Survey of Substance Abuse in Iraq

Final Report
August 2015

Award No: S-INLEC-13-GR-1008

Prepared for U.S. Department of State/Bureau of International Narcotics and Law Enforcement by the Substance Abuse Survey Program under Center for Human Services, Award No. S-INLEC-13-GR-1008
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Acknowledgments

This report contains information from a national household survey conducted in Iraq from November 2013 – May 2015. Research was conducted under the Survey of Substance Abuse in Iraq Grant, awarded by the Department of State Bureau of International Narcotics and Law Enforcement Affairs (DOS/INL) and implemented by the Center for Human Services (CHS), in partnership with the Iraqi Society of Addiction Medicine (IRSAM), University of Baghdad—College of Medicine, and UCLA Integrated Substance Abuse Programs (ISAP). The survey was led by Dr. Jawad Al Diwan of CHS, with guidance from the project’s Steering Committee—particularly its chairman Dr. Salih Al-Hasnawi and Dr. Nesif Al Hemiar, both representatives of IRSAM, together with CHS field supervisors Drs. Emad Abdulrazaq Abdulghani and Mushtaq Talib Hashim Al-Hachami. Dr. Ali A. Kadhim Abutiheen of IRSAM coordinated the data collection and data entry. The survey team consisted of 17 trained surveyors who conducted the project interviews and saliva testing in the field in all 18 Iraqi governorates, supervised by 3 regional coordinators, Drs. Radhwan Al-Tuhafy, Khalid Awad, and Safi Dakhil Nawam.

Data entry and quality oversight were provided by Dr. Ali A. Kadhim Abutiheen and 4 data entry staff at Karbala. This team provided a compilation of the field survey forms, which included the entry of data and the transfer of data to the UCLA data management center in a very rapid and high quality manner.

Survey implementation occurred in Iraq during a time of considerable violence and political instability. The Western/Northwestern governorates of Iraq came under attack by the forces of the Islamic State of Iraq and Levant (ISIL, also known as DAESH) in June 2014, while the survey data collection was underway. Despite these extraordinary conditions, the survey was conducted on time, with only several minor modifications of the project plan. The survey team achieved a very significant accomplishment in completing this survey under the severe conditions in Iraq during the latter half of 2014.

Dr. Neeraj Kak, CHS Senior Vice President, and Dr. Hala Jassim Al Mossawi, Associate Director, were the project leads for CHS, and Rachel Doane provided administrative support for the project. CHS, along with the project Steering Committee, consisting of members from Iraq's Ministry of Health, Ministry of Interior, Ministry of Labor and Social Affairs, Ministry of Higher Education and Scientific Research, Ministry of Education, Ministry of Justice, and IRSAM, supported this effort with good will and sustained perseverance.

The UCLA team was led by Dr. Richard A. Rawson and Albert Hasson. Rufaidah Dabbagh was the primary data analyst. David Bennett provided data management services and Valerie Antonini coordinated administrative aspects for UCLA. To assist in the scientific rigor of the investigation, an advisory group was established consisting of experts in questionnaire design, household survey methodology, and data interpretation. Members included researchers from UCLA, Texas A&M University, SAMHSA’s Center for Behavioral Health Statistics and Quality, and the University of Texas.

The project also received significant support from the Ministry of Health (MoH) and Ministry of Planning (MoP). The MoH hosted all Steering Committee meetings, along with providing transportation for surveyors and support for the National Symposium to launch the survey. The MoP Central Office of Statistics assisted greatly in providing the sampling methodology to ensure the survey was representative of the Iraqi community.
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Abbreviations

AE    Adverse Event
CEWG  Community Epidemiology Work Group
CHS   Center for Human Services
DOS   Department of State
GoI   Government of Iraq
HCl   Household Crowding Index
HIV   Human Immunodeficiency Virus
I-CEWG Iraqi Community Epidemiology Work Group
ID    Identification
INL   Bureau of International Narcotics and Law Enforcement Affairs
INHSAD Iraqi National Household Survey on Alcohol and Drug Use
IRSAM Iraqi Society of Addiction Medicine
ISIL (or Daesh) Islamic State of Iraq and Levant
ISAP  Integrated Substance Abuse Programs
MOH  Ministry of Health
NSDUH National Survey on Drug Use and Health (U.S.)
SAMHSA Substance Abuse and Mental Health Services Administration (U.S.)
SDS   Severity Dependence Scale
SUD   Substance Use Disorder
UCLA  University of California, Los Angeles
UNODC United Nations Office on Drugs and Crime
1. Executive Summary

Background and Objectives

The Iraq National Household Survey on Alcohol and Drug Use (INHSAD) provides previously unavailable population-based information collected from 18 governorates in Iraq and from several selected subgroups. The overall objective for the INHSAD was to understand the extent of tobacco, alcohol and drug use in Iraq. There were four specific aims: (1) to compile data on self-reported prevalence of tobacco and alcohol use, and licit and illicit drug misuse; (2) to identify trends and patterns of substance use in the Iraqi population; (3) to identify specific factors that may be associated with substance use; and (4) to identify reasons for use, substance availability and consequences of use.

Survey Team and Method

The survey project was a cooperative project, funded by DOS/INL, and implemented by a U.S.-based international health organization (CHS) in partnership with a U.S. university (UCLA) and an Iraqi team with leaders from Iraqi universities (Universities of Baghdad and Kerbala), an Iraqi professional society (IRSAM), and the Iraqi Ministry of Health. A team of Iraqi surveyors were trained to administer the survey and collect saliva samples for drug analysis. Another Iraqi data management team compiled the data in Kerbala and sent it to the UCLA data center for processing and analysis. The UCLA team conducted the data analysis and prepared the report draft.

The participant sample for the household survey consisted of one individual from 3200 randomly selected households; a minimum of 100 households to be selected from each of the 18 governorates and more households were added in approximate proportion to the governorate population, for a total of 3200 individuals/households. In the analysis of substance use rates, an adjustment by gender for substance use prevalence were computed and applied to provide an estimate for the Iraq adult population, since the sample was 72% male/28% female and the general population is approximately 50% male/female.

In addition, 464 individuals (14.5%) were randomly selected to provide a saliva sample for analysis for 5 illicit drugs. 395 saliva tests (12.3%) were completed and valid for analysis. An additional 100 participants from 3 selected subgroups completed the survey, of which 58 were randomly selected to provide a saliva sample. 52 saliva tests (17.3%) were completed and valid for analysis. The project was conducted in the midst of extreme violence and political, social, and military turmoil and chaos of Iraq in 2014. The accomplishment of the survey under these very challenging circumstances is an extraordinary accomplishment by the Iraqi team.

Results

Overall self-reported “lifetime” (any use during lifetime) tobacco use was 29.0% and “current” (past 12 months) use was 23.4% in the household survey sample. Self-reported “lifetime” and “current” alcohol use was 8.6% and 3.4%, respectively. Alcohol and tobacco use differed significantly across regions, population groups, and genders. “Lifetime” and “current” licit drug misuse (cough syrup, tramadol, somadril, benzodiazepines, benzhexol, anabolic steroids, other pills) was reported at 2.5% and 1.2%, respectively. The most misused licit drugs were steroids and benzodiazepines in the household survey sample. “Lifetime” and “current” illicit drug use (cannabis, Captagon/amphetamine-type stimulants (ATS), opium/heroin, and inhalants) were reported at 0.4% and 0.2%, respectively. Summaries of self-reported total “lifetime” and “current” substance use (adjusted for gender) in totals in the household survey sample are detailed below:

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Lifetime Use</th>
<th>Current Use</th>
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<tbody>
<tr>
<td>Any Substance</td>
<td>10.3%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Alcohol, Licit or Illicit Drugs</td>
<td>10.3%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Any Drug</td>
<td>2.7%</td>
<td>1.3%</td>
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</table>

* Estimates presented in this box are adjusted for unequal gender distribution.
Results of this survey indicate that tobacco use is a significant public health problem in Iraq. Current alcohol use is reported in 6.7% of males. Drug use is reported at low levels, and saliva test results support this finding.

Of the 3200 participants in the household survey, only one individual reported a history of drug injection; 7 of 395 (1.8%) of the randomly selected participants who provided a saliva test had a positive result for any drug use. Approximately 19.5% of the participants in the household survey reported that they knew someone who misused licit drugs and 11.0% knew someone who used illicit substances. The rates of knowing someone was very low in the governorates in the middle and Baghdad regions and much higher in the Southern region, where more than a third of the region reported knowing others who used licit or illicit drugs. Responses to “reasons for drug and alcohol use” suggested that the most widely cited reasons were for coping with the negative conditions and negative emotional status associated with life in 21st century Iraq.

Three subpopulations were selected for closer examination. The groups included internally displaced persons (IDPs), Hawasim, and individuals recently released from prison (another group from the military was planned, but was cancelled due to security issues). One hundred individuals were surveyed from each subpopulation. Results from these analyses indicated that rates for IDPs were comparable with the household survey sample. “Lifetime” and current tobacco use was reported at higher rates for the Hawasim group, as compared to the household survey. “Lifetime” use rates of tobacco, alcohol, and drugs among the group recently released from prison (who were all males) were higher than that of males from the household survey sample.

In focus groups with the surveyors it was estimated that 3-20% of participants may not have accurately reported their drug use. Focus groups with military and police personnel reported that they saw alcohol as a problem in the police and military and that drug use was increasing in these groups.

Discussion

The successful completion of this survey under the violent and politically contentious circumstances of 2014 Iraq was a very impressive accomplishment. The survey design, plan, and oversight, along with the data management plan for the survey data were appropriate and successfully carried out. There was minimal missing data, and the refusal rate was not excessive. Results of this survey indicate that tobacco use is a significant public health problem in Iraq. Current alcohol use is reported in 6.7% of males, and the average number of drinks on a day of drinking was reported at 6 drinks per day. Drug use is reported at low levels, and saliva test results generally support this finding. However, the self-report data in this survey likely suffers from under-reporting concerning the licit and illicit drug categories, particularly in highly religious areas and in areas with serious security problems. The fact that the vast majority of saliva tests were negative for illicit drugs supports the perception from the self-reports that the use of illicit drugs in Iraq is much lower than in other countries in the region, such as Iran and Afghanistan. However, since the saliva tests do not test for alcohol or licit drugs, the self-reported low rates of alcohol use and licit drug misuse was not assessed with a biological measure.

Conclusions and Recommendations

The information collected in the first Iraq National Household Survey of Alcohol and Drug Use (INHSAD) suggests that the drug problem in Iraq is still in a gestational phase. With the conditions of economic distress, social chaos, violence, and generally stressful environment, as well as escalating drug trafficking and availability (reported in the 2012 and 2014 CEWG meetings); it is highly probable that Iraq is at very high risk for the emergence of a substantial societal problem with licit and illicit drugs. A set of recommendations are given in areas of policy development, future alcohol and drug monitoring activities, capacity-building and practice development.
2. Introduction

During the past decade, a number of reports have documented an increase in the prevalence of substance use disorder (SUD) issues in Iraq. Since 2007, and with the support and guidance of international donors, the government of Iraq (GoI) has become committed to assessing the extent and type of drug use in Iraq. There is evidence from law enforcement, customs and UNODC reports that Iraq is clearly a transit country for drugs (U.S. Department of State, 2011). However, at present, there is considerable uncertainty about the extent of drug and/or alcohol use, what drugs are being used, what groups are using them and which geographic regions have elevated levels of drug and/or alcohol use in Iraq. The nature and extent of drug and alcohol problems in a society is critically important information since these problems substantially impact the health, criminal justice, and social service systems. As has been demonstrated during recent years in such diverse societies as Russia, Iran, Mexico, and the United States, drug and alcohol use has driven the HIV epidemic, has been the source of incredible violence, and has created a broad range of social disruption and billions of dollars of social costs.

In an effort to better understand the magnitude of alcohol and drug use in Iraq, the Iraq Ministry of Health, with financial support from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), collaborated with substance use researchers from the United States to develop the Iraqi Community Epidemiology Work Group (Iraqi-CEWG), a national drug and alcohol use surveillance program that oversees the trends and magnitude of substance use in the country in order to help direct policy on substance use control (Al-Hemiary, et al. 2014). The methodology used in the development of the Iraqi CEWG was adopted from the U.S. CEWG, which was developed in 1976. The U.S. CEWG was developed to use all available data sources on substance use, including records from hospitals, drug treatment centers, law enforcement, national surveys, and centers for public health, in order to gain insight on the epidemiology of substance use in the US (Al-Hemiary, et al. 2014). The methodology has been successful in tracking drug and alcohol trends in the US and the methodology has been adopted in many countries around the world.

The nature and extent of drug and alcohol problems in a society is critically important information since these problems substantially impact the health, criminal justice, and social service systems.

The first Iraqi CEWG meeting was held in Baghdad in 2012. During that meeting, members gathered from various disciplines, including the health sector, law enforcement sector, and Iraq Ministries of Health and Interior, along with local and international research experts, to present information about alcohol and drug use collected from a variety of sources in order to give a brief description of the current drug problem in the region. The findings from this meeting suggest that since the time of the reports by Aqrawi and Humphreys (2009) and Al Diwan (2011) on drug use in Iraq, some things have remained relatively stable, while there have been significant changes in other areas.
The psychoactive substances most widely used in Iraq continue to be alcohol and the following prescription drugs: benzodiazepines, benzhexol, codeine, and a variety of psychiatric medications. This set of “primary drugs” is consistent with the earlier reports. However, there was near universal agreement that the use of hashish, tramadol (an opioid-type analgesic), and amphetamine-type substances (ATS) is increasing in some areas and that drug and alcohol use overall is increasing. Reports from Al-Basrah health officials and police were noteworthy. Two types of ATS have made an appearance in Iraq: “01 Pills” (tablets of Captagon, an amphetamine-type drug) and “crystal” (methamphetamine) have been seized in considerable quantities in Al-Basrah. In addition, reports from Mosul and from federal drug-seizure data suggest that the use of tramadol is also increasing in regions of Iraq. At the present time, there is little evidence of increased use of heroin in Iraq, and rates of injection drug use appear to continue to be low. One recommendation from this meeting was that a national survey on substance use was needed to inform future Iraqi CEWG meetings and to help direct policy decisions (Al-Hemiary et al., 2014). This recommendation led to the development of the present Survey of Substance Abuse in Iraq Grant, awarded to CHS by DOS/INL in August 2013.

In May of 2015, a second CEWG meeting was held in Baghdad. The findings have not been fully prepared, but a preliminary summary indicates that the trends identified in 2012 have continued and evidence of drug use and availability has expanded (Al-Hemiary, personal communication).

### 2.1 Survey Objectives

The overall objective of the INHSAD was to understand the extent of substance use in Iraq. The substances in question included tobacco, alcohol, illicit drugs, and licit drugs. Secondary aims were to explore the prevalence of illicit and licit substance use with respect to demographic data, to identify patterns of substance use and contributing factors, and to identify social disincentives for drug and alcohol use. The project plan collected survey information from a nationally representative sample and additional data on three subgroups (initially there were four, explained below). In addition, qualitative methods were used to gather information from surveyors and key stakeholders about drug availability and substance use disorder treatment services in Iraq. Focus group interviews were conducted with project surveyors and a group of physicians, to discuss general trends of substance use among the general population as well as military and police personnel.

### 2.2 Quantitative Methods

#### Survey Design

A cross-sectional design was used to collect data from 18 governorates in Iraq. The governorate of Baghdad was separated into two parts (East and West) due to its population density, totaling 19 data collection geographic areas. The calculated sample size was 3,200, or a mean number of 180 participants per governorate (range 80–800) (using an α level of 5% and a margin of error of ± 0.7 within each governorate) from the non-institutionalized general population and 300 participants from special population groups.

The method used to sample from the general non-institutionalized population was multistage cluster sampling. The whole country was divided into four regions (North, Middle, South and Baghdad), each of which consists of...
multiple governorates, and Baghdad consisted of two areas (Risafah [East] and Kerkh [West]). Each governorate was then divided into districts, and ten districts were randomly selected from each governorate. From the full list of home addresses within each district, a house number was randomly selected to designate the first house to be approached for an interview in that district. Following the first house selected, every 10th house in that district was approached until 10 houses were selected from each district. The “most recent birthday method” was used to select the participant to interview within each household. A purposeful sampling method was used to select the 300 participants from special population groups.

Survey Population

Household Survey Sample (3200)
People eligible for the interview included 3,200 Iraqi adults (ages 18 and older), both male and female, who were non-institutionalized individuals and able to give consent to participate in the survey. Surveys were developed in English and then translated into Arabic and Kurdish, so it was necessary that participants could understand at least one of these two languages.

Special Population Sample (300)
People in this sample of 300, included adult male and female Iraqis who belonged to one of the following categories: (1) internally displaced persons (IDPs), (2) random areas: people currently living in houses built after 2003 on municipal land inside and on the periphery of cities without being officially enumerated and registered, locally known as “Hawasim” and (3) individuals who were recently in prison. A fourth group of members of the military was planned to be included, but data from the military group were not collected (see below in results).

Subgroup 1: Internally displaced persons (IDPs) (n=100)
The identification and selection strategy for the IDPs was as follows: among the regions of Iraq, those surveyed included 30 participants from the north, 30 from the south, and 40 from the middle. The Government of Iraq (GoI) maintains a list of households that have been displaced. This list was provided to the study team by the Ministry of Health (MOH) and used to randomly select individuals among the three regions to be invited to participate in the study. Using this list of household addresses, a random number was identified in which to begin household selection. Subsequent households were selected at intervals using the same random number (every 10th address on the list). This sampling plan is consistent with the strategy noted in the initial approved study design.

Subgroup 2: Individuals from “Hawasim” areas (n=100)
To identify and select Hawasim participants, a list of Hawasim areas across all governorates was provided by the Ministry of Health. From this list, a random number was identified in which to begin the Hawasim area selection. Subsequent Hawasim areas were selected at intervals using the same random number (e.g., every 10th area). Within each randomly selected area, addresses were collected in a list, and from this list, a random number was identified in which to begin household selection. Subsequent Hawasim area households were selected at intervals using the same random number (e.g., every 10th address on the list). This sampling plan is also consistent with the strategy noted in the initial approved study design.

Subgroup 3: Individuals recently released from prison (n=100)
In order to identify and select individuals who were recently released from prison, the study team was informed by the prison authority on a monthly basis (at a minimum) of a list of individuals with their addresses and release dates. The research team randomly selected individuals from each release group (e.g., every 5th on the list; note: shortened from 10 due to list size) to be invited to participate in the study. Study invitations were sent to individuals after they were discharged from the prison and off of the prison grounds. They were not considered prisoners at the time of recruitment or participation. Following study protocol, these individuals were assured that their participation in the survey was voluntary and anonymous, and that they could choose to withdraw from the study at any time. As in the household survey sample, the special population participants included those who understood at least one of the two languages used for the survey.

Survey Tool
The survey tool used in this project was a questionnaire adapted from the National Survey on Drug Use and
Health (SAMHSA, 2010) and the United Nations Office on Drugs and Crime (UNODC) surveys. The survey was developed in a way that facilitated skip patterns and was in a computer-readable format to allow for computerized transfer of data into the secure research team database. The questionnaire was composed of 21 sections. These included demographics; tobacco use; alcohol use; illicit drug use (cannabis use, amphetamine use, opium/heroin use, and inhalant use) and misuse of licit drugs (cough syrup, tramadol, somadril, benzodiazepines, benzhexol, anabolic steroids, and other pill use); injection use of any drug; substance dependence; reasons for drug or alcohol use; place of use; perceived availability of drugs; immediate and later consequences of alcohol or drug use; and intention for treatment.

