

WOMEN INJECTING DRUG USERS

in the Middle East & North
Africa Region (MENA)

**Context, service needs and factors
influencing service uptake – Operational research**



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- This report is dedicated to all those in the community who have lost their lives as a result of a lack of available help and support.
- This report is also dedicated to all the women injecting drug users, their families, and their partners.

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List of abbreviations

HIV	Human immunodeficiency virus
HR	Harm Reduction
IDU	Injecting drug user
KH	Knowledge hub
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MMT	Methadone maintenance treatment
NSP	Needle syringe exchange program
OST	Opioid substitution treatment
OR	Operational research
STI	Sexually transmitted infection
VCT	Voluntary counseling and testing
WIDU	Women injecting drug user

Foreword

There is no denying that drug users are highly stigmatized and discriminated against in the Middle East and North Africa (MENA) region. Since its inception, the Middle East and North Africa Harm Reduction Association (MENAHRRA) has perpetuated the promotion and implementation of the advocacy and capacity needed to support the drug using community. As Executive Director, it is my prerogative to solicit the needs for harm reduction in the region and advocate for visibility and support of people who inject drugs in the MENA region.

Women injecting drug users (WIDUs) are profoundly hard to reach as they are a tremendously hidden population. Lack of visibility of the issues of women injecting drug users has greatly hindered awareness in regards to their needs and has limited the resources available for their assistance.

With the financial support of the Global Fund to Fight Aids, Tuberculosis, and Malaria, MENAHRRA was able to conduct a thorough investigation into the lives and needs of WIDUs in six countries of the region, Afghanistan, Egypt, Lebanon, Morocco, Pakistan, and Tunisia. This scientific study is an operational research project which seeks to assess the situation and harm reduction services available to WIDUs, their families, and the female partners of injecting drug users in the MENA region. As part of the repertoire of resources available at MENAHRRA to all those who seek to make a difference in the lives of drug users in the region, we hope this report and its recommendations can be used as an advocacy tool among the stakeholders and policy makers, and a capacity building tool among those working in the field to generate increased support and awareness of the needs of women injecting drug users.

MENAHRRA would like to thank the investigators, Ms. Anna-Leena Lohiniva and Ms. Manal Benkirane who were able to produce this report under an exceedingly tight schedule and many constraining obstacles. We thank them for all their efforts and hard work. We would like to also extend a warm thank you to the MENAHRRA strategic partners, UNAIDS, UNODC, and WHO for their continued collaboration, to all those who contributed to the compilation of this report, the six participating countries, the MENAHRRA team, and the Global Fund for making the production of this report possible.



Mr. Elie Aaraj
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The investigators would like to pay a special tribute to the 49 women who accepted to take part in this study and opened their hearts to share their experiences and thoughts of drug use among women. The conduction of the research and elaboration of this report would have not been possible without their valuable contributions.

This report was designed by Marc Ghayad.

Executive summary

Uptake of harm-reduction services among women is low in the Middle East and North Africa (MENA) region. A qualitative operational research was conducted to provide recommendations on how to improve the uptake of harm reduction services among women injecting drug users (WIDUs). By understanding the factors that influence service uptake, program managers can develop meaningful strategies to increase uptake of their services.

Objectives of study

- To explore the context of drug use among WIDUs
- To identify barriers and facilitators to accessing harm-reduction services
- To provide recommendations on how to improve access to harm-reduction services

In-depth interviews were conducted with 57 women and 26 key informants from Afghanistan, Egypt, Lebanon, Morocco, Pakistan and Tunisia. In each country, field teams were trained to collect data. A socio-ecological framework was used for data analysis. The study protocol was approved by the Ethical Review Board of the Ministry of Public Health in Afghanistan.

Findings

■ Background characteristics of participants

Study participants were relatively young (mean age 32.2), had low educational levels and were mostly socially disadvantaged. The mean age at which participants began using drugs was 21.4 years old. On average, study participants had used drugs for more than ten years. Heroin was the most commonly-used drug by women in all countries except Tunisia where Buprenorphine was more prevalent. Most participants were poly-drug users.

