounts to 67% of the income of a skilled worker within a given time period. This issue is also true in many cases, especially during periods of excessive drug use. However, in most situations, drug users used narcotics collectively at their gathering centers, sharing the smoke in an enclosed environment, in which case the daily cost of consumption was reduced to a minimum.

At the end, in conclusion, it should be noted that despite the existing fields limitations and problems, this survey provides a relative and estimated set of statistics on issues such as the most commonly used types of narcotic drugs, factors leading to drug use, the financial pressure of continuous drug use on household economies, the percentage of simultaneous use of multiple types of drugs, and the factors behind the substitution of opium and heroin after 2023, and related matters.

Views of the Directorate for Survey and Analysis of Narcotics:

- If the number of drug users could have been estimated from the figures of this survey countrywide
- Driving factors behind the higher use of intoxicating tablets in Kabul as the country's capital could have been mentioned.
- Figures on treatment and employment of drug users could have been collected countrywide.
- And likewise, during the course of the survey, field-related problems and issues could have been addressed through the relevant authorities.
- Then these would have enhanced the comprehensiveness of the survey and its report.