Demographic information was collected on the participant’s age, sex, governorate, education level, marital status, number of children, work status, number of rooms per house, number of people per house, and religion.

Questions for each substance used asked about “lifetime” use (ever used), age at first use, “current” use (during the past 12 months), use during the past 30 days, number of times used per day, feasibility of obtaining the substance, and whether they knew people who used the substance.

The substance dependence questions in the survey were adapted from the Severity Dependence Scale (SDS) for cannabis dependence (Gossop, 1995). The Severity of Dependence Scale (SDS) is a questionnaire that provides a score indicating the severity of dependence on a specific category of drugs; the higher the score, the higher the level of dependence. The SDS takes less than a minute to complete. The SDS was devised to provide a short, easily administered scale which was used to measure the degree of dependence experienced by users of different types of drugs. The SDS contains five items, all of which are explicitly concerned with psychological components of dependence. These items are specifically concerned with impaired control over drug taking and with preoccupation and anxieties about drug use. Substance dependence was suggested when the participants’ scores exceeded the following cutoff points described in previous literature: (1) 3 or more for alcohol; (2) 4 or more for cannabis or amphetamines; (3) 5 or more for heroin or opioids; and (4) 7 or more for licit drugs (benzodiazepines, benzhexol, somadril, tramadol, cough syrup or steroids (Castillo et al. 2010).

2.2.1 Saliva Testing
In addition to the questionnaire, 522 participants from both population samples (the household survey sample [n=3,200] and the special population sample [n=300]) were randomly selected for a saliva test to examine the use of amphetamines, marijuana, cocaine, opiates, and benzodiazepines, for comparison with self-report data. Saliva tests were conducted using the Oratect III Saliva Testing Device.

2.2.2 Training of the Surveyors and Data Entry Staff
A 5-day protocol training for all project staff (including field interviewers/surveyors, regional coordinators, field supervisors, and data entry specialists) was held in Erbil, Iraq, from Jan. 6–10, 2014 (a pre-session meeting occurred on Jan. 5 for leadership only). UCLA and Iraqi Society of Addiction Medicine project leaders facilitated the training activities, following a welcome and review of project goals from CHS and INL. UCLA developed the curriculum following discussions and consultations with the project leadership and advisory groups. The curriculum covered the following areas: Good Research Practices/Ethics Training; Data Quality and Security; Survey Implementation and Standard Operating Procedures; and Overcoming Barriers and Challenges.

Protocol Training Materials
Two UCLA staff travelled to Erbil, Iraq, for the January training event. A participant training package was created for the event that included the following documents: Training Agenda, Survey Protocol, Survey, Study Information Sheet, Study Tools, Recruitment Tracking Form, Field Interviewer Enrollment, Log, Data Entry Tracking Log, Saliva Test Instruction, and Confidentiality Pledge.

The participant training package (available in both English and Arabic) was disseminated at the trainings to all participants. It was determined that a field binder that included the survey data collection form and all survey tools to be used for the recruitment and data collection.
process would be useful for each surveyor/interviewer. Each field binder included the following documents: Survey Protocol, Recruitment Form and Addresses, Survey, Study Information Sheet, Progress Notes, Survey Tracking Form, Incident Reports, Saliva Test Instructions, Drug Image Cards, and Response Scale Cards. UCLA developed this binder, in conjunction with CHS project team leadership, which was distributed to the 17 surveyors on March 9, 2014 to initiate the pilot testing.

2.2.3 Survey Data Collection
Data collection was initiated in April 2014. As of November 2014, 3,200 surveys from the household survey sample were collected. Trained surveyors approached participants by going door to door to the corresponding houses of the randomly selected addresses. Once the surveyor contacted a household member, introduced him/herself and briefly explained the nature of the visit, he/she asked for the adult member with the most recent birthday to be selected to participate in the interview process. After providing the participant and his/her family with detailed information about the study and obtaining voluntary verbal consent for participation, the one-on-one interview was conducted, following the exact wording of the questions in the questionnaire. Interviews were conducted in a private room at the house of the participant, whenever possible. Participant responses were directly recorded on the paper questionnaires. Additionally, saliva tests were performed at the end of the interview (on a randomly selected subsample) and results were recorded on the last page of the questionnaire. When there was no initial response when approaching a house, two return attempts were conducted and if unsuccessful, the next house on the list was used as a replacement. Interviews were conducted in the appropriate language of the consented participant.

Data Management
Regional field coordinators collected the completed questionnaires from each governorate, which were then securely transported for computerization at the CHS data center in Kerbala. Data were “batched” and sent via a secure network to the UCLA ISAP data management center in Los Angeles. Survey data were completely anonymous (no self-identifying information was collected) and all data were handled with strict confidentiality.

Ethical Considerations
The INHSAD was conducted following the regulations and with the approval of the UCLA Institutional Review Board and the Iraq Ministry of Health. All research investigators and surveyors had appropriate human subject research training prior to data collection, and surveyors were trained by qualified field research coordinators. Participation in the survey was completely voluntary, and verbal consent was obtained prior to survey administration and the performance of saliva tests. As noted above, to ensure subject privacy and comfort, surveyors interviewed participants in private rooms in their households, whenever feasible. No monetary compensation was given to subjects for participation in this survey.

All research investigators and surveyors had appropriate human subject research training prior to data collection, and surveyors were trained by qualified field research coordinators. Participation in the survey was completely voluntary, and verbal consent was obtained prior to survey administration and the performance of saliva tests.

Following the completion of the survey report, data will be stored in safe and encrypted computers and will not be shared or revealed except for future research purposes. Results from the survey will be shared with the scientific research community from UCLA ISAP, CHS, the Iraq Ministry of Health, and U.S. State Department. Furthermore, study results will be published in relevant journals and presented in appropriate substance use and addiction health conferences and symposia.

2.3 Qualitative Methods
2.3.1 Focus Groups with Surveyors
Following the completion of data collection, the surveyors were contacted to gain a better understanding of the process by which they approached and were received by community members in their efforts to administer the survey. While there previously had been a National
Household Survey addressing mental health issues (Iraq Mental Health Survey, 2006–07), with the ever-changing and volatile political climate in Iraq, little was understood as to how the surveyors would be received when asking questions about the use of illegal substances. To gain such an understanding, an email invitation was sent to all surveyors to attend a focus group in Baghdad on Dec. 4, 2014. This focus group discussed issues of participant response, survey implementation, honesty of participant responses, saliva test administration, and interviewers’ overall perception of drug availability and drug trafficking.

2.3.2 Focus Group Discussion about Substance Use among Military and Police Personnel

The survey team also held a discussion with military health care workers intended to explore the views and experience of military physicians on drug and alcohol use among soldiers and policemen. The focus group was designed to explore the following: general aspects of drug and alcohol use, including, but not limited to: who is using what; groups at risk for SUDs; the trends in drug and alcohol use over the last 5 years; how money is obtained to purchase drugs and alcohol; and source(s) of drugs and alcohol. In addition, physicians were asked about services for patients with SUDs in their clinics or departments including: number of patients examined for SUDs in their respective clinics in the last 12 months; the types of services available; and policies and procedures of their respective departments as they pertain to the treatment of SUDs. Finally, physicians were asked what they thought should be done to prevent substance use and what they could do/have done in their clinics to prevent drug and alcohol use.

Focus Groups Study Sample and Data Collection

Four military physicians were purposefully selected to participate in this focus group discussion. They were provided information on the nature and purpose of the focus group in relation to the context of the parent project, the INHSAD. Each participant was provided and asked to sign an informed consent document prior to the initiation of the focus group interview. Any questions they had regarding the process were answered at that time. A questionnaire was used to guide the discussion; however, the discussion was not audio recorded.

2.3.3 Survey Analysis

Variable Measures

Primary outcome measures included “lifetime” tobacco and alcohol use, “lifetime” use of illicit substances (amphetamines, cannabis, heroin/opium, and inhalants), and “lifetime” misuse of licit substances (cough syrup, tramadol, somadrol, benzodiazepines, benzhexol, and anabolic steroids). In addition, one question asked if the individual had “ever injected” any drug. “Lifetime” use was defined as “any use during your lifetime”. Variables were also created for “current use.” A current smoker

A current alcohol drinker was defined as someone reporting consumption of alcohol during the past 12 months. Individuals who reported not using or consuming alcohol during the past 12 months and people who reported “never drinking” were coded as Non-drinkers. For all other substances, a current user was defined as reporting use of the substance during the past 12 months.

was defined as someone reporting use of tobacco during the past 12 months. Individuals who reported not using tobacco during the past 12 months and people who reported “never using” tobacco were coded as “non-smokers.” In addition to cigarette smoking, information about frequency of hookah smoking and cigar use per day was also measured. A current alcohol drinker was defined as someone reporting consumption of alcohol during the past 12 months. Individuals who reported not using or consuming alcohol during the past 12 months and people who reported “never drinking” were coded as Non-drinkers. For all other substances, a current user was defined as reporting use of the substance during the past 12 months. Perceived level of accessibility of drugs was measured on a 4-point scale (1=very easy, 2= somewhat easy, 3= somewhat difficult, 4=very difficult).
Most demographic characteristics were recorded as categorical variables. Age was initially measured as a continuous variable, but was then divided into 4 categories (18–34 years, 35–49 years, 50–64 years, and 65 years and older). Marital status was divided into 3 categories (never married, married, and widowed, divorced or separated). Employment status was measured 6 categories (employed, homemaker, student, retired, receiving social support, and unemployed), but was then reduced 5 categories (collapsing unemployed and receiving social support group into “unemployed”). Education was classified as “less than primary” for no schooling, “primary” for 1–6 years of schooling, “secondary” for 7–12 years of school and “higher” for high school graduate or more. Socioeconomic level was not directly measured in the survey, and therefore the household crowding index (HCI), defined as the number of people residing in the household per room, was used as a proxy measure. HCI was calculated as number of people per household divided by number of rooms per house. Using the HCI as a proxy for socioeconomic status has been mentioned in the literature, and it has been suggested that the HCI correlates negatively with socioeconomic status (Baum & Epstein, 1978; Edwards. et al. 1994; Freedman, 1975; Melki, et al., 2004; Uday, 1987). Religion was also measured and was divided into two groups (Muslim and “other”).

Other measures used to understand extent of substance use were “knowing others who used/misused” and “number of people you know who use/misuse” (European Monitoring Centre for Drugs and Drug Addiction, 1997; Hickman et al.; 2002). These were measured for individual substances and also measured collectively for substance categories. These are common proxy measures used to assess drug use among populations that may have difficulty admitting use (i.e., high stigma, moral confliction, threat of severe punishment). Knowing others who misused licit drugs was defined as reporting knowing others who misused one of the following: cough syrup, tramadol, somadril, benzodiazepines, benzhexol or anabolic steroids. Knowing others who used illicit drugs was defined as reporting knowing others who used one of the following: amphetamines, cannabis, heroin/opium, or inhalants. Other information related to patterns of use was collected for most substances. These included age at first use, number of times of use per day, and feasibility and accessibility of substances (1=very easy, 2= somewhat easy, 3= somewhat difficult, 4=very difficult).

For people who reported current alcohol or drug use, substance dependence was measured using questions adapted from the Severity Dependence Scale (SDS). The original scale is formed of 5 questions, each with a 4 point scale, ranging from 0-3. Scores for each question are summed to form a composite score out of 15. In the current Iraqi survey, the questions were modified to a 5-point scale and the question that asked “Did you think your use of cannabis was out of control?” was substituted with “To what extent has your substance use disrupted your work, social life or family life?”. For the purpose of analysis, two variables for substance dependence were created. The first was the SDS composite score out of 20, which was considered a continuous variable. The second was a dichotomous “substance dependent” variable, which identified participants as “substance dependent” if their scores exceeded the previously defined cutoff points for each substance (Castillo et al. 2010). SDS cutoff points for substance dependence were defined as follows: 1) 3 or more for alcohol; 2) 4 or more for cannabis or amphetamines; 3) 5 or more for heroin or opioids; and 4) 7 or more for benzodiazepines and other licit substances (benzhexol, tramadol, somadril, cough syrup and steroids). For participants who reported use of alcohol or drugs, 14 supplemental questions were asked about reasons for use. Responses to these were measured as “yes=1” when present and as “no=0” when they were not reported by the participant.

Socioeconomic level was not directly measured in the survey, and therefore the household crowding index (HCI), defined as the number of people residing in the household per room, was used as a proxy measure.

The governorate and region where the participant resided were noted as part of the study. A total of 18 governorates and 4 regions were surveyed. Risafah and Kerkh were classified as the “Baghdad” region. Kirkouk, Ninawa,
Dohouk, Erbil, and Sulaimaniyah were classified as the “North” region. Babylon, Kerbala, Najaf, Al-Qadisiyah, Wasit, Diala, Al-Anbar, and Salahuddin were classified as the “Middle” region. Al-Muthanna, Thi Qar, Al-Basrah, and Maysan were classified as the “South” region.

Other measures used to understand extent of substance use were “knowing others who used/misused” and “number of people you know who use/misuse.” These were measured for individual substances and also measured collectively for substance categories. These are common proxy measures used to assess drug use among populations that may have difficulty admitting use (i.e., high stigma, moral confliction, threat of severe punishment).

Information about the selection for a saliva test, completion of the saliva test, and results for the saliva test were all recorded. Saliva test results were measured as “positive=1” or “negative=0.”

Data Analysis
Sample means were calculated for age, number of children, number of rooms, and number of people in the household. Frequencies were calculated for other categorical demographic variables. To examine the association between demographic characteristics and substance use, chi-square statistics were calculated for categorical variables. Lifetime and current tobacco and alcohol use were calculated and were compared across demographic characteristics, governorates, and population groups. Additionally, patterns and types of tobacco use were explored, as well as patterns of alcohol use. Frequencies of lifetime use/misuse of licit and illicit drugs were tallied and compared across demographic characteristics, governorates, and population groups. An alpha level of 0.05 was used for examining chi-square statistics calculated to examine substance use differences across demographic characteristics. Adjustments by gender for substance use prevalence in the household survey sample were computed and applied to provide an approximate estimate for the Iraq adult population, since the sample was 72% male/28% female and the general population is approximately 50% male/female. However, no adjustments were applied to results for the special population sample, as this was a convenience sample.

To obtain a more informative picture of the scope of substance use in the sample, frequencies for “knowing other people who use/misused” were tallied for licit and illicit substances and were compared across governorates, regions, and population groups. Additionally, the mean number of people that respondents knew who used drugs was tallied, and 95% confidence intervals for the mean were calculated. Furthermore, frequencies were tabulated for perceived level of accessibility of substances and reasons for use.

Severity of dependence on alcohol and drugs was examined by calculating frequencies of participants with “substance dependence.” Saliva tests were assessed by tabulating frequencies of test completion and positive tests, and by exploring agreement between saliva test results and self-reported drug use. In order to explore degree of agreement, saliva test results and responses to corresponding drugs were linked by survey subject ID.
3. Results

3.1 Household Survey Sample

3.1.1 Demographic Profile
A total of 3,200 records were collected from 18 governorates in Iraq with 19 data collection geographic areas due to separating Baghdad into two parts (East and West). The overall response rate for the survey was 90.6%. Most of the refusals were from females (90.0%) in Baghdad governorate. Reasons for refusal included not having permission to participate from male guardians, suspicions about the nature of the interview, and religious reasons (females thought that talking with a stranger without the presence of a male family member would be sinful). Plus, during the time of the survey, violence and militia activity made security considerations extreme in this area.

The largest proportion of records were collected from the Middle region of Iraq (926, or 28.94%); 811 (25.34%) were collected from the North region, 800 (25.0%) were collected from the Baghdad region, and 633 (20.72%) were collected from the South region (Figure 2).

Figure 2. Distribution of Participants from the Household Survey Sample across Governorates and Regions
Table 1. Demographic Characteristics of the Household Survey Sample, by Region, From the Iraq National Household Survey on Alcohol and Drug Use, 2014.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>North Region n = 811</th>
<th>Middle Region n = 926</th>
<th>Baghdad Region n = 800</th>
<th>South Region n = 663</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>637 (78.6%)</td>
<td>617 (66.6%)</td>
<td>510 (63.8%)</td>
<td>525 (79.2%)</td>
</tr>
<tr>
<td>Female</td>
<td>173 (21.4%)</td>
<td>309 (33.4%)</td>
<td>290 (36.3%)</td>
<td>138 (20.8%)</td>
</tr>
<tr>
<td>Age, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–34</td>
<td>425 (53.1%)</td>
<td>347 (37.5%)</td>
<td>313 (39.1%)</td>
<td>265 (40.0%)</td>
</tr>
<tr>
<td>35–49</td>
<td>243 (30.3%)</td>
<td>364 (39.3%)</td>
<td>279 (34.9%)</td>
<td>244 (36.8%)</td>
</tr>
<tr>
<td>50–64</td>
<td>107 (13.4%)</td>
<td>171 (18.5%)</td>
<td>169 (21.1%)</td>
<td>127 (19.2%)</td>
</tr>
<tr>
<td>65+</td>
<td>26 (3.3%)</td>
<td>44 (4.8%)</td>
<td>39 (4.9%)</td>
<td>27 (4.1%)</td>
</tr>
<tr>
<td>Education level, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than primary</td>
<td>72 (8.9%)</td>
<td>119 (12.9%)</td>
<td>83 (10.4%)</td>
<td>83 (12.5%)</td>
</tr>
<tr>
<td>Primary</td>
<td>171 (21.1%)</td>
<td>259 (27.8%)</td>
<td>234 (29.3%)</td>
<td>149 (22.5%)</td>
</tr>
<tr>
<td>Secondary</td>
<td>347 (42.8%)</td>
<td>339 (36.6%)</td>
<td>256 (32.0%)</td>
<td>279 (42.1%)</td>
</tr>
<tr>
<td>Graduate or more</td>
<td>220 (27.2%)</td>
<td>209 (22.6%)</td>
<td>227 (28.4%)</td>
<td>152 (22.9%)</td>
</tr>
<tr>
<td>Marital Status, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>530 (65.5%)</td>
<td>752 (81.2%)</td>
<td>618 (77.3%)</td>
<td>517 (78.2%)</td>
</tr>
<tr>
<td>Widowed, Divorced/Separated</td>
<td>35 (4.3%)</td>
<td>42 (4.5%)</td>
<td>33 (4.1%)</td>
<td>32 (4.8%)</td>
</tr>
<tr>
<td>Never married</td>
<td>244 (30.2%)</td>
<td>132 (14.3%)</td>
<td>149 (18.6%)</td>
<td>112 (16.9%)</td>
</tr>
<tr>
<td>Number of children, mean (sd)</td>
<td>2.4 (2.56)</td>
<td>3.9 (3.33)</td>
<td>3.1 (3.34)</td>
<td>3.6 (3.15)</td>
</tr>
<tr>
<td>Work status, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>538 (66.4%)</td>
<td>415 (44.8%)</td>
<td>427 (53.4%)</td>
<td>450 (68.0%)</td>
</tr>
<tr>
<td>Homemaker*</td>
<td>70 (8.6%)</td>
<td>263 (28.4%)</td>
<td>209 (26.1%)</td>
<td>76 (11.5%)</td>
</tr>
<tr>
<td>Student</td>
<td>92 (11.4%)</td>
<td>62 (6.7%)</td>
<td>48 (6.0%)</td>
<td>28 (4.2%)</td>
</tr>
<tr>
<td>Retired</td>
<td>35 (4.3%)</td>
<td>64 (6.9%)</td>
<td>71 (8.9%)</td>
<td>23 (3.5%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>75 (9.3%)</td>
<td>122 (13.2%)</td>
<td>45 (5.7%)</td>
<td>85 (12.8%)</td>
</tr>
<tr>
<td>House Crowding Index, mean (sd)</td>
<td>1.7 (0.92)</td>
<td>2.8 (2.19)</td>
<td>2.4 (1.43)</td>
<td>2.8 (1.36)</td>
</tr>
<tr>
<td>Religion, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>788 (97.3%)</td>
<td>917 (99.2%)</td>
<td>798 (99.8%)</td>
<td>662 (99.9%)</td>
</tr>
<tr>
<td>Christian</td>
<td>18 (2.2%)</td>
<td>5 (0.5%)</td>
<td>1 (0.1%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (0.5%)</td>
<td>2 (0.2%)</td>
<td>1 (0.1%)</td>
<td>0</td>
</tr>
</tbody>
</table>

* Females constituted the majority of homemakers (98.2%).