■ Context of Drug use

Experiences and patterns of drug use

The study found that drug use is often initiated by men, encouraged by social networks and motivated by problems related to poverty and breaking gender norms.

Habits of injecting drug use

Drug use often progresses from orally-ingested drugs and smoking to injecting. It is a hidden activity that takes place in multiple settings such as in groups, with a male partner or alone. Injecting is a habit that is generally kept secret due to the stigma associated with it.

Sharing needles

The sharing of needles was reported frequently due to a lack of awareness of the risks, financial constraints, inability to obtain needles from pharmacies and the fear of police. Sharing needles with a partner is common; it can have deeper social meanings, such as love or trust. Women who are dependent on men for supplying them with drugs are not always aware of where they can acquire needles. Meanwhile, limited freedom of movement, often prevents women from leaving their homes to obtain needles. Needle sharing also occurs within a social setting as an expression of friendship.

Drug overdose

Drug overdoses were common across the countries sampled. Factors that induce an overdose include mixing drugs, consuming higher doses than usual, relapses after a period of abstinence, and trying out new types of drugs. Lack of knowledge of overdose management was prevalent while medical assistance for an overdose was rarely sought due to the fear of being reported to the police.

Health status and access to health care

Menstrual irregularities, loss of sexual desire, unwanted pregnancies, pregnancy complications and unsafe abortions represented the main reproductive health problems associated with female drug use. Fatigue, weight loss and withdrawal pain are highly associated with drug use among women. Depression and suicide attempts were frequent. Lack of injecting skills caused vein injuries with the risk of severe complications. Reports of sexually transmitted infections (STIs) and Hepatitis were frequent.

Access to healthcare was mainly hindered by strong stigma against WIDUs, lack of interest to care for health and limited financial capacity.

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Unsafe sex

Some women engage in unsafe sexual practices, such as having multiple partners or engaging in unprotected and/or forced sex. Gender-related factors undermine condom use among women and increase their risk of infection. Overall, access to care is limited due to high levels of stigma and discrimination in the healthcare setting, lack of self-care and financial constraints.

Vulnerabilities among women who inject drugs

Violence associated with drug use

Violence against WIDUs is common and can deeply affect women's lives. Women are mainly exposed to violence by intimate partners, male drug users and drug dealers. Family, police and community are also important perpetrators of violence. Gender roles and the stigma associated with drug use are the main drivers of violence. Perceived lack of legal protection prevents women from reporting violent incidents to the authorities.

Changes in social relations

Drug use tends to result in social seclusion, marginalization, loneliness and rejection by family, distancing from children, marital and relationship problems and lost friendships.

Changes in financial status

WIDUs lose all their financial resources due to drug use. Women have often more financial responsibilities than men.

Sex work

Sex work was a common income-generating activity and a major consequence of drug use. Although engaged in selling sex, many women do not identify themselves as sex workers. Women perceive sex work as humiliating, a practice that exposes them to potential sexual health problems, violence and stigma – more than those who inject drugs but do not sell sex.

Rights violations

The types of rights violations women experienced include deprivation from children, denial of family inheritance, home evictions and the denial of the right to work and schooling.

Stigma

Stigma against women drug users was driven by social judgments, intersecting stigmas regarding sex work and gender, and a lack of trust. Stigma and discrimination were reported frequently and manifested in various ways, such as distancing, rejection, humiliation and denial of rights.

Factors motivating access to HR services

Individual level factors: Health status, motherhood, pregnancy, homelessness, a willingness to change lifestyle, and experiences of violence.

Interpersonal level factors: Lack of social contacts, partner/family support and role models.

Harm Reduction service-related factors: The attitude of the service provider, the availability of HIV and Hepatitis testing and psychological services, pregnancy and family planning services, STI screening and treatment, female-friendly logistics, needle distribution, substitution treatment and social services, women only services .

■ **Barriers to accessing HR services**

Individual level factors: Self-stigma, limited financial capacity

Interpersonal level factors: Fear of stigma, social relations

HR service-related factors: Previous negative experiences with Harm Reduction or drug-treatment services, treatment relapses and breaches of confidentiality, mixed services (men-women)

■ **Conclusions**

HR programs should include gender specific services in order to respond to women's needs and increase their access to these services.