* Overall average household crowding index (HCI) was 2.5 (sd=1.64). HCl >0.6 indicate crowding.

Males constituted 71.55% of the sample, and 28.45% were females. The distribution of age was skewed to the right, with a median age of 37 years. Overall, most participants were between 18 and 34 years of age (42.32%), 35.42% were between 35 and 49 years, 17.99% were between 50 and 64 years, and 4.26% were ages 65 years or greater. Demographic characteristics are described by region in Table 2.
3.1.2 Substance Use/Misuse Data

Throughout the presentation of all substance use data (tobacco, alcohol and drugs), “Lifetime” use or misuse refers to ever having used the substance in a persons' lifetime. “Current” use or misuse refers to having used the substance in the past 12 months.

**Tobacco.** Overall, 29.0% of participants reported ever using tobacco, and 23.4% reported current tobacco use. “Lifetime” and “current” tobacco use were significantly different between governorates ($X^2=249.4$, df=18, $p<0.001$, and $X^2=246.6$, df=18, $p<0.001$, respectively), with the highest gender-adjusted “lifetime” and “current” tobacco use prevalence in Dohouk governorate (46.0% and 45.0%, respectively). This was followed by Salahuddin governorate where lifetime and current tobacco use were reported at 42.5% and 38.8%, respectively. Furthermore, male tobacco use in these two governorates were rather high (current tobacco use was reported at 81.4% and 63.3% among males in Dohouk and Salahuddin, respectively). This was followed by Salahuddin governorate where lifetime and current tobacco use were reported at 42.5% and 38.8%, respectively. Furthermore, male tobacco use in these two governorates were rather high (current tobacco use was reported at 81.4% and 63.3% among males in Dohouk and Salahuddin, respectively). Figure 3 shows lifetime use and current use of tobacco by regions. Both “lifetime” and “current” tobacco use totals were significantly higher among males and differed significantly across education and work categories (Table 3). Other features of tobacco use are described in Table 4.

| Tobacco Use* |
|---|---|
| % with lifetime use | 29.0% |
| % with current use | 23.4% |
| % who know someone who uses | 89.1% |

*Estimates presented in this box are adjusted for unequal gender distribution.

**Alcohol.** Overall, 8.6% of participants reported ever drinking alcohol, and 3.4% reported current drinking. Both “lifetime” and “current” alcohol use significantly differed by governorate ($X^2=215.4$, df=18, $p<0.001$ and $X^2=195.5$, df=18, $p<0.001$, respectively), with the highest gender-adjusted self-reported “lifetime” alcohol use was in Kirkuk governorate (19.2%), while the highest current use was reported in Salahuddin governorate (10.1%). Figure 3 shows frequencies of “lifetime” use and “current” use of alcohol by regions. Self-reported alcohol use was significantly higher among males compared to females, and no female reported current alcohol use. Self-reported “lifetime” alcohol use significantly differed by age, and both “lifetime” and “current” alcohol use totals differed significantly across education levels, work categories, and regions (Table 3). Furthermore, participants who were Muslim had significantly lower self-reported alcohol use.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Lifetime Tobacco Use %</th>
<th>Current Tobacco Use %</th>
<th>Lifetime Alcohol Use %</th>
<th>Current Alcohol Use %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Male (n=2289)</td>
<td>53.0 %</td>
<td>43.3 %</td>
<td>16.7 %</td>
<td>6.7 %</td>
</tr>
<tr>
<td>Female (n=910)</td>
<td>5.1 %</td>
<td>3.4 %</td>
<td>0.6 %</td>
<td>0.11 %</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>18–34 (n=1350)</td>
<td>37.2 %</td>
<td>33.1 %</td>
<td>9.8 %</td>
<td>4.5 %</td>
</tr>
<tr>
<td>35–49 (n=1130)</td>
<td>37.8 %</td>
<td>31.0 %</td>
<td>12.8 %</td>
<td>5.7 %</td>
</tr>
<tr>
<td>50–64 (n=574)</td>
<td>46.2 %</td>
<td>32.9 %</td>
<td>16.1 %</td>
<td>4.7 %</td>
</tr>
<tr>
<td>65+ (n=136)</td>
<td>47.8 %</td>
<td>27.2 %</td>
<td>15.4 %</td>
<td>1.5 %</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Less than primary (n=357)</td>
<td>36.7 %</td>
<td>30.3 %</td>
<td>6.2 %</td>
<td>1.4 %</td>
</tr>
<tr>
<td>Primary (n=813)</td>
<td>43.1 %</td>
<td>36.8 %</td>
<td>13.7 %</td>
<td>5.6 %</td>
</tr>
<tr>
<td>Secondary (n=1221)</td>
<td>41.9 %</td>
<td>33.8 %</td>
<td>13.0 %</td>
<td>5.8 %</td>
</tr>
<tr>
<td>Graduate or more (n=808)</td>
<td>32.9 %</td>
<td>25.1 %</td>
<td>12.2 %</td>
<td>4.2 %</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Married (n=2417)</td>
<td>40.2 %</td>
<td>31.9 %</td>
<td>12.7 %</td>
<td>4.5 %</td>
</tr>
<tr>
<td>Widowed, Divorced or separated (n=142)</td>
<td>39.4 %</td>
<td>32.4 %</td>
<td>12.7 %</td>
<td>7.8 %</td>
</tr>
<tr>
<td>Never married (n=637)</td>
<td>36.3 %</td>
<td>32.3 %</td>
<td>10.1 %</td>
<td>5.7 %</td>
</tr>
<tr>
<td><strong>Work status</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Employed (n=1830)</td>
<td>49.1 %</td>
<td>41.2 %</td>
<td>16.2 %</td>
<td>6.8 %</td>
</tr>
<tr>
<td>Homemaker (n=618)</td>
<td>4.4 %</td>
<td>3.1 %</td>
<td>0.2 %</td>
<td>0</td>
</tr>
<tr>
<td>Student (n=230)</td>
<td>27.8 %</td>
<td>23.9 %</td>
<td>3.0 %</td>
<td>1.7 %</td>
</tr>
<tr>
<td>Retired (n=193)</td>
<td>52.9 %</td>
<td>33.2 %</td>
<td>22.8 %</td>
<td>4.7 %</td>
</tr>
<tr>
<td>Unemployed (n=327)</td>
<td>50.5 %</td>
<td>39.8 %</td>
<td>12.3 %</td>
<td>5.6 %</td>
</tr>
<tr>
<td><strong>House Crowding Index (mean)</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Baghdad (n=800)</td>
<td>30.9 %</td>
<td>26.4 %</td>
<td>6.8 %</td>
<td>2.9 %</td>
</tr>
<tr>
<td>North (n=811)</td>
<td>46.0 %</td>
<td>38.5 %</td>
<td>19.0 %</td>
<td>9.5 %</td>
</tr>
<tr>
<td>Middle (n=926)</td>
<td>37.0 %</td>
<td>30.4 %</td>
<td>11.3 %</td>
<td>3.8 %</td>
</tr>
<tr>
<td>South (n=663)</td>
<td>44.7 %</td>
<td>33.0 %</td>
<td>11.6 %</td>
<td>3.0 %</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Muslim (n=3165)</td>
<td>39.3 %</td>
<td>32.0 %</td>
<td>11.7 %</td>
<td>4.4 %</td>
</tr>
<tr>
<td>Other (n=32)</td>
<td>46.9 %</td>
<td>31.3 %</td>
<td>53.1 %</td>
<td>46.7 %</td>
</tr>
</tbody>
</table>

* Chi-square p-value <0.01  ** Chi-square p-value <0.001  *** Chi-square p-value <0.0001
% with lifetime use 8.6%
% with current use 3.4%
% who know someone who uses 43.4%

### Alcohol Use*

<table>
<thead>
<tr>
<th></th>
<th>North Region</th>
<th>Middle Region</th>
<th>South Region</th>
<th>Baghdad Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with lifetime use</td>
<td>8.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% with current use</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% who know someone who uses</td>
<td>43.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Estimates presented in this box are adjusted for unequal gender distribution.

### Table 4. Patterns of Tobacco Use from the Household Survey Sample

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age at first tobacco use</td>
<td>22.3</td>
</tr>
<tr>
<td>Average number of days used tobacco in the past month</td>
<td>27.0</td>
</tr>
<tr>
<td>Average number of cigarettes smoked per day</td>
<td>23.0</td>
</tr>
<tr>
<td>Average number of cigars smoked per day</td>
<td>0.2</td>
</tr>
<tr>
<td>Average number of minutes/day spent on smoking pipe, hookah, or shisha</td>
<td>23.7</td>
</tr>
<tr>
<td>Average number of days smoked pipe, hookah, or shisha per month</td>
<td>15.1</td>
</tr>
<tr>
<td>Average number of minutes spent on chewing tobacco, on a day of chewing</td>
<td>16.2</td>
</tr>
</tbody>
</table>

* Estimates presented in this table adjusted for unequal gender distribution.
Table 5. Patterns of Alcohol Use among Male Participants from the Household Survey Sample

<table>
<thead>
<tr>
<th>Feature</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age at first alcohol consumption</td>
<td>20.9</td>
</tr>
<tr>
<td>Average number of days consumed alcohol in the past month</td>
<td>10.6</td>
</tr>
<tr>
<td>Average number of drinks consumed on a day the person drinks</td>
<td>6.0</td>
</tr>
<tr>
<td>Average maximum number of drinks consumed on a day a person drinks</td>
<td>7.7</td>
</tr>
</tbody>
</table>

totals compared to participants of other religions (Table 3). Only one female participant reported current alcohol use (0.11%), thus we only report patterns for alcohol use among male participants in this sample (Table 5).

Patterns of Substance Misuse (Licit Drugs) and Use (Illicit Drugs)

Licit Drug Misuse. The category of “licit” drugs includes approved medications with an approved medical use. While individuals may take these medications as prescribed, the survey asked if they misused them. The licit medications that were asked about in this survey were cough syrup, tramadol, somadril, benzodiazepines, benzehexol, anabolic steroids, other pills. Information on licit drug misuse and illicit drug use is presented in Table 6.

Overall, 2.5% of participants reported ever misusing any of the licit drugs. Self-reported “lifetime” licit drug misuse was significantly different across regions ($\chi^2=314.4$, $df=18$, $p<0.001$). The highest “lifetime” misuse of any licit drug was reported in Maysan governorate (14.6%), in which 17.7% of females and 11.5% of males reported ever misusing benzodiazepines, 4.6% of males reported ever misusing benzhexol and 4.6% males reported ever misusing steroids. Additionally, 11.8% of females and 4.6% of males reported ever misusing allermine. “Lifetime” any licit drug use was reported at a similar rate in Thi-Qar governorate (14.3%), in which 20% of males reported ever using anabolic steroids. Self-reported use of licit drugs by region is illustrated in Figure 4.

Overall, males reported significantly higher rates of ever misusing licit drugs compared to females (4.3% and 0.7%, respectively). Self-reported licit drug misuse significantly differed by education level, marital status, geographic region, and employment (Table 6). Compared to other employment categories, people who were unemployed had the highest self-reported rates for ever misusing licit drugs (7.7%; Table 6). When self-reported lifetime licit drug misuse is examined for each substance individually, the highest calculated self-reported “lifetime” misuse of a licit substance was for steroids and benzodiazepines (1.1% and 1.0%, respectively; Table 7). Average age at first misuse of licit drugs ranged from 17 to 30 years of age (Table 7).

Illicit Drug Use. The category of “illicit” drugs includes drugs that have no approved medical use. Hence any use of these drugs is illegal and of concern. The survey asked if individuals used the following drugs: cannabis, Captagon/amphetamine-type stimulants (ATS), opium/heroin, and inhalants.

Overall, 0.4% of the participants reported ever using any of the illicit substances. Only 0.7% of males reported ever using illicit drugs and no females reported any illicit drug use. Thus, we only compare male self-reported use across governorates and regions. Self-reported “lifetime” use of illicit drugs significantly differed by governorate ($\chi^2=46.7$, $df=18$, $p=0.001$), with the highest calculated self-reported “lifetime” illicit drug-use prevalence being in Erbil governorate, where 4.3% males reported ever using illicit drugs. Additionally, Erbil governorate also had the highest male self-reported “lifetime” use for cannabis and opium or heroin (2.9% and 1.4%, respectively). Figure 5 shows the distribution of self-reported “lifetime” illicit drug use among
Table 6. Self-reported Lifetime Licit Drug Misuse, Illicit Drug Use and Combined Drug and Alcohol Use by Demographic Characteristics in the Household Survey Sample, From the Iraq National Household Survey on Alcohol and Drug Use, 2014.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Licit Drug Misuse (N=105) %</th>
<th>Illicit Drug Use (N=16) %</th>
<th>Licit and Illicit Drug Use (N=7) %</th>
<th>Licit and Illicit Drug use, and alcohol use (N=6) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (n=2289)</td>
<td>4.3 %</td>
<td>0.7 %</td>
<td>0.3 %</td>
<td>0.3 %</td>
</tr>
<tr>
<td>Female (n=910)</td>
<td>0.7 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–34 (n=1350)</td>
<td>3.9 %</td>
<td>0.9 %</td>
<td>0.4 %</td>
<td>0.3 %</td>
</tr>
<tr>
<td>35–49 (n=1130)</td>
<td>3.2 %</td>
<td>0.3 %</td>
<td>0.2 %</td>
<td>0.2 %</td>
</tr>
<tr>
<td>50–64 (n=574)</td>
<td>3.0 %</td>
<td>0.4 %</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>65+ (n=136)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than primary (n=357)</td>
<td>2.8 %</td>
<td>1.1 %</td>
<td>0.8 %</td>
<td>0.8 %</td>
</tr>
<tr>
<td>Primary (n=813)</td>
<td>2.6 %</td>
<td>0.7 %</td>
<td>0.3 %</td>
<td>0.1 %</td>
</tr>
<tr>
<td>Secondary (n=1221)</td>
<td>5.0 %</td>
<td>0.3 %</td>
<td>0.2 %</td>
<td>0.2 %</td>
</tr>
<tr>
<td>Graduate or more (n=808)</td>
<td>1.6 %</td>
<td>0.5 %</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (n=2417)</td>
<td>2.7 %</td>
<td>0.3 %</td>
<td>0.1 %</td>
<td>0.1 %</td>
</tr>
<tr>
<td>Widowed, Divorced or separated (n=142)</td>
<td>5.6 %</td>
<td>0.7 %</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never married (n=637)</td>
<td>5.2 %</td>
<td>1.6 %</td>
<td>0.8 %</td>
<td>0.6 %</td>
</tr>
<tr>
<td>Work status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed (n=1830)</td>
<td>3.6 %</td>
<td>0.7 %</td>
<td>0.2 %</td>
<td>0.2 %</td>
</tr>
<tr>
<td>Homemaker (n=618)</td>
<td>0.3 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Student (n=230)</td>
<td>4.4 %</td>
<td>0.4 %</td>
<td>0.4 %</td>
<td>0.4 %</td>
</tr>
<tr>
<td>Retired (n=193)</td>
<td>1.6 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unemployed (n=327)</td>
<td>7.7 %</td>
<td>0.9 %</td>
<td>0.6 %</td>
<td>0.3 %</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baghdad (n=800)</td>
<td>0.1 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>North (n=811)</td>
<td>4.0 %</td>
<td>1.1 %</td>
<td>0.5 %</td>
<td>0.4 %</td>
</tr>
<tr>
<td>Middle (n=926)</td>
<td>0.9 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South (n=663)</td>
<td>9.7 %</td>
<td>1.2 %</td>
<td>0.5 %</td>
<td>0.5 %</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim (n=3165)</td>
<td>3.3 %</td>
<td>0.5 %</td>
<td>0.2 %</td>
<td>0.2 %</td>
</tr>
<tr>
<td>Other (n=32)</td>
<td>6.3 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Chi-square p-value <0.01  ** Chi-square p-value <0.001  *** Chi-square p-value <0.0001
male participants across the 4 regions. The highest self-reported use of Captagon, opium or heroin and inhalants was among males in the South region (0.57%, 0.38% and 0.57%, respectively; Figure 5). However, the highest self-reported “lifetime” use of cannabis was among males from the North region (0.94%; Figure 5).

When self-reported “lifetime” use of illicit drugs was examined for each substance individually for the total sample, “lifetime” use prevalence was lower than that for licit substances. The highest calculated self-reported “lifetime” use of an illicit substance was for cannabis (0.2%; Table 7). Average age at first use of illicit drugs ranged from 14 to 29 years of age (Table 7).

**Drug Injection.** Although all participants (3,200) responded to the question regarding “knowing others who used injection drugs”, only 470 responded to the question that asked about “lifetime” injection use. Of these, only one individual reported ever having injected a drug.

### 3.1.3 Summary: Alcohol and Drug Use

The box below provides summary of gender-adjusted “lifetime” and “current” use of any drugs or alcohol, or both. These represent the central quantitative finding from the study.

---

**Figure 4. Gender-adjusted Proportions of Self-reported Lifetime Licit Drug Misuse by Substance Type from the Household Survey Sample, by Region**

<table>
<thead>
<tr>
<th>Substances</th>
<th>North Region</th>
<th>Middle Region</th>
<th>South Region</th>
<th>Baghdad Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough Syrup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somadril</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzhexol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anabolic Steroids</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 5. Proportions of Self-reported Lifetime Illicit Drug Use by Substance Type, among Males from the Household Survey Sample by Region**

<table>
<thead>
<tr>
<th>Substances</th>
<th>North Region</th>
<th>Middle Region</th>
<th>South Region</th>
<th>Baghdad Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opium/Heroin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Captagon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This graph show percentages of illicit drug use in the North and South regions. Numbers inside the bars represent the percentage of those who reported ever using the substance within each region.

**No Participants reported ever using illicit drugs in the Middle and Baghdad regions.**

*This graph show proportions of licit drug misuse in the North, Middle, and South regions. Bars represent the percent of those who reported ever misusing the substance within each region. In the Baghdad region, only one person reported the use of anabolic steroids (not presented in graph).*
Table 7. Self-reported Lifetime Drug Use/Misuse by Substance and Average Age at First Use/Misuse in the Household Survey, From the Iraq National Household Survey on Alcohol and Drug Use, 2014.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Self-reported Use/Misuse %</th>
<th>Average Age at First Use Mean age (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licit Drugs*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td>1.1 %</td>
<td>24.8 (22.7, 27.0)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>1.0 %</td>
<td>30.7 (27.9, 33.5)</td>
</tr>
<tr>
<td>Benhexol</td>
<td>0.5 %</td>
<td>22.8 (18.3, 27.2)</td>
</tr>
<tr>
<td>Other Pills**</td>
<td>0.5 %</td>
<td>28.2 (23.1, 33.3)</td>
</tr>
<tr>
<td>Somadril</td>
<td>0.3 %</td>
<td>20.7 (11.9, 29.5)</td>
</tr>
<tr>
<td>Tramadol</td>
<td>0.2 %</td>
<td>28.3 (21.3, 35.2)</td>
</tr>
<tr>
<td>Cough syrup</td>
<td>0.2 %</td>
<td>17.1 (9.5, 24.8)</td>
</tr>
<tr>
<td>Illicit Drugs***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>0.2 %</td>
<td>27.3 (21.2, 33.4)</td>
</tr>
<tr>
<td>Inhalants</td>
<td>0.1 %</td>
<td>13.8 (-0.2, 27.7)</td>
</tr>
<tr>
<td>Captagon or ATS</td>
<td>0.1 %</td>
<td>21.0 (18.5, 23.5)</td>
</tr>
<tr>
<td>Opium or heroin</td>
<td>0.1 %</td>
<td>29.3 (18.2, 40.3)</td>
</tr>
<tr>
<td>Injection****</td>
<td>0.02 %</td>
<td>—</td>
</tr>
</tbody>
</table>

* Estimates for licit drugs are adjusted for unequal gender distribution.

** Other pill use was only reported by 17 participants. These included allermin (reported by 10), codeine (reported by 2) and 1 reported the use of methadone. Four participants refused to name the type of other pills they used.

*** No females reported illicit drug use. The estimate reported are adjusted for unequal gender distribution.

**** Only one participant reported ever using by injection. No data was collected on age at first use of injection.

Knowing Others Who Ever Misused Licit or Illicit Drugs

Adjusting for unequal gender distribution, 19.5% of participants (30.4% of males and 8.6% of females) reported knowing other people who misused licit drugs, and 11.0% (16.7% of males and 5.4% of females) reported knowing others who used illicit drugs. Reporting knowing others who use licit drugs significantly differed between male and female participants ($X^2=160.8$, df=1, $p <0.001$), as did reporting knowing people who used illicit drugs ($X^2=70.4$, df=1, $p <0.001$). Knowing others who misused licit drugs significantly differed by governorate ($X^2=914.7$, df=18, $p <0.001$), as did knowing others who used illicit drugs ($X^2=1138.8$, df=18, $p <0.001$). The highest proportion of participants who reported knowing others who misused licit or illicit drugs were from the South region (specifically Al-Basrah governorate had highest rates with 68% and 62.8%, respectively). Figure 6 shows the distribution of people who reported knowing others who used licit vs. illicit drugs, by region.

When knowing others who use drugs was further examined by substance, most participants reported knowing others who misused steroids (17.6%; Table 8).

Saliva Test Results

A total of 464 participants were randomly selected for a saliva test. Of these 53 refused (11.4%), 4 (0.9%) had test failures and 12 (2.6%) were excluded because of improper storage (Figure 7). The most common reasons for refusal were pregnancy, fear of legal consequences, fear of physical harm from the test, and that the test was bothersome and time consuming. Others did not give specific reasons for refusal. Thus, there were 395 (85.1%) completed saliva tests valid for analysis. This information is illustrated in Figure 7.
Of the 395 completed tests, only 7 (1.8%) were positive. Of these, one participant was positive for ATS, 2 were positive for cocaine and benzodiazepines, 2 were positive for benzodiazepines alone, 1 was positive for marijuana alone, and 1 was positive for cocaine alone. None of the tested participants was positive for opiates. Therefore, 4 (1.0%) people tested positive for a licit substance and 5 (1.3%) people tested positive for an illicit substance. Cocaine was not queried in the survey, so its saliva test result cannot be compared to self-report.

Perceived Availability of Drugs
In general, tramadol, benzodiazepines, and benzhexol were perceived as difficult to obtain, whereas cough syrup, steroids, and other pills were perceived as being easily attainable. With respect to illicit substances, cannabis was perceived as very difficult to obtain and Captagon, or ATS, was perceived as very easy to obtain. Opium users responded differently; half perceived opium as very easy to obtain and the other half perceived it as very difficult to obtain.

3.1.4 Substance Use-Related Experiences
The following section reflects data that were only collected from people who reported ever using alcohol or drugs (n=457; 14.3%).

Alcohol or Drug Dependence
Only individuals who reported that they had used alcohol or drugs (“lifetime” use) in the past 12 months completed the Substance Dependence Scale (SDS). Table 9 shows proportions of substance dependence by substance in the household survey sample.

Reasons for Alcohol or Drug Use
Of the 457 who reported “lifetime” alcohol or drug use, 249 responded to questions inquiring about reasons for drinking alcohol or drug use, and data were missing for 208 participants. Reasons for alcohol and drug use that
were most frequently reported by participants were: “Help me forget my problems” (47.8%), “For socializing with friends” (45.8%), “To make me feel less depressed” (45.8%), and “To make me feel less anxious” (41%; Figure 8).

Places Where You Usually Use Substances

Among those who reported ever using alcohol or drugs (457), 242 provided responses regarding where they usually used substances. Their responses were as follows: 61.9% said they used at home, 28.1% at a cafe, 36.8% at the bar, 31.8% at parties, and 28.1% at “other” places (mostly referred to as “everywhere”). It is important to note here that we were unable to distinguish whether they were referring to alcohol use or drug use, but it seems to refer mostly to those who ever used alcohol because their frequency is much higher than those who reported ever using any drugs.

People You Use Substances With

Of the participants who reported ever using alcohol or drug use, 242 provided information about people with whom they used the substances; 74.8% said they used alone, 76.5% said they used with their friends, 14.1% said they used with siblings, 10.3% used with a spouse, 19% used with a coworker, 11.2% used with strangers, and 0.8% used with “other” people.

Physical Experiences after Substance Use

Of participants who reported ever using alcohol or drugs, 236 provided information about immediate physical symptoms they experienced after using a substance; 68.2% said they became happy, 26.7% became violent, 5.5% forgot to take other medications (for TB or heart disease, etc), 12.7% missed or reported late for work, 31.4% lost their appetite, 3.8% experienced “other” things (relaxation, fatigue, respiratory problems, tremors, backache, gastric upset); and 8.1% “didn’t know.”

Table 8. Responses to “Do you know others who misuse/use this drug?” and “How many people who misuse/use this drug do you know?” in the Household Survey Sample.

<table>
<thead>
<tr>
<th>Substance</th>
<th>“Do you know others who misuse/use this drug?”* N=3,200 % responded yes</th>
<th>Average Age at First Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licit Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td>17.6 %</td>
<td>18 (11.9, 23.3)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>12.1 %</td>
<td>18 (9.6, 25.4)</td>
</tr>
<tr>
<td>Cough syrup</td>
<td>9.1 %</td>
<td>10 (5.4, 14.6)</td>
</tr>
<tr>
<td>Benzhexol</td>
<td>6.4 %</td>
<td>13 (7.2, 19.0)</td>
</tr>
<tr>
<td>Tramadol</td>
<td>2.6 %</td>
<td>8 (4.5, 11.8)</td>
</tr>
<tr>
<td>Somadril</td>
<td>2.1 %</td>
<td>21 (-3.6, 45.7)</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td>5.8 %</td>
<td>10 (2.2, 18.4)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>4.6 %</td>
<td>21 (7.9, 33.9)</td>
</tr>
<tr>
<td>Opium or heroin</td>
<td>4.7 %</td>
<td>17 (6.1, 27.8)</td>
</tr>
<tr>
<td>Injection</td>
<td>2.1 %</td>
<td>7 (3.9, 9.3)</td>
</tr>
<tr>
<td>Captagon or ATS</td>
<td>1.9 %</td>
<td>12 (6.8, 17.5)</td>
</tr>
<tr>
<td>Other Pills</td>
<td>4.9 %</td>
<td>10 (-0.5, 20.3)</td>
</tr>
</tbody>
</table>

* Estimates for knowing others who use drugs are adjusted for unequal gender distribution.

Note: These proportions should not add up to 100%, because responses are not mutually exclusive.

Table 9. Proportion of Substance Dependence by Substance among Participants Who Reported Current Use, in Household Survey Sample

<table>
<thead>
<tr>
<th>Substance</th>
<th>Reported Current Use Count</th>
<th>Substance Dependence Count (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol</td>
<td>4</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>ATS or Captagon</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Somadril</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Cough Syrup</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Benzhexol</td>
<td>12</td>
<td>11 (92%)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>27</td>
<td>21 (78%)</td>
</tr>
<tr>
<td>Opium/Heroin</td>
<td>4</td>
<td>3 (75%)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>155</td>
<td>110 (71%)</td>
</tr>
<tr>
<td>Steroids</td>
<td>8</td>
<td>2 (25%)</td>
</tr>
</tbody>
</table>
Figure 8. Reasons for Using Substances among Those Who Reported Ever Using Alcohol or Drugs in the Household Survey Sample

Long-term Consequences of Substance Use
Among people who reported ever using alcohol or drugs, 251 provided information about long-term consequences that were associated with their substance use; 12.4% were unable to attend work, 56.9% were criticized by friends and family, 14.3% had an injury, 19.9% had a fight, 17.9% damaged or ended a relationship with a friend or spouse, 9.6% felt regret or shame for something they did while intoxicated, 17.5% had no negative consequences, 2.0% had “other” consequences (bad smell in clothes), and 4.4% “didn’t know.”

3.2 Special Population Sample
3.2.1 Demographic Profile
A total of 300 records were collected from IDPs, Hawasim, and recently-released-from-prison populations. Males constituted 72.3% of this sample. The IDPs and Hawasim groups included both males and females. The released prisoner population was entirely composed of male participants (Table 10).

Overall, the highest percent of participants in this sample were between the ages of 18 and 34 years, had at least 6 years of school education, and were married. Participants were almost entirely Muslim (Table 10). When comparing socio-economic indicators between the three population groups, the IDP population seemed to have the highest HCl and the highest average number of children per household.

3.2.2 Drug and Alcohol Use Data
Patterns of Substance Use (Tobacco and Alcohol)
Tobacco. The box above shows summary estimates for tobacco use in the total special population by gender. “Lifetime” tobacco use and “current” tobacco use was significantly higher among males ($X^2=70.4$, df=1, $p<0.001$ and $X^2=69.9$, df=1, $p<0.001$, respectively). Additionally, both “lifetime” and “current” tobacco use differed significantly across employment categories ($X^2=61.1$, df=5, $p<0.001$, and $X^2=62.8$, df=5, $p<0.001$), with the highest rates being reported among the unemployed group.

Figure 9 presents the rates of “lifetime” and “current” use of tobacco, by gender, across the 3 special population groups compared to the household survey sample. Results for males show that both the “recently released prisoner” group and Hawasim group have higher rates of “lifetime” and “current” smoking and lifetime alcohol use than the IDP group or the household survey sample. Estimates for lifetime and current tobacco use in the IDP group are comparable with males in the household survey sample. Current tobacco use significantly differed
Table 10. Demographic Characteristics by Special Population Group, From the Iraq National Household Survey on Alcohol and Drug Use, 2014.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Internally Displaced Persons n = 100 %</th>
<th>Hawasim n = 100 %</th>
<th>Released Prisoners n = 100 %</th>
<th>Household Sample n = 3200 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54 %</td>
<td>63 %</td>
<td>100 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Female</td>
<td>46 %</td>
<td>37 %</td>
<td>0</td>
<td>29 %</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–34</td>
<td>40.0 %</td>
<td>45.0 %</td>
<td>54.0 %</td>
<td>42.3 %</td>
</tr>
<tr>
<td>35–49</td>
<td>32.0 %</td>
<td>37.0 %</td>
<td>39.0 %</td>
<td>35.4 %</td>
</tr>
<tr>
<td>50–64</td>
<td>20.0 %</td>
<td>17.0 %</td>
<td>5.0 %</td>
<td>18.0 %</td>
</tr>
<tr>
<td>65+</td>
<td>8.0 %</td>
<td>1.0 %</td>
<td>2.0 %</td>
<td>4.3 %</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than primary</td>
<td>37.0 %</td>
<td>20.2 %</td>
<td>20.0 %</td>
<td>11.2 %</td>
</tr>
<tr>
<td>Primary</td>
<td>33.0 %</td>
<td>34.3 %</td>
<td>38.0 %</td>
<td>25.4 %</td>
</tr>
<tr>
<td>Secondary</td>
<td>27.0 %</td>
<td>34.3 %</td>
<td>32.0 %</td>
<td>38.2 %</td>
</tr>
<tr>
<td>Graduate or more</td>
<td>3.0 %</td>
<td>11.1 %</td>
<td>10.0 %</td>
<td>25.3 %</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>89.0 %</td>
<td>59.0 %</td>
<td>66.0 %</td>
<td>76.0 %</td>
</tr>
<tr>
<td>Widowed, Divorced/Separated</td>
<td>4.0 %</td>
<td>9.0 %</td>
<td>0</td>
<td>4.0 %</td>
</tr>
<tr>
<td>Never married</td>
<td>7.0 %</td>
<td>32.0 %</td>
<td>34.0 %</td>
<td>20.0 %</td>
</tr>
<tr>
<td>Number of children, mean (sd)</td>
<td>4.0 (2.87)</td>
<td>3.0 (3.05)</td>
<td>2.0 (2.37)</td>
<td>3.3 (2.98)</td>
</tr>
<tr>
<td>Work status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>36.0 %</td>
<td>49.0 %</td>
<td>27.0 %</td>
<td>57.2 %</td>
</tr>
<tr>
<td>Homemaker*</td>
<td>42.0 %</td>
<td>33.0 %</td>
<td>0</td>
<td>19.3 %</td>
</tr>
<tr>
<td>Student</td>
<td>0</td>
<td>6.0 %</td>
<td>0</td>
<td>7.2 %</td>
</tr>
<tr>
<td>Retired</td>
<td>5.0 %</td>
<td>3.0 %</td>
<td>0</td>
<td>6.0 %</td>
</tr>
<tr>
<td>Unemployed</td>
<td>17%</td>
<td>9.0 %</td>
<td>73.0 %</td>
<td>10.2 %</td>
</tr>
<tr>
<td>House Crowding Index, mean (sd)a</td>
<td>12.6 (20.16)</td>
<td>3.5 (1.15)</td>
<td>3.1 (2.11)</td>
<td>2.5 (1.64)</td>
</tr>
<tr>
<td>Religion, number (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>100 %</td>
<td>100 %</td>
<td>99.0 %</td>
<td>99.0 %</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1.0 %</td>
<td>1.0 %</td>
</tr>
</tbody>
</table>

* Females constituted the majority of homemakers (98.1 %).
a Overall average household crowding index (HCI) was 2.5 (sd=1.64). Mean HCI was significantly different across the 4 groups (F=234.7, df=3, p <0.001).
across population groups in males ($X^2=13.9$, df=3, $p=0.003$), with the highest use reported among the group recently released from prison (61%; Figure 9).

When comparing female tobacco and alcohol use across population groups, female participants from the Hawasim group reported higher rates of lifetime tobacco use compared to those from the household survey sample (10.8% and 5.1%, respectively; Figure 9). However, they reported similar rates for current tobacco use (2.7% and 3.4% for Hawasim and household survey sample, respectively; Figure 9). None of the females from the IDP group reported any tobacco use. Other features of tobacco use in the total special population sample are described in Table 11.

**Alcohol.** “Lifetime” use of alcohol was reported among 12.4% of male participants, and only 0.9% reported “current” drinking. No females in the special population groups reported alcohol use. The average HCl index for people who reported “lifetime” drinking alcohol, 3.2, was significantly lower than the average HCl for people who reported “never” drinking, 6.7 (t-test=-4.08, df=283.6, $p<0.001$).

Lifetime and current alcohol use also differed significantly across male population groups ($X^2=10.3$, df=3, $p=0.02$, and $X^2=11.5$, df=3, $p=0.01$, respectively). The group “recently released from prison” reported higher rates for lifetime alcohol use compared to males from the household survey sample (19% and 16.7%, respectively; Figure 9). However, both “recently released from prison” and Hawasim groups reported lower rates for current alcohol use compared to the household survey sample (Figure 9). Because none of the females reported alcohol use, we only describe other features for alcohol use in the male special population sample (Table 12).

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with lifetime use</td>
<td>43.7%</td>
<td>58.5%</td>
<td>4.8%</td>
</tr>
<tr>
<td>% with current use</td>
<td>39.3%</td>
<td>53.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>% who know someone who uses</td>
<td>80.3%</td>
<td>82.0%</td>
<td>24.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol Use</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with lifetime use</td>
<td>9.0%</td>
<td>12.4%</td>
<td>0</td>
</tr>
<tr>
<td>% with current use</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0</td>
</tr>
<tr>
<td>% who know someone who uses</td>
<td>24.3%</td>
<td>31.3%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>
Table 11. Patterns of Tobacco Use in the Special Population Sample

<table>
<thead>
<tr>
<th>Feature</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age at first tobacco use</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Average number of days used tobacco in the past month</td>
<td>29.5</td>
<td></td>
</tr>
<tr>
<td>Average number of cigarettes smoked per day</td>
<td>26.8</td>
<td>0</td>
</tr>
<tr>
<td>Average number of cigars smoked per day</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Average number of minutes/day spent smoking hookah</td>
<td>47.6</td>
<td></td>
</tr>
<tr>
<td>Average number of days smoked hookah per month</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Average number of minutes spent on chewing tobacco, on a day of chewing</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 12. Patterns of Alcohol Use among Male Participants from the Special Population Sample

<table>
<thead>
<tr>
<th>Feature</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age at first alcohol consumption</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Average number of days consumed alcohol in the past month</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Average number of drinks consumed on a day the person drinks</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>Average maximum number of drinks consumed on a day a person drinks</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Figure 10. Comparing Lifetime and Current Licit Drug Misuse and Illicit Drug Use among Males across All Population Groups

Patterns of Substance Use (Licit and Illicit Drugs)

Licit Drugs. Overall, 4.6% of male participants in the special population groups reported ever misusing any of the licit drugs. No females in these groups reported licit drug use or even knowing someone who used licit drugs. Thus we only report male estimates for licit and illicit drug use in this section. Figure 10 illustrates the rates of licit and illicit drug “lifetime” and “current” misuse/use among males across the 3 special population groups, compared to the household survey sample. Self-reported “lifetime” licit drug misuse was significantly different across the special population groups (X²=12.3, df=2, p=0.002). None of the participants from IDP or Hawasim populations reported ever using licit drugs. Thus, we report drug use by substance for the group recently released from prison only. Lifetime misuse for licit drugs among the group recently released from prison, whom were all males, was higher than that reported among males in the household survey sample (10% and 3.3%, respectively). Among the group recently released from prison, the highest self-reported “lifetime” misuse of licit drugs was for benzhexol (2.7%; Table 13). Average age at first misuse of licit drugs in this group ranged from 22 to 44 years of age (Table 13).
Illicit Drugs. Only 4 male participants in this special population sample reported ever using an illicit substance, all of whom were from the group “recently released from prison”. Thus we only report results for that group in this section of the report. Self-reported “lifetime” illicit drug use was higher among those recently released from prison compared to males from the household survey sample (3.0% and 0.7%, respectively; Figure 10). When self-reported “lifetime” illicit drug use was examined more closely for the group recently released from prison, the highest self-reported “lifetime” use was for Captagon (2%; Table 13). Furthermore, none reported ever using opium/heroin or inhalants (Table 13).