■ **Recommendations**

Women should be prioritized in Harm Reduction activities, particularly in needle distribution and education on injecting skills. Efforts should be deployed to address women's reproductive health needs and increase their awareness of risk practices. Empowerment strategies to increase the abilities of women to negotiate condom use and provisions of female condoms should be considered. Harm Reduction services should also consider women's social vulnerabilities and include counseling for victims of violence, family mediation initiatives and income-generating activities to reduce women's risks and improve their socio-economic conditions. WIDUs who sell sex should be prioritized. Addressing stigma and discrimination against WIDUs should be a priority. Strategies that motivate uptake of HR services should be adopted.



1. Introduction



Injecting drug use among women is growing worldwide (European Monitoring Centre for Drugs and Drug Addiction Annual Report 2006). Although the actual proportion of women who inject drugs in the Middle East and North Africa (MENA) region is unknown, anecdotal data from the region implies similar growing trend in injecting drug use among women as seen elsewhere in the world.

Despite evidence that women injecting drug users (WIDUs) have different experiences than men injecting drug users (IDUs) and limited access to harm reduction services, gender sensitive interventions are rarely integrated into harm reduction programs. Previous research and experience suggest that gender-based services can increase the uptake of harm reduction services among women (Pinkam et al. 2007).

Limited studies from the MENA region on WIDUs hinder the understanding of this vulnerable population. Recent studies describe WIDUs as a hidden population in the region that encounters higher stigma than men IDUs, which is believed to result in the low use of harm reduction (HR) services (Abu-Raddad, Ayodeji Akala, et al., 2010). Recent studies have also shown that WIDUs in the region have generally lower socio-economic statuses than men IDUs and that drug use is associated with poverty, mental problems and violence (Abadi, et al., 2012; El-Sawy et al 2010).

This operational research (OR) study was undertaken by the Middle East and North Africa Harm Reduction Association (MENAHR) in five countries in the region (Afghanistan, Egypt, Lebanon, Morocco and Tunisia) to understand the context of drug use among WIDUs and factors that hinder or facilitate access to harm reduction services.

Purpose of the research

The purpose of this qualitative OR is to provide recommendations for harm reduction programs in the region on how to improve the uptake of the services for WIDUs in the MENA region. By understanding factors that are bottlenecks for effective implementation of harm reduction services for WIDUs, policy makers and program managers in the MENA region can make evidence based program decisions that will lead to more effective approaches to programming.

Research objectives

- To explore the context of drug use among women WIDUs
- To describe gender based needs of WIDUs
- To identify factors that influence the uptake of harm reduction services among WIDUs
- To provide recommendations to improve the uptake of harm reduction services among WIDUs.

Study participating countries and NGOs

The selection of countries was based on the concept of regional culture diversity. The initial plan involved the selection of two to three countries from each knowledge-hub (KH) of MENHRA, which represent different regions of MENA ¹. The MENAHRA secretariat contacted their partners in various countries and invited them to participate in the study. The final set of countries and NGOs that took part in the study included:

- **Afghanistan** – Organization of Harm Reduction in Afghanistan (OHRA)
- **Lebanon** - Soins Infirmiers et Développement Communautaire (SIDC) and Skoun
- **Egypt** – Befrienders and Youth Association for Population and Development
- **Morocco** – Réseau des associations de réduction des risques (RDR), section de Rabat, Association Hassnouna Tangiers, Association de Lutte Contre le Sida, Tetouan.
- **Tunisia** - Association Tunisienne de Lutte Contre le Sida (ATL)
- **Pakistan**- Pakistan Society

1. MENAHRA knowledge hubs: KH- Ar-razi- Morocco, Algeria, Tunisia, Libya-2. INCAS- Iran, Afghanistan, Pakistan 3. KH-SIDC- Bahrain, Egypt, Jordan, Kuwait, Lebanon, Palestine, Qatar, Saudi-Arabia, Oman, Syria, Yemen and United Arab Emirates.

HIV-situation and harm reduction services in study participating countries

HIV epidemics among drug users in Afghanistan, Egypt, Lebanon, Morocco and Tunisia vary, as do the harm reduction services targeting them. The following table summarizes the HR services available in each country.