Drug Injection. None of the participants in the special population group reported ever having injected a drug.

In summary, lifetime alcohol use was reported at a higher rate among the group recently released from prison (19%) as compared to the Hawasim and IDP groups (11.1% and 1.9%, respectively). None of the IDPs or Hawasim participants reported ever using licit or illicit drugs. When comparing substance use estimates for the group “recently released from prison” to males from the household survey sample, lifetime any substance use, lifetime any drug use and lifetime alcohol use were all higher for the group recently released from prison than that reported among males in the household survey sample. However, current alcohol use was higher among males from the household survey compared to the group “recently released from prison” (6.7% and 1%, respectively).

Knowing Others Who Ever Misused Licit or Used Illicit Drugs

A total of 10.3% of male participants from the special population sample reported knowing other people who misused licit drugs, and 7.8% reported knowing others who used illicit drugs. Figure 11 illustrates the proportions of male individuals in the 3 special population groups (and the household survey sample) who reported that they knew someone who used licit or illicit drugs. As illustrated, individuals in these samples reported similar, or lower rates of “knowing others” than in the household survey sample. Knowing others who misused licit drugs significantly differed by population group ($X^2=69.2$, df=3, $p <0.001$), as did knowing others who used illicit drugs ($X^2=15.1$, df=3, $p=0.002$). The group recently released from prison reported much higher rates for knowing others who used licit drugs (17%) or knowing others who used illicit drugs (14%) as compared to the IDPs and Hawasim groups (Figure 11). When knowing others who use drugs was further examined by substance among the group recently released from prison, most participants reported knowing others who misused benzhexol (10%; Table 14).

### Table 13. Self-reported Lifetime Drug Use/Misuse by Substance and Average Age at First Use/Misuse In the Group Recently Released From Prison, From the Iraq National Household Survey on Alcohol and Drug Use, 2014.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Self-reported Use/Misuse %</th>
<th>Average Age at First Use Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Licit Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzhexol</td>
<td>8%</td>
<td>22.8</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>3%</td>
<td>33.0</td>
</tr>
<tr>
<td>Somadril</td>
<td>3%</td>
<td>24.0</td>
</tr>
<tr>
<td>Cough Syrup</td>
<td>3%</td>
<td>24.3</td>
</tr>
<tr>
<td>Tramadol</td>
<td>1%</td>
<td>44.0</td>
</tr>
<tr>
<td>Steroids</td>
<td>1%</td>
<td>30.0</td>
</tr>
<tr>
<td>Other Pills</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td><strong>Illicit Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Captagon or ATS</td>
<td>2%</td>
<td>30.5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>1%</td>
<td>11.0</td>
</tr>
<tr>
<td>Injection</td>
<td>1%</td>
<td>NA</td>
</tr>
<tr>
<td>Opium/Heroin</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Inhalants</td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>
Summary of Substance Use in the Group Recently Released From Prison

<table>
<thead>
<tr>
<th>Substance</th>
<th>% Responded Yes</th>
<th>Mean (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Licit Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzhexol</td>
<td>10 %</td>
<td>30</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>8 %</td>
<td>27</td>
</tr>
<tr>
<td>Cough syrup</td>
<td>5 %</td>
<td>15</td>
</tr>
<tr>
<td>Steroids</td>
<td>4 %</td>
<td>5</td>
</tr>
<tr>
<td>Somadril</td>
<td>3 %</td>
<td>25</td>
</tr>
<tr>
<td>Tramadol</td>
<td>1 %</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Illicit Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Captagon or ATS</td>
<td>10 %</td>
<td>23</td>
</tr>
<tr>
<td>Inhalants</td>
<td>5 %</td>
<td>11</td>
</tr>
<tr>
<td>Cannabis</td>
<td>2 %</td>
<td>12</td>
</tr>
<tr>
<td>Opium or heroin</td>
<td>2 %</td>
<td>47</td>
</tr>
<tr>
<td>Injection</td>
<td>2 %</td>
<td>9</td>
</tr>
<tr>
<td>Other Pills</td>
<td>1 %</td>
<td>10</td>
</tr>
</tbody>
</table>

Perceived Availability of Drugs

Only one participant reported ever using tramadol, benzodiazepines, or benzhexol, and also reported their perception of the availability of these substances, saying it was "very easy." Information on perceived availability of substances was missing for the remainder of participants who reported ever using any drug.

Saliva Test Results

A total of 58 participants (19.3%) were randomly selected for a saliva test in the special population sample, and the response rate was 96.6%. Only 2 participants refused the test, and results were invalid for 4 records. None tested positive for any of the substances tested.
3.2.3 Substance Use-Related Experiences

The following section reflects data that were only collected from people who reported ever using alcohol or drugs. In the special population sample, only 35 (11.7%) participants reported ever using alcohol or drugs (1 from the IDPs group; 7 from the Hawasim group; and 27 from the recently released prisoner population).

Reasons for Alcohol or Drug Use

Of the 35 participants who reported ever drinking alcohol or using drugs, only 28 responded to further inquiry about reasons for using either alcohol or drugs. Data were missing for 7 of these participants. Reasons for alcohol and drug use that were most frequently reported by participants were “An important source of pleasure” (46.4%), “To give me something to look forward to” (42.9%), and “To help me forget my problems” (28.6%; Figure 12).

Long-term Consequences of Substance Use

With respect to long-term consequences of substance use, 78.6% reported that they were criticized by a friend or family member, 2 participants reported being unable to attend work, and 1 participant reported having had an injury, had a fight, and felt regret or shame for doing something while intoxicated. Two participants reported not experiencing any negative consequences.

3.3 Results of Focus Groups with Surveyors

3.3.1 Survey Implementation Questions

Questions that were unimportant. The majority of surveyors thought that all of the questions in the survey were important. However, some surveyors thought that the following questions were unnecessary: (1) asking about the number of rooms and persons living in households; (2) asking women about alcohol use; and (3) asking about smoking in the last 12 months. They did not provide reasons for why these questions were considered unnecessary.

Questions that were not answered or received with suspicion or fear. Surveyors thought that participants were rather suspicious about being asked “How many people do you know use the substance?” and being asked about unfamiliar substances.

Language. Most surveyors agreed the language in the survey was clear and questions were well understood. One surveyor felt that the survey was long, and a few faced difficulties when interviewing illiterate people.

Substances not asked about but were reported by people. Some surveyors mentioned a few substances that were mentioned by participants but were not
considered in the survey. These included “Maa Ghareeb” or Gripe water, a sedative-like substance that is used to relieve abdominal pain and gas in infants. Participants from rural areas mentioned eating the dry bell of the opium plant (where the seeds are stored) after it was grilled and ground.

Questions not asked. Some surveyors thought it might have been helpful to ask an open question about substance use in the participant’s city. Others suggested asking about the participant’s perception of experimentation with substances and what prevented them from doing so. When surveyors were asked about questions that had not been asked but if asked might have improved the understanding of data or survey process, they gave a few suggestions. These included asking about places where drugs are sold in a person’s city, number of people participants know who work as drug dealers, places from which the drugs enter the country, and background of drug dealers.

Time needed to complete the interview. The time needed to complete the interviews ranged from 10–45 minutes, with most surveyors completing the survey in 20–25 minutes.

Level of participant comfort in giving information. When surveyors were asked whether or not people were comfortable giving information, most responded “yes” (70–90%). Surveyors believed that participants’ comfort in responding was facilitated by their giving a good explanation of the survey, obtaining consent, good communication skills, and holding an official badge from the Ministry of Health.

3.3.2 Honesty of Answers (Veracity)
Percentage of participants who were not telling the truth. When asked about the apparent truthfulness of participants’ responses to substance use, the level of truthfulness perceived by surveyors ranged from 80-97%. The substances that surveyors thought were reported most inaccurately included benzodiazepines, cough syrup, tramadol, and amphetamines. Surveyors thought that reasons for inaccurate reporting may have been fear of stigma, fear of legal consequences, and fear of others knowing, especially family members.

3.3.3 Drug Supply and Drug-Trafficking Perspectives
Did you gain any information of or have a perspective on how drugs are obtained by individuals you surveyed. When asked this question, surveyors said that they believed that drugs were obtained from pharmacies (both private and governmental), drug dealers, cafes, and sports and gym centers.

Discussion of where the drugs were coming from or which groups are trafficking or selling drugs. Surveyors explained that participants discussed the possibility that drugs enter the country through Iran and the Saudi borders. It was suggested that ATS came from both Saudi Arabia and Iran and that opium and hashish mostly came from Iran. Others believed that drugs were brought into the country by foreign visitors.

3.3.4 Negative Incidents Related to Substance Use
Have you been aware of any incidents related to substance abuse in the area from which you had collected your data. Surveyors reported hearing about 16 deaths in the areas they surveyed related to drug overdose: 6 cases from Baghdad, 3 from Sulaimaniyah, 2 from Thi Qar, 2 from Dohouk, 1 each in Kerbala, Najaf, and Maysan. Additionally, two homicides and one car accident were also thought to be related to drug use. One surveyor mentioned that a family was forced to leave the city because of the problems their addicted son caused for the neighbors.

3.4 Results of Focus Group Discussion with Military and Police Personnel
A discussion was held with military health care workers intended to explore the views and experience of military physicians on drug and alcohol use, in general, and among soldiers and policemen, in particular. Four physicians participated in the focus group; their ages ranged from 29.5 to 34.5, with a mean of 32. All participants regarded drug and alcohol use as a potentially dangerous behavior and recognized an increasing trend in substance use over the last five years. Three participants thought that drug and alcohol use
was common in Iraq. The group believed that substance use cut across all socio-economic strata, did not differentiate between occupations, and included unskilled workers, law enforcement officers, and professionals. One participant noticed that substance use disorders are common among policemen and border checkpoint personnel, which he assumed is primarily a result of ease of access. All participants shared that the combination of economic hardship as a result of unemployment and the societal difficulties, which ensued following the war, contributed to the increase in access, availability, and subsequent use of alcohol and other drugs.

**What are the resources people are utilizing to obtain drugs and alcohol?**

One group member indicated that alcohol and other drugs were not prohibitively expensive; consequently, those individuals with a steady source of income and access could get drugs and alcohol. Two other group members shared that crimes such as stealing, jugglery, and dupery were committed as a means to obtain drugs and alcohol. The fourth group member found that the individual’s parent(s) may provide the funds to obtain alcohol and drugs. In regard to the military and police, there have been reported instances where officers had neglected their duties or had quarreled with their colleagues or other individuals at the checkpoints as a result of drug and alcohol use.

**Sources of Drugs Coming into Iraq**

Two participants indicated that drugs are coming in from Saudi Arabia, whereas others shared that they were also coming in from Iran and Yemen. Unfortunately, this data are not collected in a formal manner within the military departments or clinics at the hospital. Participants were unaware if there is any monitoring of drug or alcohol use within the military. The presence of bars and pubs has contributed to the wider use of alcohol, which, in combination with what appears to be greater cultural acceptance of alcohol, seems to have increased the availability of and use of alcohol.

**Number of Patients Seen at the Clinic for Substance Use Disorders**

In the last 12 months, 3 of the participants examined 4 persons with complications arising from drug and alcohol use, whereas one participant indicated that no one with an SUD was seen at his clinic.

**The Availability and Type of Services Provided**

No services, including detoxification, were provided by the discussants to individuals who presented with an SUD. None of the participants was aware of any prevention services, nor were they aware of any support groups in Iraq. Two of the participants regarded the clergy as being able to provide support to those individuals challenged by an SUD.

**The Laws Governing Substance Use**

Participants believed that enforcement of laws governing substance use would serve both as a preventive measure and to better control the phenomenon of substance use. Additionally, a comprehensive treatment system would be helpful to provide badly needed services to those who become dependent. At this time, there are no formal military services available to treat individuals presenting with SUDs.
4. Strengths and Limitations

The INHSAD is the first national population-based household survey to collect data on substance use in Iraq. Results from this study will help provide a broader understanding of the extent of substance use in Iraq and add to the limited existing literature on substance use in this population. It is also considered the first of its kind in Iraq and one of the few in the UN Middle East and North Africa (MENA) region, which lacks population-based surveys capturing current national estimates for substance use. There is no doubt that an enormous amount of effort was spent to collect a representative sample of the Iraqi population and that scientifically sound methods were executed in order to collect data in the midst of ongoing national security instability.

The project was developed, implemented, conducted by an Iraqi team, who provided the leadership and vision for the project. A tremendous amount of Iraqi input and support was provided by the Iraqi government, Iraqi universities and the Iraqi Society of Addiction Medicine. The Iraqi Ministry of Health played a key role in providing on-the-ground coordination with data collection and data transfer. Without strong Iraqi leadership and commitment to the project, it would have been impossible to conduct. Even under the best of circumstances, conducting a household survey on a topic as sensitive as drug and alcohol use, is challenging. However, in 2014 Iraq, the circumstances could hardly have been worse. Serious national political turmoil, local militia activity along with frequent and unpredictable violence made the environment extremely challenging to mount and sustain and effort. On top of these very difficult conditions, halfway through the project, ISIL entered Iraq and brutalized and terrorized much of the country. Certainly, there were many opportunities and excuses for the Iraqi team to abandon this project. But they persevered and through their dedication and commitment, the project was completed in an excellent manner.

The survey used very well established scientific methodology, including sampling methods, survey construction and data collection and analysis methods. The use of saliva tests is the first time that biological measures of drug use have been included in any Iraqi drug use epidemiological efforts. The special populations selected provided some detailed information on groups of individuals frequently excluded from epidemiological studies. The focus group information gave human perspective to the data and recommendations for improvements in future surveys. Throughout the entire project, the steering committee provided remarkable leadership, guidance and support to the project.

Several limitations of this study should be considered. Although selection of households for the survey was done randomly via house address lists, surveyors only interviewed those who responded to the door knock and consented for interview. Characteristics of non-responders were not captured and not measured for analysis, which introduces an element of selection bias. Like most household surveys, all information collected in the survey was based on self-report, so social desirability could have influenced responses, making the validity of data on sensitive information somewhat questionable. Nevertheless, the novelty of information collected in the survey and in this population, given the current circumstances in Iraq, outweighs these limitations.

It has been established that underreporting of drug and alcohol use, particularly in societies where it violates religious codes and is highly stigmatized affects household survey results. Underreporting is particularly problematic in
Adolescents are typically at very high risk for experimentation with substances and it is important to assess this segment of the population. One of the future elements in assessing the substance use situation in Iraq should be directed toward adolescents.

regard to illegal and highly stigmatized drugs (e.g., heroin, ATS). Surely the circumstances in 2014 Iraq are precisely those that would promote underreporting. Because of these circumstances and the high rate of refusal by females, the degree of underreporting is likely most problematic in gauging the problem of drug and alcohol use for women in Iraq. In order to truly understand the nature and extent of the substance use situation in Iraq, the survey data should be used as one data source within a context of data from other sources such as those used in the CEWG methodology.

The survey was restricted to individuals 18 years old and older. Data on use by adolescents is an essential element in any comprehensive epidemiological assessment of the drug and alcohol use situation in any country. Adolescents are typically at very high risk for experimentation with substances and it is important to assess this segment of the population. One of the future elements in assessing the substance use situation in Iraq should be directed toward adolescents.

Another limitation to the current preliminary report is the inability to conduct a comprehensive weighted analysis, due to absence of sampling design weights and of detailed Iraq census data for computing post-stratification weights. Although partial adjustment for unequal gender distribution was applied for substance use estimates, comprehensive post-stratification weights should be calculated and applied to all household survey sample results to more accurately represent the adult Iraqi population.

One of the hopes for this survey project was that it would produce better information on the source of drug supplies and who supplied drugs, where the drugs came from and how people gained access to drugs. The information this project produced in this domain was very limited. The reasons for the paucity of information in this area are:

1. Very few of the survey participants reportedly currently using drugs, so the people we surveyed, for the most part, did not have direct information about these issues;
2. Asking questions about where you or other people buy their drugs (an illegal activity) is a very risky in an environment where people are suspicious and there are major safety and security problems; 3. The surveyors were instructed not engage in any behavior that would put them at risk as they did the survey. They felt and actually received some feedback from participants that they were uncomfortable answering these questions; 4. The primary purpose of this project is to conduct a household survey of drug use to find out the extent and nature of which drugs people are using to better understand alcohol/drug use prevalence. The project was not designed to be a drug supply surveillance project.
5. Discussion

There is limited data on the extent of illicit drug use in Iraq (Al-Hemiary et al., 2014). A questionnaire about perceptions of treating psychiatrists towards substance use in Iraq reported that psychiatrists perceived non-medical use of prescription drugs including benzhexol (muscle relaxant), benzodiazepines (anti-anxiety medication) and codeine (opiate painkiller), as the most common form of illicit drug use (Al-Hasnawi et al., 2009). Others believe that areas close to the Iraq-Iran border have widespread opium use (Aqrawi and Humphreys, 2009). In 2004, World Health Organization estimates reported that the 12 months prevalence for any drug use disorder (drug abuse or drug dependence) in Iraq was 0.66% among males and 0.24% among females (WHO, 2010). In 2006, the Iraqi Mental Health Survey (IMHS) was launched to estimate the prevalence of different mental disorders including substance use disorders (WHO, 2009). This was the first national household survey to explore mental health problems in a representative Iraqi population sample (WHO, 2009). Results reported lifetime abuse of any drug in 1.29% of males and 0.25% of females (WHO, 2009; Al-Hasnawi et al., 2009). However, “drug abuse” must not be confused with “drug use”. In the IMHS, drug abuse was defined according to the DSM-IV definition. The results reflected people who fulfilled the diagnosis of “drug abuse”, but not individuals who used without reaching the level of abuse. Another study conducted in the capital city Baghdad reported the lifetime prevalence of any illicit drug use at 7% (Al-Hemiery et al., 2010). A different study conducted on a convenient sample of 172 male bodybuilders in Baghdad, reported that 44.8% used anabolic steroids (Habeeb, 2012). Other information about drug use in Iraq is collected from seizure reports (Al-Hemiary et al., 2014). These indicate that prior to 2009, cannabis was the drug most confiscated by authorities (Al-Hemiary et al., 2014). Opium accounted for 15% of the total drugs seized in 2010, but this was reduced to 5% of all drugs seized in 2011 (Al-Hemiary et al., 2014). Furthermore, reports from a drug treatment center, the Baghdad Medical City Detoxification Unit, suggested that tramadol was the primary drug related to substance use disorder admissions at their facility (Al-Hemiary et al., 2014). However, there are no reported data that reflect trends and correlates of lifetime or current illicit drug use in a representative Iraqi population. Estimating the prevalence of illegal and socially unacceptable behaviors is quite challenging, especially in a country like Iraq where people are conservative and abide by religious principles (Aqrawi and Humphreys, 2009).

The most remarkable aspect of this project is that the survey team was able to complete the data collection under the circumstances in Iraq in 2014. The circumstances in 21st-century Iraq have been consistently challenging since 2003, with periods of respite interspersed with periods of increased turmoil and violence. However, with the emergence of ISIL in 2014, conditions deteriorated rapidly and became extremely dangerous in many areas of Iraq. Despite these conditions, the Iraqi team was able to collect household data from all areas of Iraq, with the exception of Al-Anbar governorate. In an effort to collect data from Al-Anbar, the surveyors collected information from “refugees” of Al-Anbar who were displaced in Baghdad to escape the violence created by ISIL. While these data may not be entirely equivalent to the standard survey results, they represent an exceptional adaptation by the survey team to collect information from this region, despite the extraordinary situation. In view of the extremely challenging circumstances in Iraq in 2014, the survey team deserves tremendous credit for their courage and perseverance in completing the survey data collection and submitting an excellent and complete data set to the UCLA data center.
There was minimal missing data in the project, the refusal rate was not excessive (refusal by females (primarily in the Baghdad governorate) due to cultural considerations was expected and aside from these refusals, there was an excellent level of survey participation. In the two Baghdad governorate areas, there was an exceptionally high rate of refusal. This elevated refusal rate in the Baghdad region warrants further examination, but is surely in part, related to the violence and insecurity during the period of the survey.
6. Findings from the Survey

6.1 Household Survey Sample

Tobacco Use
In the Iraq survey, the gender-adjusted rate of lifetime tobacco use is 29.0% (53.0% for males; 5.1% for females), while gender-adjusted current tobacco use is 23.4% (43.3% for males; 3.4% for females) suggesting that tobacco use is a significant public health issue in Iraq particularly for men. These estimates are much higher than reported by the Iraqi Family Health Survey in 2006, in which current tobacco use was reported at 14.8% (26.5% for males and 2.9% for females), suggesting a possible increase in overall tobacco use in the country (Iraq Family Health Survey Group, 2008). Additionally, it is greater than the overall current tobacco use prevalence of 18% reported in the 2011 World Health Organization Report on the Global Tobacco Epidemic (WHO, 2013). Examination of tobacco-use patterns indicates that there is a high rate of tobacco use in multiple forms (chewing, cigarettes, shisha) and that these patterns suggest heavy use. Those who smoke cigarettes smoke daily (28.5 days per month), and on days that they smoke, they smoke an average of 25 cigarettes per day. There is tremendous geographical variation in tobacco use rates, with some governorates having very high rates (e.g., Dohouk and Salahuddin, over 60%), whereas others report much lower rates (e.g., Sulaimaniyah and Risafah, below 18%). The fact that Dohouk is a tobacco producing area may contribute to the elevated rate in this governorate. In these areas, increased attention to tobacco prevention and tobacco cessation services should be considered.

Alcohol Use
In the present Iraq survey, the gender-adjusted lifetime rate of alcohol use is 8.6% (16.7% for males; 0.6% for females), whereas the gender-adjusted current alcohol use rate is 3.4% (with 6.7% for males and 0.11% for females), suggesting that alcohol use by females is very rare. These findings suggest an increase in the overall lifetime alcohol use prevalence reported in the Iraqi Mental Health Survey–2006/7 (IMHS), where lifetime alcohol use was only reported as 3.6% (6.82% for males; 0.58% for females) (WHO, 2009). Moreover, calculated 12-month use of alcohol detected from INHSAD for males is double that previously reported among males in the IMHS (2.9%). Although our 12-month/“current” alcohol use result is lower than the most recent World Health Organization estimate (5.4%), the INHSAD findings indicate similar rates of lifetime alcohol use (with WHO lifetime alcohol use reported at 9.2%) (WHO, 2014). For the men who currently drink, they drink on an average of 10.5 days per month, and on days when they drink alcohol, they drink heavily (6 drinks per day on average). Approximately 43.4% of participants knew someone who drinks. As with tobacco use, there is tremendous geographical variation in alcohol use. In 3 of the 5 Northern governorates (Erbil, Dohouk, and Kirkouk) and in Salahuddin, gender-adjusted rates of current alcohol use are over 8% (Salahuddin at 10.1% was highest). In contrast, in the Middle region, 5 of 7 governorates (Al-Anbar, Wasit, Al-Qadisiyah, Kerbala, Babylon) and Risafah had very low rates (under 1.5%) of current alcohol use. The data on alcohol use suggests that in governorates with high rates of alcohol use (and apparently heavy alcohol use) treatment services for alcohol withdrawal and dependence are a priority service to be developed.

Licit Drugs
In previous reports about drug use in Iraq, licit drugs has were the most extensively misused category of drugs (WHO, 2010). In the present survey, the rates of current...
misuse are reported to be very low; consequently, we will examine lifetime rates of misuse. Among these medications, which can be prescribed and may be acquired via the pharmacy system in Iraq, anabolic steroids and benzodiazepines (anabolic steroids, 1.1%; benzodiazepines 1%) are the most widely misused, with benzehexol and “other pills” (mostly allermine) next in order of reported lifetime misuse; reported at 0.5% each. Somadril, Tramadol and cough syrup were misused the least; reported at 0.3%, 0.2% and 0.2%, respectively. The misuse of these medications, while low overall, has tremendous geographical variation, which is noteworthy. In the South region, specifically the Maysan

Of interest is the fact that although the mean age at first use of those who reported lifetime use of cannabis, ATS/Captagon and opium/heroin use was over 20 years old, inhalant users reported their age at first use as 13.8 years. These data suggest that prevention efforts with youth should include information on the dangers of inhalants.

Illicit Drugs

Similar to the licit drug category, self-reported rates of current use of illicit drugs is very low, so lifetime rates will be discussed. Lifetime cannabis use was reported by 0.2%, while the use of inhalant, ATS/Captagon and opium/heroin was reported at 0.1% each. Of interest is the fact that although the mean age at first use of those who reported lifetime use of cannabis, ATS/Captagon and opium/heroin use was over 20 years old, inhalant users reported their age at first use as 13.8 years. These data suggest that prevention efforts with youth should include information on the dangers of inhalants.

Regarding the item on “knowing someone who used XX”, these numbers generally reflected the same pattern across drugs as the self-report data. Knowing someone who uses inhalants by more than 5% of participants for each, while knowing someone who uses cannabis was reported by 4.6%. Knowing someone who used ATS/Captagon was reported by 2.3%. Although opium/heroin self-reported lifetime rates were lowest of any illicit drug category, over 4% of participants reported knowing someone who uses this category of drugs. Consistent with self-report data, in all regions except the South, rates of knowing someone who used an illicit drug are under 10%, except in Erbil (11.0%). In the South, in Al-Muthanna governorate the rate of knowing someone who used an illicit drug was under 10%, however, in Al-Basrah (62.8%) and Thi Qar (34.9%), the rates of knowing someone were much higher. This major disparity between the geographical areas as well as between the self-reported lifetime rates and the “knowing someone” rates call for further exploration of the extent of drug use in the Southern region.

Drug Injection

In the entire sample, only one individual self-reported that he ever injected drugs. Similarly only 2% of the sample reported that they knew someone who injected drugs. These data suggest that at present, injection of drugs in Iraq is at a low rate.

Reasons for Using/Misusing Drugs and Alcohol.

Survey participants who reported any drug or alcohol use in the past 12 months were asked to respond to the question “for which of the following reasons did you
use alcohol or drugs?”. Of the 4 responses selected by over 40% of the participants, 3 of the 4 were to remove negative conditions (e.g., makes me less anxious, less depressed, and help to forget my problems). It is not surprising that in an environment which has had as many challenges as Iraq, the major reasons given for substance use are those that emphasize escaping from negative conditions.

**Substance Dependence**

While there were relatively low self-report rates of drug and alcohol use, in those cases where drug and alcohol use was reported, the use was at a heavy level of as measured by the SDS; 70% of alcohol users scored in the “dependence” range and almost all the drug users scored in this high range. These limited data suggest that of the people who use drugs and alcohol, they use at high levels. This finding is parallel to the data on cigarette smoking.

**6.2 Special Population Sample**

Survey data were collected on 3 special population groups that are thought to possibly be at higher than normal risk for alcohol and drug use. The groups included: internally displaced persons (IDPs), “Hawasim,” and recently released prisoners. When analysis was stratified by gender, the IDPs groups were quite comparable to the household survey group. However, males from both the group recently released prisoner and the Hawasim group reported higher rates of lifetime and current tobacco use compared to males from the household survey. Furthermore, the group recently released from prison reported higher rates of ever using alcohol, licit or illicit drugs, as compared to males from the household survey. Curiously, although the percentage of the released prisoner group who reported knowing illicit drug users was about the same as in males from the household survey sample, a much smaller percentage of male individuals in all 3 groups in the special populations knew licit drug misusers compared to males from the household survey sample. This may reflect the fact that these disenfranchised groups came from social groups with fewer resources to purchase medications from the pharmacy. Regarding reasons for use, over 40% of the special population groups reported finding drugs and alcohol useful as a way to produce pleasure and as something positive to look forward to. Unlike the household survey sample, they seemed to find drugs and alcohol more about producing positive benefits than avoiding negative emotional states.

**6.3 Focus Group Findings**

**Surveyors**

The information from the focus groups and other input from the surveyors were, for the most part, confirmatory of the information collected in the survey. There was a perception that most participants were generally comfortable being asked to participate, but there was some suspicion among some participants. Some were uncomfortable with the questions about “Do you know anyone who uses XX” and “How many people do you know who uses XX”. Also, as indicated by the refusal rates, females were less comfortable than men. In addition, refusal rates were particularly high in the Baghdad governorate. This was attributed to the security situation, whereby, people who are not known to the family were not invited into the house. The result is that in many cases, particularly in the Baghdad area, the surveyor would be asked to stay outside and a member of the family would be sent out to answer the questions, in an outdoor setting.

Surveyors reported that they thought that most participants were truthful. Their estimate was 80-97% of participants answered truthfully. Surveyors thought that reasons for inaccurate reporting may have been fear of stigma, fear of legal consequences, and fear of others knowing, especially family members. In addition security conditions were a constant issue during the time period of the survey, increasing in severity in later months, after ISIL made its entry into Iraq. When participants went outside to answer questions, surveyors felt that it was possibly because the family had a drug user in the house. It would
have been very easy to send out a non-using family member to avoid the possibility that the drug-using family member might be overheard by neighbors or others outside. In general, because of security concerns, privacy when administering the survey was frequently poor and could have easily caused underreporting particularly in the Baghdad region.

Questions about sources of drugs produced speculative responses that the drugs came from Iran, Saudi Arabia, and with visitors, although there were few details to

There is a belief by the MDs that alcohol is rapidly gaining acceptance in the society, with the proliferation of bars and clubs in some regions. There is a perception that there is no organized program to identify drug users in the military and no prevention or treatment services.

support these speculations. However, there were reports of 16 known overdose deaths from drugs, and knowledge of this type and the source of this information could be useful for future I-CEWG meetings and future drug use estimation efforts.

Military and Police Personnel
All four of the physicians questioned felt that drug and alcohol use was a significant public health problem in Iraq and that the problem was becoming more severe. In addition, there is an agreed-upon perception that police at check points and border crossings frequently get involved in drug trafficking activities. In addition, funds for drug purchases also come from petty crime and from families. There is a belief by the MDs that alcohol is rapidly gaining acceptance in the society, with the proliferation of bars and clubs in some regions. There is a perception that there is no organized program to identify drug users in the military and no prevention or treatment services.

6.4 The Problem of Under-reporting of Drug Use

Veracity of Self-reported Substance Use
Veracity of data obtained from self-reported substance use surveys has always been of concern to researchers, particularly when substance use policies and decisions are to be made based upon the results of the self reports (Sloan, et al. 2004). The greater the drug is stigmatized in a population, the more this discrepancy increases, and the greater the penalties or religious sanctions are for drug use, the greater is the problem of underreporting (Harrison, 1997). The magnitude of the underestimates can be very substantial. For example, the 2001 British Crime Survey, with a sample size of over 30,000 participants, found fewer than 50 people reporting that they used heroin in the last month, giving an estimate for Britain of 33,000 heroin users, which is fewer than the number of heroin users who presented for treatment in 2001 (Aust, et al. 2002). This likely represents at least a 5-fold underestimate.

For this reason, many researchers prefer validating self-reports by relying on other sources of substance use information, such as biological assays, medical records, and criminal records, and asking the participant’s family members and friends (Harrison, 1997; Fendrich, et al. 1999). However, when biological assays are used, including urine testing and saliva testing, the drug metabolites are typically only detectable for 24-48 hours, so these assays do not “validate” reports over a 30-day or 12-month period. Assays of hair can provide a larger window of data, and methods have been developed and validated for measuring opioids in hair, but not for other drugs of abuse and not for non-opioid licit drugs. In addition, use of hair for testing is expensive.

Although studies suggest that only half of individuals in treatment who test positive (with urine or saliva test) self-report drug and alcohol use, this phenomenon has never been examined in large representative populations and should not be generalized to population-based surveys. Researchers have suggested that self-report substance use in general population surveys may be more accurate than that in high risk institutionalized populations because the former generally use less alcohol and drugs and may not have experienced negative consequences related to
their use (Fendrich et al., 1999). Given the challenges of assessing accuracy of self-reported substance use, there is no doubt that self-report surveys will still remain a major source for gathering knowledge about substance use incidence and prevalence in large populations (Del Baco & Noll, 2000; Harrison, 1999).

The self-report data in this survey likely suffers from some degree of under-reporting, particularly around the licit and illicit categories. The fact that the tobacco and alcohol self-reports are in line with or exceed earlier estimates suggest that the surveyors did their jobs to the best of their abilities and that surveys were conducted according to good survey practices to the extent that the environment and circumstances would allow.

In this project, saliva tests included substances that were asked about in the report (amphetamines, marijuana, opium or heroin, and benzodiazepines) and self-reported validation could be assessed. The overall current use total for any drug use (licit or illicit) of 1.8% is consistent with the self-reported current use of any drug (1.3%). Somewhat curiously, when saliva test results for cocaine are excluded (cocaine was not queried in the survey), the data shows that 1.5% (6 participants) of those who were selected for saliva testing tested positive for at least one of the 4 substances queried about in the survey. The fact that the vast majority of saliva tests were negative for illicit drugs supports the conclusion from self-reports that the use of illicit drugs in Iraq is much lower than in other countries in the region, such as Iran and Afghanistan. However, there were a considerable number of refusals for both the survey and the saliva test, and the selection of the specific family member for testing and the lack of privacy in the testing setting all are factors that would contribute to underreporting.

### 6.5 The Recent History of Iraq and Drug/Alcohol Use

The results of this survey need to be placed in historical context. As discussed in the initial Iraq Community Epidemiology Workgroup meeting in 2012, during the tenure of Sadaam Hussein’s rule of Iraq (1979-2003), life in Iraq was highly monitored. Although alcohol was available in Iraq, drug use was illegal and penalties for drug use and trafficking were severe, including capital punishment.

The predominantly Muslim population apparently used alcohol during this time, but at lower rates than in non-Muslim countries. Supplies of illegal drugs were highly restricted, as the borders with Iran and Iraq’s other neighbors were tightly restricted and traffic of people and drugs into and out of Iraq was very difficult. As a result, in the first several attempts to assess drug use in Iraq, the drugs being misused were benzhexol and benzodiazepines (Al-Hemiary et al., 2014). There was very little evidence of illegal drug use and most drugs being misused were coming from Iraqi pharmacies.

**However, the presence of drugs does not immediately translate into drug use.**

**In a country with no recent “tradition” of drug use, few users of illicit drugs, and no tradition of drug injection, the availability of drugs does not translate into high rates of drug use overnight.**

More recently, there have been multiple reports of Iraq becoming much more central to the trafficking of drugs in the Middle East. Transit of heroin from Iran, Captagon from the Gulf and from labs in the chaos in Syria and more recently Lebanon, and tramadol from pharmacies and from Jordan and the Pakistan and Indian laboratories are all being reported in increasing amounts (Al-Hemiary, et al. 2014; United Nations, 2012; Robins, 2015).

However, the presence of drugs does not immediately translate into drug use. In a country with no recent “tradition” of drug use, few users of illicit drugs, and no tradition of drug injection, the availability of drugs has not translated into high rates of drug use overnight.

Increases in drug availability are a necessary, but not sufficient condition, for the development of a significant drug use problem. However, increases in drug production, drug trafficking, and drug availability are essential elements of the “gestational” period of a drug problem. When drug problems emerge in societies, police departments are among the first agencies to recognize changes in drug trends. Drug laboratories begin to appear, drug seizures increase, and depending on the type of drug, other signals occur. Hospital
emergency room overdose data will often reflect an influx of high potency heroin, since overdoses and overdose deaths increase dramatically. With ATS, drug-induced psychosis and drug violence is often seen at early stages. In the United States in the 1990s and early 2000s, the methamphetamine epidemic spread from West to East. At every stage, law enforcement people saw the drug supply go up before methamphetamine use indicators went up. However, after a period of several years of

The information collected in the first Iraq National Household Survey of Alcohol and Drug Use (INHSAD) suggests that the drug problem in Iraq is still in a gestational phase. However, with the conditions of economic distress, social chaos, violence, and generally stressful conditions, it is highly probable that Iraq is at very high risk for the emergence of a substantial societal problem with licit and illicit drugs.

increased availability (and typically, decreased price), the users started to show up in the health and criminal justice statistics.

The information collected in the first Iraq National Household Survey of Alcohol and Drug Use (INHSAD) suggests that the drug problem in Iraq is still in a gestational phase. However, with the conditions of economic distress, social chaos, violence, and generally stressful conditions, it is highly probable that Iraq is at very high risk for the emergence of a substantial societal problem with licit and illicit drugs. Next-door is Iran, a country with arguably the world’s worst heroin problems, with whom commerce and traffic of all types is increasing. Heroin is undoubtedly coming into Iraq from Iran in the East and likely from Turkey in the North and with increased availability will come increased use. With increased heroin use will come overdose deaths and eventually injection drug use will occur because regardless of how people begin to use heroin (e.g., smoking or snorting), they eventually transfer to injection of heroin. And along with heroin injection will come infectious diseases, including HIV and hepatitis. Amphetamine-type stimulants are now being seized in increasing quantities by law enforcement authorities from the Gulf (Captagon) and from Iran (crystal methamphetamine). Emergency rooms will see increases in patients with drug-induced psychosis and law enforcement will see increased violent crime related to ATS use. Pharmaceutical tramadol is coming out of loosely regulated Iraqi pharmacies, and illicitly manufactured tramadol is coming in through the Gulf access in Al-Basrah, from Pakistan and India in the South, and from Turkey in the North. Tramadol users will develop seizures from elevated doses of tramadol and emergency rooms will see these individuals in larger numbers.

It is unclear what the timetable will be for these developments and which will occur sooner and which later. However, the likelihood for some or all of them is very high. It would be unwise for policymakers in Iraq to wait for surveys to signal increased drug problems. Surveys will eventually detect increases in use, but the earliest signals will be seen by law enforcement and customs officials. It appears from the CEWG report (Al Hemiary et al., 2014) the United Nations (2012), and recent compilations of information (Robins, 2015) that all of the signs of increased drug trafficking and availability are underway. There are other indicators that are likely to signal the next phase in the drug problem in Iraq.

Data from emergency rooms, poison control centers, treatment admissions in the emerging treatment program, and if possible, biological samples from high risk groups, including newly incarcerated offenders will be critical to recognizing emerging drug problems. It is important that another survey be conducted to compare trend line data using this first survey as an initial anchor point, but future surveys should only be one element in an Iraqi drug use monitoring program.
7. Conclusions

The conclusions from this INHSAD are organized according to the original objectives of the project.