Table 1: HR services by study participating countries

	Afghanistan	Egypt	Lebanon	Morocco	Tunisia	Pakistan
Harm reduction strategy adopted by the GOV	*			*		
IDU as a priority group in the AIDS National strategic plan		*			*	*
Opioid substitution treatment (OST)	*		*			
Methadone maintenance treatment (MMT)				*		
Voluntary counseling and testing (VCT)	*	*	*	*	*	*
Treatment of sexually transmitted infections (STI)	*	*	*	*		
Needle distribution	*	*	*	*	*	*
Condom distribution	*	*	*	*	*	*
Specific services for WIDUs	*					

Afghanistan

Afghanistan is a low HIV prevalence country with an estimated HIV prevalence among IDUs of approximately 5% (Nasir, et al., 2011; Todd, et al., 2011). Previous studies among IDUs indicate low HIV knowledge and common high risk practices including needle sharing and unprotected sex (Nasir, et al., 2011; Todd, et al., 2010). The most common drugs used in the country are cannabis, followed by opium and heroin (UNODC, et al., 2009).

The estimated number of IDUs in Afghanistan is 20,000. No gender segregated data is available. The country has adopted a harm reduction strategy as part of the National AIDS control program. A number of NGOs provide HR services including needle and condom distribution. Opioid substitution treatment (OST) was adopted in 2010 but methadone maintenance treatment (MMT) has not continued in the country. One NGO in Kabul provides services for women, which include voluntary counseling and testing (VCT), sexually transmitted infections (STI) testing and treatment, condom and needle distribution.

Egypt

Egypt has a low HIV prevalence among the general population, but concentrated epidemics have been detected among IDUs ranging from 0.6-6.8. Injecting drug use contributes to 28% of HIV cases in the country. Recent studies have also shown that unsafe injecting drug use, as well as unprotected sex are common among IDUs (FHI/MOH 2006; FHI/MOH 2010; Sievert, et al., 2011).

The main drugs of use in Egypt are cannabis and opioids (UNODC, 2011).

The estimated number of IDUs in Egypt is approximately 90,000 (Menahra 2012). Gender segregated data is not available. Egypt's National AIDS Program strategic plan has prioritized interventions targeting key populations including IDUs. A group of NGOs provide harm reduction services including VCT and condom and needle distribution. OST is not available. An umbrella network of NGOs providing harm reduction services was established in 2013 to better coordinate harm reduction efforts in the country. No gender sensitive services for women drug users are available.

Lebanon

Lebanon is also a low HIV prevalence country. Various studies indicate HIV prevalence among IDUs to be less than 6% (Lebanon MoPH, 2012). Risk practices among IDUs, including needle sharing and unsafe sex are reported to be common (Lebanon MoPH, 2010; Mahfoud, Afifi, et al., 2010). The most common used drugs in Lebanon are cannabis, cocaine, and opioids.

The estimated number of IDUs in Lebanon ranges from 2,000 to 3,000 persons (Lebanon MoPH, 2012). It is also estimated that from 30% to 60% of drug users are injecting drug users (Skoun Lebanese Addictions Center, et al., 2011). No gender segregated data is available. Harm reduction policy is adopted as part of the National AIDS Strategy. Harm reduction services are well established in the country and they include OST, needle syringe exchange program (NSP) and condom distribution (Menahra 2012). No gender sensitive services are available.

Morocco

Morocco remains a low HIV prevalence setting with concentrated epidemics reported among key populations including IDUs (Morocco MoH, 2012). Injecting drug use contributes to approximately 6.5% of the epidemics in the country (Morocco MoH, 2012). A modeling study on HIV modes of transmission conducted in 2010 estimated the national rate of HIV prevalence among IDUs to be 2% (Mumtaz, et al., 2010). Bio-Behavioral Surveillance Surveys (BBSS) have estimated HIV prevalence among IDUs to be from 9 to 28%. More high risk behaviors among women IDUs are reported than among men IDUs in Morocco (Morocco MoH, 2005).