Objective 1:
To compile data on self-reported prevalence of tobacco and alcohol use, and licit and illicit drug misuse

- The survey was conducted over the planned time course and according to the planned survey protocol (with several slight modifications) from all 18 governorates (and 2 Baghdad areas), despite extraordinary conditions of violence and civil strife (including the attacks by ISIL in many parts of the country) in Iraq during 2014.
- Survey data on 3,200 Iraqis was collected, plus an additional 300 surveys were collected from individuals in 3 special population groups: Hawasim, internally displaced persons, and recently released prisoners. Data from military personnel were not available since the Iraqi army was engaged in extensive military operations (interviews with military physicians provided some information on drug use among the military).
- The Iraqi team successfully transferred all survey forms to the data center at Kerbala, where it was entered completely and accurately entered and transferred to UCLA in a timely manner for analysis.
- Data from 447 completed saliva tests from both household survey [n=395] and special population samples [n=52] (screened for opiates, cannabis, amphetamine, cocaine and benzodiazepines) provided support for the findings from the survey data regarding the use of these drugs.
- Focus groups with surveyors and key individuals were conducted as planned. Focus groups provided information on survey refusal reasons and limited information on origins of drug supplies.
- There were no adverse events associated with the survey or any project activities and focus groups with surveyors did not reveal any major methodological deviations.
- The Iraqi Steering Committee met on a regular basis during the course of the project to provide direction and oversight to the project. This support and guidance from this group was critical to gaining cooperation from all agencies involved and for the overall success of the project.

Objective 2:
To identify trends and patterns of substance use in the Iraqi population.

- Results of the household survey adjusted for unequal gender distribution indicate the self reported lifetime and current use is (respectively): Tobacco: (29.0%, 32.4%); Alcohol, (8.6%, 3.4%); Licit drug misuse (2.5%, 1.2%) and Illicit drug use (0.4%, 0.2%).
- The results of the survey indicate that tobacco use is a significant public health problem in Iraq particularly among males in Dohouk (83.7%) and Salahuddin (70.6%) Governorates.
- A high proportion (53.0%) of males are current tobacco users in Iraq, they start smoking at an early age (18.6 years), most use on a daily basis, and each smokes well over a pack of cigarettes per day.
- Among males, lifetime rates of licit (4.3%) and illicit (0.7%) drug use were higher than in earlier reports.
- Rates of licit and illicit drug misuse are low based on self-report and the saliva test results appear to confirm this finding.
- In the South of Iraq, there is a perception of considerable licit and illicit drug misuse (when
participants were asked if “they know anyone who uses XX”? in the Southern region of Iraq a much high percentage of the participants personally knew drug users and a large number of users

- Anabolic steroids are the most widely used licit drug in Iraq followed by benzodiazepines and benzhexol. In the North of Iraq, there are concerns of increasing misuse of tramadol.
- Cannabis is the most widely used illicit drug, but use of stimulants (ATS and Captagon) in the South of Iraq is present.
- Lifetime rates of specific drugs were noteworthy in three governorates: Male participants in Thi Qar reported 20% lifetime use of anabolic steroids; Mayasan the use of benzodiazepines was high among both males and females.
- Among the Special Population groups, only “recently released prisoners” reported rates of alcohol and drug use that were higher than reflected in the household survey sample. 19% of this group reported lifetime use of alcohol and 11% reported lifetime use of any drugs.
- Despite an absence of prior surveys to allow for a direct comparison, a comparison of the survey data with the data from earlier mental health and I-CEWG meeting reports, suggest that alcohol and drug use are increasing in Iraq.

Objective 3:
To identify specific factors that may be associated with substance use in Iraq.

- In Iraq, drug and alcohol use violates religious codes and is highly stigmatized. As a result of the stigma and fear of the possible reactions inherent in violating religious mores, a underreporting of alcohol and drug use is likely to have occurred in some areas of Iraq.
- In religious areas and areas of active civil strife and security concerns, survey and saliva test refusals were higher than in other areas. This was particularly true in the Baghdad governorate. Rates of “refusal to participate” in the survey or saliva testing was high among females in the Risafah area of Baghdad. Aside from this high refusal rate in Risafah (and to a lesser degree, the Kerkh area of Baghdad) the “refusal to participate rates” were quite low in all other areas.
- Males use tobacco, alcohol and drugs at much higher rates than females. This finding is consistent with worldwide data, but in Iraq, this gender difference is either particularly great, or the underreporting by females is especially pronounced.
- Rates of alcohol and drug use are higher in the Northern and Southern regions of Iraq. In these areas, while the absolute rates of current use are relatively low, the number of individuals known by participants to use alcohol and drugs is higher than in other areas and this is particularly true in the Al Basrah and Thi Qar governorates.
- Among the individuals who reported tobacco, alcohol or drug use, heavy use is the norm for all substances, including tobacco.
- Rates of tobacco, alcohol and drug use appear to be higher among recently released prisoners than among the general population and among the other special population groups.
- Lifetime rates of licit and illicit drug use were higher among younger participants (18-34 years), those with less education (less than primary school) and those who were not working.

Objective 4:
To identify reasons for use, substance availability, and consequences of use.

- The most commonly cited reasons for substance use in Iraq are that drugs and alcohol allow people to forget their problems, reduce depression, reduce anxiety and allow them to socialize with friends.
- Regarding the availability of drugs and alcohol, focus groups with surveyors suggested that availability of drugs and alcohol is increasing particularly in the South (Captagon and crystal meth) and in the North (tramadol).
- Regarding sources of the drugs, there was a consensus that anabolic steroids were distributed by sports clubs, particularly body and muscle building centers, and that other licit drugs (benzodiazepines, tramadol and benzhexol) were primarily obtained though Iraqi pharmacies. It was speculated (with little evidence) that illicit drugs, including Captagon and crystal methamphetamine were brought into Iraq by trafficking through the borders with Iran and Saudi Arabia.
8. Recommendations

Policy Recommendations

- Develop and implement a National Strategy for addressing tobacco, alcohol and drug use misuse. The strategy should be guided by and compatible with WHO guidelines.
- Legislation should be drafted and moved forward that corresponds to the National Strategy and addresses the recommendations for policy, prevention, and treatment activities contained in the Strategy. When appropriate, specific fiscal provisions should be included to ensure necessary funding to implement recommended activities.
- Strengthen oversight and promote enforcement of pharmacy regulations concerning distribution of prescription medications.
- Integrate survey with I-CEWG information and ensure bidirectional sharing of new knowledge.
- Promote inter-ministerial coordination of governmental activities regarding the alcohol and drug situation.
- Dedicated funding is urgently needed to allow a scale-up of prevention and treatment services and to develop SUD research capacity in Iraq educational institutions.

Future Alcohol and Drug Use Monitoring Recommendations

- Conduct a chart review study of alcohol and drug use mentions in 4 emergency rooms in Iraq.
- Conduct a chart review of alcohol and drug use mentions in Iraqi Psychiatric Hospitals over a 3 month period.
- Conduct a project where new arrestees are tested for drugs in 4 jails around Iraq to measure drug prevalence in this high risk group.
- Conduct a subsequent household survey in 5 years using multistage cluster sampling and more extensive biologic measures.

Legislation should be drafted and moved forward that corresponds to the National Strategy and addresses the recommendations for policy, prevention, and treatment activities contained in the Strategy.

- Future surveys should use two person teams (one male and one female) to promote participation by females. Also, surveyors should not be from the communities where surveys are being done to reduce surveyor familiarity with (and violating confidentiality of) participants.
- Increase the biological sample collection and add cocaine as a drug category to future surveys.
- A drug and alcohol use survey of secondary school students should be conducted to assess youth substance use.
- An assessment of drug and alcohol use by homeless young people (“street youth”) would provide valuable information on this important high-risk population.

Capacity-Building Recommendations

- Provide training for practicing health care professionals (including physicians) of the identification of and interventions for alcohol and drug misuse, including smoking cessation programs.
- Develop curriculum, academic programs and certification of psychologists, social workers in the delivery of evidence-based SUD treatment services.
- Conduct an annual national conference on tobacco, alcohol and drug use to promote awareness and professionals skill development of prevention and treatment professionals.
Practice Recommendations

- Develop an addiction treatment service in the South, North, Baghdad and Middle regions of Iraq. Each service should have a full continuum of care and deliver evidence-based practices.

- Treatment services should be designed with current knowledge and information on smoking cessation, safe and effective withdrawal practices for alcohol users, current medications for opiate use disorders and evidence-based behavioral and psychosocial practices for stimulant and other SUD.

- Engage NGOs in the development and delivery of prevention programs.

- Develop a Center of Excellence to promote ongoing service development using most up to date new treatment advances.
9. References