The estimated number of IDUs in Morocco is 18,500. Morocco has adopted harm reduction strategies as part of the National AIDS strategic plan and NSP and condom distribution are part those services. OST and MMT are also available (Menahra 2012). No gender sensitive services for women are available.

Tunisia

Tunisia is a low HIV country where 23% of HIV transmission is attributed to injecting drug use. Recent studies indicated that HIV prevalence among IDUs ranges from 2.4% to 3.1% (Mathers, et al., 2011; Tunisia MoH, 2012). Previous studies highlight risk practices among IDUs, including needle sharing and unsafe sex. Although cannabis and psychotropic drugs are the most common drugs used in Tunisia, heroin and cocaine are also available.

Tunisia estimates there are approximately 9,000 IDUs in the country. No gender segregated data is available. The National AIDS strategy includes IDUs as an important target group. A few NGOs provide harm reduction services including syringe and condom distribution. However, these services are not adopted in the national strategic plan. OST is not available (Menahra 2012). No gender sensitive services are available.

Pakistan

Pakistan has a low HIV prevalence in the general population with concentrated epidemics among populations at risk, such as, IDUs and transgender sex workers (Pakistan MoH, 2012). Unsafe injection practices are prevalent and HIV knowledge is low. Previous studies have identified differences between cities on risk behaviors (Pakistan National AIDS Control Program, 2008, 2012).

Pakistan has approximately 125,000 injecting drug users (Pakistan Ministry of Narcotics Control, 2007). The national AIDS program addresses IDUs as the main risk group and acknowledges a harm reduction strategy. Pakistan is the first country in the region that began a needle exchange program, which has been evaluated as having high coverage (Pakistan MoH, 2012). VCT centers are few and uptake of services is low. OST and MMT are not available. No gender sensitive services are available.



2. Methods



This section describes the study design, the conceptual framework, study populations and tools. This section also describes data collection procedures including recruitment and interviewing processes as well as data analysis, ethical considerations and challenges.

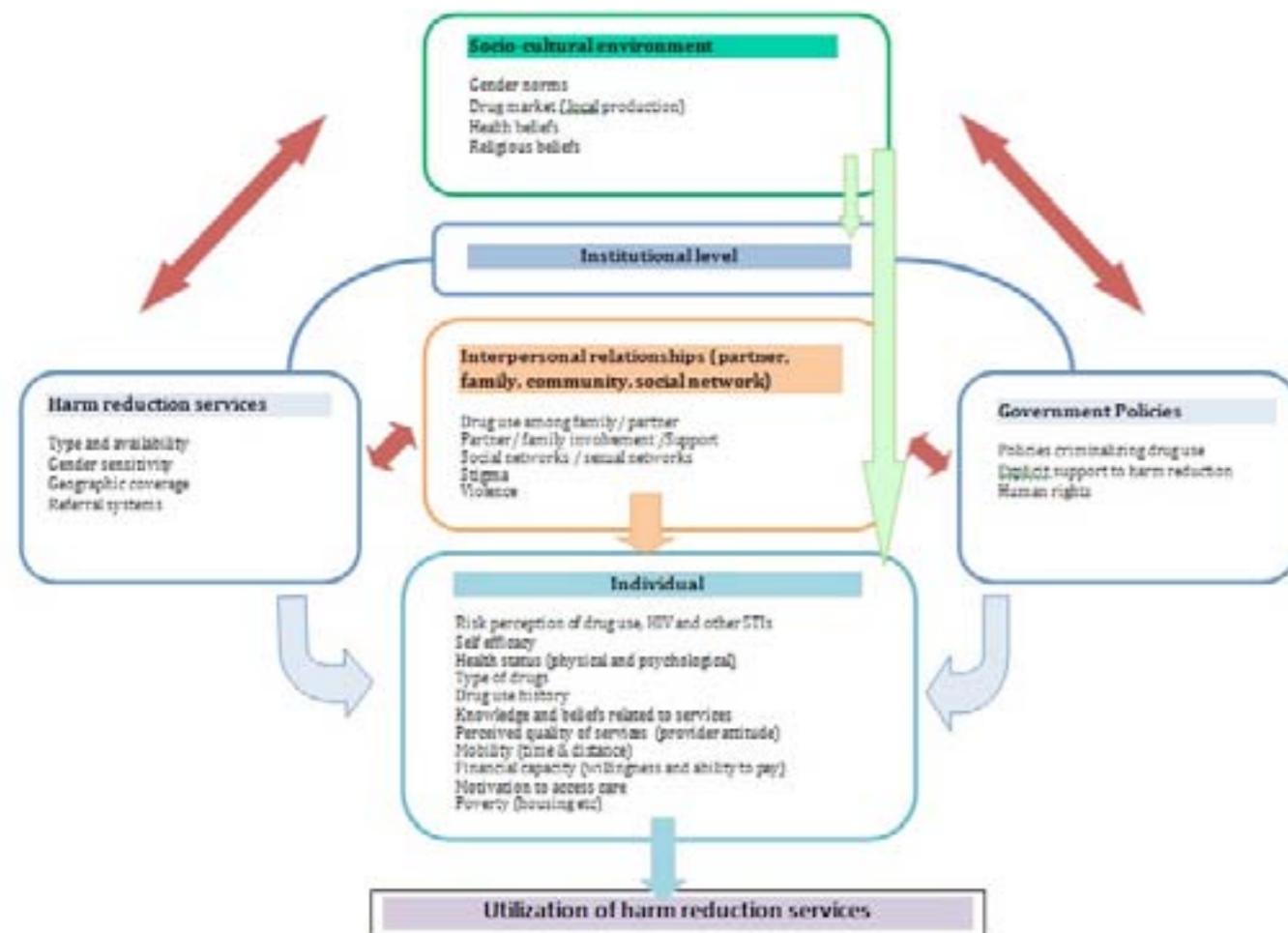
Study design

The first phase of the study design included the development of the study protocol and a literature review. The study protocol received verbal or written approvals from government representatives in each participating country. A qualitative operations research study was deemed appropriate as the purpose was to gain an in-depth understanding of the context of drug use and the potential factors that influence the uptake of harm reduction services as well as to provide practical recommendations on how to improve services targeting women in the region.

Conceptual framework

A conceptual framework was developed by reviewing frameworks that are currently used to explore service uptake and that can capture factors identified by the literature review as possible reasons and solutions for the uptake of harm reduction services. The socio-ecological model was found to be suitable because it captures factors influencing the seeking of harm-reduction services at various levels including individual, interpersonal, institutional (harm-reduction services, government policies) and socio-cultural environments (Busza et al 2012; Sinha et al 2009; Oinam et al 2008). Individual factors remain the core of the framework but operate under the influence of other levels (Figure 1).

Figure 1: Conceptual Framework for uptake of harm reduction services.

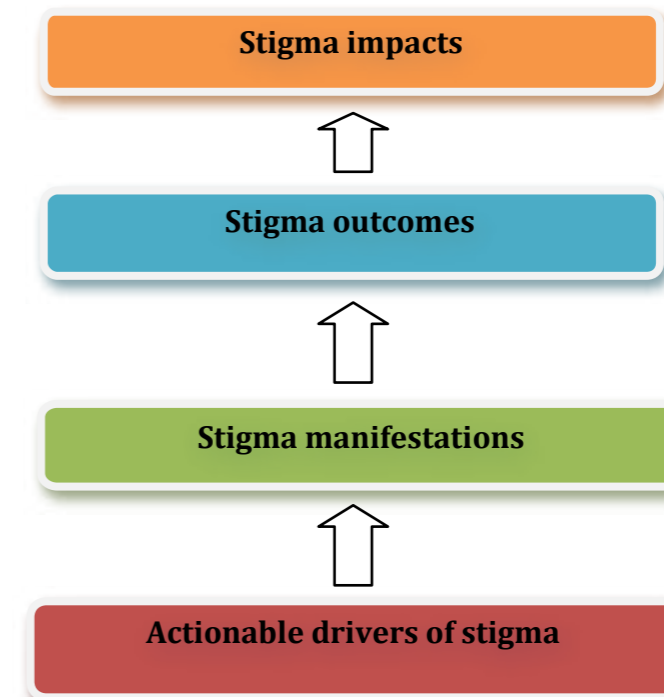


Conceptual framework for stigma

As the literature suggests that stigma plays a major role as a barrier to accessing HIV care and treatment globally (Nyblade; 2005), it was considered essential to undertake an in-depth exploration of the intersecting stigmas toward drug use, gender, poverty, HIV and others that have been identified in the literature as barriers in accessing harm-reduction services in several regions (Sinha et al 2009; Poole et al 2010), including in the MENA region (Lotfi et al 2011; Hasnain 2005).