Substance Abuse Survey
Tools and Protocols
IRAQ NATIONAL SURVEY

PARTICIPANT ID

ADMINISTERED BY

DATE OF INTERVIEW  (DD/MM/YYYY)

```plaintext


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IRAQ NATIONAL SURVEY

STUDY INTRODUCTION

Hello, my name is ____________. I am from the Center for Human Services and the Iraqi Society of Addiction Medicine. We are doing a study about attitudes and behaviors regarding drug and alcohol use, and would appreciate it if you would participate in our survey. This information will be reported to the Center for Human Services without identifying information to help plan health services for the citizens of Iraq, and to help ensure that Iraqi communities are made safe for you and your family. This information will also be summarized (without any identifying information) to inform the Higher Committee on Narcotics about the kinds of drugs and alcohol being used in Iraqi communities.

We are interviewing approximately 3600 individuals across all 18 governorates of Iraq. You have been randomly (by chance) selected to participate in the study. We have not recorded your name or address in any way that can be linked with the information we will collect from you today, and your responses will not be linked to you. All information you give us will be kept strictly confidential. We will report the results only in summary form, so no individual data will be reported. Additionally, you may be randomly selected (by chance) to complete a saliva drug test. This will take only a few minutes. Your test results will be used only to confirm your responses to the survey questions, and will be kept confidential, immediately disposed of, and will in no way be linked to your name, address or other identifying information. May I proceed?

[Begin by reading through the STUDY INFORMATION SHEET and answering any questions the participant has; Obtain voluntary verbal Informed consent]

1. WHAT IS YOUR AGE? ___ ___ ○ Refused to answer

2. HOW MANY YEARS OF SCHOOL HAVE YOU COMPLETED? ___ ___ ○ Refused to answer

3. HOW MANY CHILDREN DO YOU HAVE? ___ ___ ○ Refused to answer
TOBACCO

The first questions are about tobacco use. This includes CIGARETTES, CIGARS, PIPES, SHISHA, HOOKAH, AND CHEWING TOBACCO.

TOB1. Do you personally know people who use tobacco?

Yes 1
No 2
Refused 99

TOB2. Have you ever used tobacco yourself?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – AL1]

TOB3. About how old were you when you first tried tobacco?

AGE ___ [PROBE FOR BEST GUESS]
Refused 99

TOB4. During the last 12 months have you used tobacco?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – AL1]

TOB5. During the last 30 days, on how many days did you use tobacco? ___ ___

[PROMPT RESPONDENT WITH CATEGORIES, E.G. “ONLY ON WEEKENDS”]
Refused 99

TOB6. On a day when you use cigarettes, about how many cigarettes do you smoke?

Number of cigarettes: ___ ___ ___
Refused 99
TOB7. On a day when you use cigars, about how many cigars do you smoke?

   Number of cigars: ___ ___ ___
   Refused       99

TOB8. On a day when you smoke a pipe or use a hookah or shisha, about how many minutes do you spend smoking?

   Number of minutes: ___ ___ ___
   Refused       99

TOB9. On a day when you chew tobacco, about how many minutes do you spend chewing?

   Number of minutes: ___ ___ ___
   Refused       99
**ALCOHOL**

The next questions are about alcohol, that is: BEER, WINE, WINE COOLERS, AND LIQUOR LIKE WHISKEY, TEQUILA, RUM, VODKA, BRANDY, ARAK OR MIXED DRINKS LIKE GIN AND TONIC. We are not talking about alcohol that you may have had as part of a religious ceremony.

Count as a drink: a can or regular size bottle of beer; a wine cooler or a glass of wine, champagne, or sherry; a shot of liquor; or a mixed drink or cocktail. Count a liter bottle of beer as 3 drinks.

AL1. Do you personally know people who have had a drink of alcohol?

- Yes 1
- No 2
- Refused 99

AL2. Have you ever had a drink of alcohol yourself?

- Yes 1
- No 2
- Refused 99

   [If NO OR REFUSED, SKIP TO NEXT SECTION – CB1]

AL3. About how old were you when you first had a drink of alcohol?

____ AGE

[PROBE FOR BEST GUESS]

- Refused 99

AL4. During the last 12 months have you had a drink of alcohol?

- Yes 1
- No 2
- Refused 99

   [If NO OR REFUSED, SKIP TO NEXT SECTION – CB1]

AL5. During the last 30 days, on how many days have you had a drink of alcohol?

____ Days

- Refused 99
AL6. On a day when you use alcohol, what is the average number of drinks you consume?

Drinks

Refused 99

AL7. On a day when you use alcohol, what is the maximum number of drinks you consume?

Drinks

Refused 99
CANNABIS

The next set of questions is about your use of cannabis, also known as MARIJUANA OR HASHISH. Marijuana is usually smoked - either in cigarettes, or in a pipe. It is sometimes cooked in food.

Hashish is a form of marijuana that is also called “hash.” It is usually smoked in a pipe. Another form of hashish is hash oil.

CB1. Do you personally know people who use cannabis?

Yes  1
No  2
Refused  99

CB2. Have you ever used cannabis yourself?

Yes  1
No  2
Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – CAP1]

CB3. About how old were you when you first tried cannabis?

___ ___
AGE  [PROBE FOR BEST GUESS]
Refused  99

CB4. During the last 12 months have you used cannabis?

Yes  1
No  2
Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – CAP1]

CB5. During the last 30 days, on how many days did you use cannabis?

___ ___
Days
Refused  99
CAPTAGON

The next set of questions is about your use of CAPTAGON, or “01” PILLS:
[Use picture cards to display pills].

CAP1. Do you personally know people who use captagon?

   Yes  1
   No   2
   Refused   99

CAP2. Have you ever used captagon yourself?

   Yes  1
   No   2
   Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – CRL1]

CAP3. About how old were you when you first tried captagon?

   _____ AGE  
   [PROBE FOR BEST GUESS]
   Refused   99

CAP4. During the last 12 months have you used captagon?

   Yes  1
   No   2
   Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – CRL1]

CAP5. During the last 30 days, on how many days did you use captagon?

   _____ Days
   Refused   99

CAP6. On a day when you use captagon, about how many pills do you take:

   _____ Pills
   Refused   99
The next set of questions is about your use of crystal or methamphetamine:
[Use picture cards to display crystal and methamphetamine].

CRL1. Do you personally know people who use crystal?

Yes  1  
No   2  
Refused  99

CRL2. Have you ever used crystal yourself?

Yes  1  
No   2  
Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – H1]

CRL3. About how old were you when you first tried crystal?

AGE  
[PROBE FOR BEST GUESS]

Refused  99

CRL4. During the last 12 months have you used crystal?

Yes  1  
No   2  
Refused  99  [If NO OR REFUSED, SKIP TO NEXT SECTION – H1]

CRL5. During the last 30 days, on how many days did you use crystal?

Days  
Refused  99
HEROIN

The next questions are about HEROIN.
[Use picture cards to display heroin].

H1. Do you personally know people who use heroin?

   Yes  1
   No   2
   Refused 99

H2. Have you ever used heroin yourself?

   Yes  1
   No  2
   Refused 99  [If NO OR REFUSED, SKIP TO NEXT SECTION – OT1]

H3. About how old were you when you first tried heroin?

   ___ ___
   AGE
   [PROBE FOR BEST GUESS]
   Refused 99

H4. During the last 12 months have you used heroin?

   Yes  1
   No  2
   Refused 99  [If NO OR REFUSED, SKIP TO NEXT SECTION – OT1]

H5. During the last 30 days, on how many days did you use heroin?

   ___ ___
   Days
   Refused 99
OPIUM OR TERIAK

The next questions are about OPIUM OR TERIAK.
[Use picture cards to display opium and teriak].

OT1. Do you personally know people who use opium or teriak?

<table>
<thead>
<tr>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
</tr>
</tbody>
</table>

OT2. Have you ever used opium or teriak yourself?

<table>
<thead>
<tr>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
</tr>
</tbody>
</table>

[If NO OR REFUSED, SKIP TO NEXT SECTION – INH1]

OT3. About how old were you when you first tried opium or teriak?

______

AGE

[PROBE FOR BEST GUESS]

Refused | 99 |

OT4. During the last 12 months have you used opium or teriak?

<table>
<thead>
<tr>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
</tr>
</tbody>
</table>

[If NO OR REFUSED, SKIP TO NEXT SECTION – INH1]

OT5. During the last 30 days, on how many days did you use opium or teriak?

______

Days

Refused | 99 |
INHALANTS

The next questions are about LIQUIDS, SPRAYS, OR GASES THAT PEOPLE SNIFF, HUFF, OR BREATHE in order to get high or make them feel good.

Inhalants include GLUE, PAINT CLEANER FLUID, PAINT THINNER OR GASOLINE.
[Use picture cards to display inhalants].

INH1. Do you personally know people who have ever sniffed, huffed or inhaled any of substances listed above (inhalants)?

- Yes 1
- No 2
- Refused 99

INH2. Have you ever used inhalants, yourself?

- Yes 1
- No 2
- Refused 99  
  [If NO OR REFUSED, SKIP TO NEXT SECTION – STR1]

INH3. About how old were you when you first tried to get high using inhalants?

____ AGE
  [PROBE FOR BEST GUESS]

- Refused 99

INH4. During the last 12 months have you used inhalants?

- Yes 1
- No 2
- Refused 99  
  [If NO OR REFUSED, SKIP TO NEXT SECTION – STR1]

INH5. During the last 30 days, on how many days did you use inhalants?

____ Days

- Refused 99
ANABOLIC STEROIDS

The next questions are about ANABOLIC STEROIDS. (Powders, liquids, tablets to rapidly build muscles). [Use picture cards to display steroids].

STR1. Do you personally know people who use anabolic steroids?

Yes 1
No 2
Refused 99

STR2. Have you ever used anabolic yourself?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – CS1]

STR3. About how old were you when you first used anabolic steroids?

___ ___ AGE
[PROBE FOR BEST GUESS]
Refused 99

STR4. During the last 12 months have you used anabolic steroids?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – CS1]

STR5. During the last 30 days, on how many days did you use anabolic steroids?

___ ___ Days
Refused 99
MISUSE OF COUGH SYRUP

The next set of questions is about your use of cough syrup when you don’t have a cough [e.g. to get a pleasant feeling] or your use of larger doses than are recommended.

Cough syrups include PULMOCODIN, SIMO AND TUSSIRAM.
[Use picture cards to display medications]

CS1. Do you personally know people who have used cough syrup to relax or have fun, or who use larger doses than are recommended?

Yes 1
No 2
Refused 99

CS2. Have you ever used cough syrup to relax or have fun, or used larger doses than are recommended?

Yes 1
No 2
Refused 99  [If NO OR REFUSED, SKIP TO NEXT SECTION – TR1]

CS3. About how old were you when you first used cough syrup when to relax or have fun, or used larger doses than are recommended?

AGE
[PROBE FOR BEST GUESS]

Refused 99

CS4. During the last 12 months have you used cough syrup when to relax or have fun, or used larger doses than are recommended?

Yes 1
No 2
Refused 99  [If NO OR REFUSED, SKIP TO NEXT SECTION – TR1]

CS5. During the last 30 days, on how many days did you use cough syrup to relax or have fun, or used larger doses than are recommended?

Days
Refused 99
**MISUSE OF TRAMADOL**

The next set of questions is about your use of tramadol.
[Use picture cards to display pills]

TR1. Do you personally know people who use tramadol?

- Yes 1
- No 2
- Refused 99

TR2. Have you ever used tramadol yourself?

- Yes 1
- No 2
- Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – PK1]

TR3. About how old were you when you first used tramadol?

___ ____
AGE
[PROBE FOR BEST GUESS]

- Refused 99

TR4. During the last 12 months have you used tramadol?

- Yes 1
- No 2
- Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – PK1]

TR5. During the last 30 days, on how many days did you use tramadol?

___ ____
Days

- Refused 99

TR6. On a day when you use tramadol, about how many pills do you take:

___ ____
Pills

- Refused 99
MISUSE OF PAINKILLERS

The next set of questions is about your use of painkillers.

Painkillers include medications such as CODEINE, PETHIDINE AND NEODOL. [Use picture cards to display medications].

PK1. Do you personally know people who have used painkillers to relax or have fun, or used more than their doctor recommended?

Yes  1
No   2
Refused  99

PK2. Have you ever used painkillers to relax or have fun, or used more than your doctor recommended?

Yes  1
No   2
Refused  99 [If NO OR REFUSED, SKIP TO NEXT SECTION – BZD1]

PK3. About how old were you when you first used painkillers to relax or have fun, or used more than your doctor recommended?

AGE [PROBE FOR BEST GUESS]
Refused  99

PK4. During the last 12 months have you used painkillers to relax or have fun, or used more than your doctor recommended?

Yes  1
No   2
Refused  99 [If NO OR REFUSED, SKIP TO NEXT SECTION – BZD1]

PK5. During the last 30 days, on how many days did you use painkillers to relax or have fun, or used more than your doctor recommended?

Days
Refused  99

PK6. On a day when you use painkillers, about how many pills do you take:

Pills
Refused  99
MISUSE OF BENZODIAZEPINES

The next set of questions is about your use of BENZODIAZEPINES (tranquilizers).

These include VALIUM, ZOLAM, ATIVAN, AND OTHER TRANQUILIZERS.
[Use picture cards to display medications].

BZD1. Do you personally know people who have used benzodiazepines to relax or have fun, or used more than their doctor recommended?

Yes 1
No 2
Refused 99

BZD2. Have you ever used benzodiazepines to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – BZH1]

BZD3. About how old were you when you first tried using benzodiazepines to relax or have fun, or used more than your doctor recommended?

AGE [PROBE FOR BEST GUESS]
Refused 99

BZD4. During the last 12 months have you used benzodiazepines to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – BZH1]

BZD5. During the last 30 days, on how many days did you use benzodiazepines to relax or have fun, or used more than your doctor recommended?

__ ___ Days
Refused 99

BZD6. On a day when you use benzodiazepines, about how many pills do you take:

__ ___ Pills
Refused 99
MISUSE OF BENZHEXOL

The next set of questions is about your use of BENZHEXOL.
[Use picture cards to display medications].

BZH1. Do you personally know people who have used Benzhexol to relax or have fun, or used more than their doctor recommended?

Yes 1
No 2
Refused 99

BZH2. Have you ever used Benzhexol to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – SM1]

BZH3. About how old were you when you first tried using Benzhexol to relax or have fun, or used more than your doctor recommended?

AGE
[PROBE FOR BEST GUESS]
Refused 99

BZH4. During the last 12 months have you used Benzhexol to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – SM1]

BZH5. During the last 30 days, on how many days did you use Benzhexol to relax or have fun, or used more than your doctor recommended?

___ ___ Days
Refused 99

BZH6. On a day when you use Benzhexol, about how many pills do you take:

___ ___ Pills
Refused 99
MISUSE OF SOMADRIL

The next set of questions is about your use of SOMADRIL.
[Use picture cards to display medications].

SM1. Do you personally know people who have used Somadril to relax or have fun, or used more than their doctor recommended?

Yes 1 
No 2 
Refused 99

SM2. Have you ever used Somadril to relax or have fun, or used more than your doctor recommended?

Yes 1 
No 2 
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – OP1]

SM3. About how old were you when you first tried using Somadril to relax or have fun, or used more than your doctor recommended?

AGE 
[PROBE FOR BEST GUESS]

Refused 99

SM4. During the last 12 months have you used Somadril to relax or have fun, or used more than your doctor recommended?

Yes 1 
No 2 
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – OP1]

SM5. During the last 30 days, on how many days did you use Somadril to relax or have fun, or used more than your doctor recommended?

Days 
Refused 99

SM6. On a day when you use Somadril, about how many pills do you take:

Pills 
Refused 99
MISUSE OF OTHER PILLS

The next set of questions is about your use of any of the following other pills for some reason other than what your doctor prescribed them for—or use of more than your doctor suggested. P: ALLERMIN, METHADONE, PHENOBARBITONE. [Use picture cards to display medications].

OP1. Do you personally know people who have used any of these pills to relax or have fun, or used more than their doctor recommended?

Yes 1
No 2
Refused 99

OP2. Have you ever used any of these pills to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – INJ1]

OP3. About how old were you when you first tried using these pills to relax or have fun, or used more than your doctor recommended?

AGE [PROBE FOR BEST GUESS]
Refused 99

OP4. During the last 12 months have you used any of these pills to relax or have fun, or used more than your doctor recommended?

Yes 1
No 2
Refused 99 [If NO OR REFUSED, SKIP TO NEXT SECTION – INJ1]

OP5. During the last 30 days, on how many days did you use any of these pills to relax or have fun, or used more than your doctor recommended?

___ ___ Days
Refused 99

OP6. On a day when you use these pills, about how many pills do you take:

___ ___ Pills
Refused 99
INJECTION

INJ1. Have you ever injected any of the drugs we just discussed?

- Yes 1
- No 2
- Refused 99

[If NO OR REFUSED, SKIP TO NEXT SECTION – CU1]

If yes, please check off the type of drug you have injected
(CHECK ALL THAT APPLY):

- Heroin
- Tramadol
- Benzodiazepines
- Captagon or “01” pills
- Crystal or methamphetamine
- Other: _____________________________
- Don’t know
- Refused
**SUBSTANCE USE-RELATED EXPERIENCES**

*IF RESPONDENT HAS NEVER USED ALCOHOL OR ANY OTHER DRUG, SKIP TO MH1*

The next questions are about your experiences with substance use during the past 12 months.

CU1. During the past year, did you ever worry that you were using too much alcohol or drugs?

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<thead>
<tr>
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<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Rarely</td>
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</tr>
<tr>
<td>Sometimes</td>
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<td>Often</td>
<td>3</td>
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<tr>
<td>Always</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
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</table>

CU2. During the past year, did the prospect of not being able to drink alcohol or get drugs make you feel anxious or worried?

<table>
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<th>Value</th>
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<tbody>
<tr>
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<td>Sometimes</td>
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<tr>
<td>Always</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
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</tbody>
</table>

CU3. During the past year, did you wish you could stop alcohol or drug use?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Value</th>
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<tbody>
<tr>
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<tr>
<td>Often</td>
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<tr>
<td>Always</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
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</table>

CU4. During the past year, how difficult did you find it to stop, or go without alcohol or drugs?

<table>
<thead>
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<th>Difficulty</th>
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<tr>
<td>Somewhat difficult</td>
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<tr>
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<td>Impossible</td>
<td>3</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
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</table>
CU5. During the past year, to what extent has your alcohol or drug use disrupted your work, social life, or family life?

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<td>Mildly</td>
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<td>Moderately</td>
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<tr>
<td>Quite a bit</td>
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<tr>
<td>Extremely</td>
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<tr>
<td>Refused</td>
<td>99</td>
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</table>
TREATMENT EXPERIENCE

[IF RESPONDENT HAS NEVER USED ALCOHOL OR ANY OTHER DRUG, SKIP TO MH1]

TE1. During your lifetime, have you ever wanted to get help for your use of drugs or alcohol?

<table>
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<th>Count</th>
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<td>Yes</td>
<td>1</td>
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<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>99</td>
</tr>
</tbody>
</table>
MENTAL HEALTH QUESTIONS

ASK ALL RESPONDENTS:

I’m going to read a list of ways you may have felt. Please tell me how often you have felt this way during the past year: never, rarely, sometimes, often, or always.

MH1. During the past year, I did not feel like eating; my appetite was poor.

0 Never
1 Rarely
2 Sometimes
3 Often
4 Always
99 Refuse to Answer

MH2. During the past year, I had trouble keeping my mind on what I was doing.

0 Never
1 Rarely
2 Sometimes
3 Often
4 Always
99 Refuse to Answer

MH3. During the past year, I felt depressed.

0 Never
1 Rarely
2 Sometimes
3 Often
4 Always
99 Refuse to Answer

MH4. During the past year, I felt everything I did was an effort.

0 Never
1 Rarely
2 Sometimes
3 Often
4 Always
99 Refuse to Answer
DT7. Drug Test Result: OP

Positive 1
Negative 2
Invalid 99

DT8. Drug Test Result: BZ

Positive 1
Negative 2
Invalid 99

End1. That completes our survey. We appreciate your time and cooperation. Your answers, along with those of many others, will help us better provide for the residents of our state. We want to reassure you that your responses will be kept strictly confidential. Thank you so much.
DEMOGRAPHIC QUESTIONS

I’d like to ask you a few questions about yourself so that we can see how different groups of people feel about the things we’ve been talking about.

DM1. Which of the following best describes your current marital status.

Are you:

1. Married
2. Living as married
3. Widowed
4. Divorced or separated
5. Never married
6. Refused

DM2. What is your current work status?

1. Working full time, i.e. 35 or more hours per week in one or more jobs, including self-employment
2. Working part time
3. Have a job, but out due to illness, leave, furlough or strike
4. Have seasonal work, but currently not working
5. Unemployed
6. Full-time homemaker
7. In school only
8. Retired
9. Disabled for work (such as SSI)
88 Other [IF OTHER, SPECIFY]
99 Refused

DM3. Last year, what was your total family income?

Under $10,000
1
$10,000 to $20,000
2
$20,000 to $50,000
3
Over $50,000
4
Don’t know
7
Refused
99

DM4. Are you a veteran of the Armed Forces (Army)?

1. Yes
2. No
3. Refused

99
NATIONAL IRAQ SURVEY
INCIDENT/GRIEVANCE REPORT

Reported by: ________________________  Date of Incident: _____________

Governorate: ______________________

Interviewer: _______________________

Description of Incident/Grievance:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Person(s) Involved (do NOT include survey participant names, ID numbers only):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Action Taken:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Future Action Planned:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Date form completed: _________________________________

Reporter name/signature: ______________________________

Date reviewed by supervisor: ___________________________

Supervisor name/signature: ____________________________
The research team:
If you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact:

Nesif Al-Hemiary, MD at:
964-770-191-2781
University of Baghdad
Jadriyah, Baghdad, Iraq
nesif2012@gmail.com,

Hala Jassim AlMossawi, MSC, MSHCA at:
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Center for Human Services
hjassim@URC-CHS.COM

Richard Rawson, PhD at:
011-310-267-5311
University of California, Los Angeles
11075 Santa Monica Blvd., Suite 100
Los Angeles, CA 90025
rrawson@mednet.ucla.edu

UCLA Office of the Human Research Protection Program (OHRPP):
If you have questions about your rights while taking part in this study, or you have concerns or suggestions and you want to talk to someone other than the researchers about the study, please call the OHRPP at 011-310-825-7122 or write to:

UCLA Office of the Human Research Protection Program
11000 Kinross Avenue, Suite 211, Box 951694
Los Angeles, CA 90095-1694
DT7. Drug Test Result: OP

Positive 1
Negative 2
Invalid 99

DT8. Drug Test Result: BZ

Positive 1
Negative 2
Invalid 99

End1. That completes our survey. We appreciate your time and cooperation. Your answers, along with those of many others, will help us better provide for the residents of our state. We want to reassure you that your responses will be kept strictly confidential. Thank you so much.
FIELD INTERVIEWER QUESTIONS

[COMPLETE THIS SECTION AFTER THE INTERVIEW]

INT1. SEX OF RESPONDENT

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<td>Male</td>
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<td>Female</td>
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<td>Don’t Know</td>
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INT2. VERSION OF QUESTIONNAIRE

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INT3. INTERVIEWER EVALUATION OF RESPONDENT: PLEASE RATE THE RESPONDENT ON THE FOLLOWING DIMENSIONS:

<table>
<thead>
<tr>
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<tr>
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<tr>
<td>Truthfulness</td>
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<td>2</td>
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<tr>
<td>General understanding of questions</td>
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<td>2</td>
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<tr>
<td></td>
<td>3</td>
<td>4</td>
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INT4. WAS ANYONE ELSE IN THE ROOM WITH THE RESPONDENT

<p>| | |</p>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
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</table>
Nesif Al-Hemiary, MD, from Baghdad Medical University, Hala Jassim AlMossaw, MD, from the Center for Human Services and Richard Rawson, PhD, from the Integrated Substance Abuse Programs at the University of California, Los Angeles (UCLA) are conducting a research study.

You were randomly selected as a possible participant in this study because you live in the Iraq community. Your participation in this research study is voluntary.

Why is this study being done?

We are doing a study about attitudes and behaviors regarding drug and alcohol use, and would appreciate it if you would participate in our survey. This information will be used by the Center for Human Services to help the Ministry of Health plan health services for its citizens, and to help ensure that this community is made safe for you and your family.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- Respond to a series of questions regarding your attitudes, behaviors and experiences with drug and alcohol use, as well as basic demographic information.
- This information will be collected in the privacy of your home, in a private room.
- You may be randomly selected (by chance) to complete a saliva drug test. This will take only a few minutes. Your test results will be kept confidential, immediately disposed of, and will in no way be linked to your name, address or other identifying information.
- You may be contacted by a study supervisor in the near future to verify the completion of this interview. Again your responses to this contact will be confidential and only used for the for data quality purposes.

How long will I be in the research study?

Participation will take a total of about 30 minutes.

Are there any potential risks or discomforts that I can expect from this study?

- There are few anticipated physical, psychological, social, or legal risks to participation. However, some possible risks to participating in this study include discomfort or embarrassment related to questions dealing with drug or alcohol use, and unauthorized disclosure of confidential information.
- We have found the likelihood and seriousness of these risks to be minimal.
IRAQ NATIONAL SURVEY

FIELD INTERVIEWER ENROLLMENT LOG

Interviewer ID Number: _________________

<table>
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<th>Assigned ID Number</th>
<th>Date of Interview</th>
<th>Governorate/district</th>
<th>Date Paper Survey SUBMITTED to Supervisor</th>
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</table>
• **The research team:**
  If you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact:

  Nesif Al-Hemiary, MD at:
  964-770-191-2781
  University of Baghdad
  Jadriyah, Baghdad, Iraq
  nesif2012@gmail.com,

  Hala Jassim AlMossawi, MSC, MSHCA at:
  964-790-173-5183
  Center for Human Services
  hjassim@URC-CHS.COM

  Richard Rawson, PhD at:
  011-310-267-5311
  University of California, Los Angeles
  11075 Santa Monica Blvd., Suite 100
  Los Angeles, CA 90025
  rrawson@mednet.ucla.edu

• **UCLA Office of the Human Research Protection Program (OHRPP):**
  If you have questions about your rights while taking part in this study, or you have concerns or suggestions and you want to talk to someone other than the researchers about the study, please call the OHRPP at 011-310-825-7122 or write to:

  UCLA Office of the Human Research Protection Program
  11000 Kinross Avenue, Suite 211, Box 951694
  Los Angeles, CA 90095-1694
IRAQ NATIONAL SURVEY
RECRUITMENT TRACKING FORM

Supervisor: ____________________ Date Issued to Interviewer: _____________
Interviewer: ___________________

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IRAQ NATIONAL SURVEY

FIELD INTERVIEWER ENROLLMENT LOG

Interviewer ID Number: ________________

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## IRAQ NATIONAL SURVEY

### DATA ENTRY TRACKING LOG

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NATIONAL IRAQ SURVEY
INCIDENT/GRIEVANCE REPORT

Reported by: ____________________ Date of Incident: ____________
Governorate: ____________________
Interviewer: ____________________

Description of Incident/Grievance:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Person(s) Involved (do NOT include survey participant names, ID numbers only):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Action Taken:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Future Action Planned:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Date form completed: ____________________

Reporter name/signature: ____________________

Date reviewed by supervisor: ____________________

Supervisor name/signature: ____________________
Drugs of Abuse
Methamphetamines/Ecstasy (ME)
Marijuana* (TH)
Cocaine (CO)
Amphetamines (AM)
Opiates (OP)
Phencyclidine (PC)
or
Benzodiazepines (BZ)

Test Cut-off Levels
25 ng/mL
40 ng/mL
20 ng/mL
25 ng/mL
10 ng/mL
4 ng/mL
5 ng/mL

*Parent THC

For forensic use only
The Oratect® III Oral Fluid Drug Screen Device is a simple one-step test for the detection of drugs of abuse in oral fluid.

**Oratect® III Procedures** -- Refer to package insert for detailed instructions and technical information.

1. **Remove** the blue cap by holding the sides and pulling gently. This will expose the collection pad. **Make sure there is a blue line present in each window area indicating an unused device.**

2. **Open** mouth and gently **rub** the collection pad inside mouth against cheek in a circular motion several (approximately 15-20) times. Make sure to **keep head level.**

3. **Gently rub** the collection pad against the opposite cheek in circular motion several (approximately 15-20) times.

4. **Gently rub** the collection pad **on top** of the tongue several (approximately 15-20) times. **Do not chew, suck, bite or bend the collection pad.**

5. **Rub** the collection pad **underneath** the tongue several (approximately 15-20) times.

6. Place the collection pad **underneath** the tongue for approximately 30 seconds to collect saliva. Instruct the donor to hold the device in place with hand. **Sufficient amount of saliva collected is indicated by the flow of the blue lines. Repeat steps 2-6 until blue lines flow.**

7. **Remove** from mouth as soon as blue lines flow at both of the test windows. **Re-cap** the device.

8. Lay the device on a flat surface and **read results in 5 minutes after removing the device from mouth.** See Package Insert.

**Interpreting Oratect® III Test Results**

- **Invalid Result**
  - When no colored band appears in the CONTROL (C) region, the test is **invalid** even if there is a band in the test region. **Repeat** the test with a new device.

- **Negative Result**
  - For each test, two colored bands should be observed:
    - One in the CONTROL (C) region
    - One in the specific TEST region
  - The color of the test band may be slightly darker or lighter than the control band. Any visible band that can be seen is a **negative** result.

- **Presumptive Positive Result**
  - A colored band at the CONTROL (C) region should be observed. When there is no colored band at the specific TEST region, the test is presumptive positive for that particular drug.

**Example Interpretation:**

<table>
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<tr>
<th>ME</th>
<th>TH</th>
<th>CO</th>
<th>AM</th>
<th>OP</th>
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Oratect® III is for forensic use only

*Remark: This document contains guidelines and instructions for using the Oratect® III Oral Fluid Drug Screen Device. It is crucial to understand and follow these instructions carefully to ensure accurate and reliable results.*