The conceptual framework used to explore stigmas against WIDUs was modified from a framework developed by Stangl et al (2011) to explore HIV stigma. The framework includes factors that induce stigma (actionable causes of it), and could be changed as a result of interventions. It also includes manifestations of stigma that consist of anticipated stigma (the fear of negative consequences if ones' drug use practices or positive HIV status was known, experiences of stigma (the experience of discrimination based on being associated with drug use, HIV status); discrimination (the experience of discrimination within law), internalized stigma (the acceptance among WIDUs of negative beliefs and feelings associated with drug use with themselves). And lastly, the framework captures the outcomes of stigma. The impact of stigma was not measured in this study (Figure 2).

Figure 2: Framework for stigma against WIDUs



Study Population

The study population consisted of women injecting drug users and key informants.

■ Inclusion criteria of study participants

The study included women over the age of 18 who had used illicit injected drugs in the past year. Eligible women included those who already sought harm reduction services, were under treatment at the time of the interviews, and those who had not accessed services. In addition, eligible women included those that were currently pregnant or those who had been pregnant while using illicit injecting drugs as well as women IDUs who had been incarcerated.

The inclusion criteria for key stakeholders relied on their expertise in the subject matter. Eligible key informants included various experts, governmental representatives, policy makers and representatives of the non-governmental sector that are currently working with WIDUs.

■ Exclusion criteria of study participants

Women younger than 18-years-old were excluded as study participation requires permission from the guardian that may lead to breach of confidentiality regarding drug use status. Also, women currently in prison were excluded due to ethical considerations as maintaining privacy and confidentiality was considered challenging in this setting.

Tools

Separate question guides were developed for interviews with women and key informants. The guides were developed based on the conceptual framework. They included open-ended questions related to four specific areas: 1) drug use among women; 2) impact of drug use on women; 3) personal experiences and changes in life due to drug use, and 4) barriers and facilitators in accessing harm reduction services. Questions included a set of probes that aimed at capturing issues related to each topic at different levels including within the individual, interpersonal, institutional and socio-cultural environment. A separate section in the guides was developed to collect the background information of respondents including questions related to demographic and history of drug use. The tools are attached in Annex B.

Data collection procedures

■ Identification and training of country field teams

The principal investigators of this study trained a field team of three persons in each country to conduct interviews with women and key informants, with the exception of Pakistan where only one person was trained to conduct the interviews, and Morocco where one of the principal investigators conducted the interviews.

The members of the field teams were selected by the partner NGO in each country following selection criteria that included previous experience in qualitative data collection, knowledge of drug use and HIV, and good country native language skills. The principal investigators of this study provided three-day trainings to the teams on the purpose of the study and questionnaires, how to use appropriate interview skills and how to take quality notes for the study. The training also included basics of research ethics to ensure that all persons involved in data collection had adequate knowledge to protect the study subjects from any harm including the maintaining of privacy and confidentiality during and after the study. An exception was Pakistan where a brief training was conducted via Skype. The trainings were conducted between May and July 2013, except in Pakistan where the training was conducted in September.

■ Recruitment and interviewing process

Sampling was purposive in a sense that women and key informants who were available and willing to participate were invited for an interview. Partner NGOs in each country worked with a coordinator who scheduled the interviews. The women were initially identified through harm reduction service providers in each country. A snow ball recruiting technique was used through the women who had been already interviewed, or by former or current clients of the harm reduction centers. The field team members, in collaboration with harm reduction service providers, scheduled the interview time based on the preferences of the women. The participating women were also given the choice to be interviewed at the premises of the NGO that provides harm reduction services or any other public place such as a café. All interviews were conducted in the premises of NGOs except two interviews in Egypt and four interviews in Tunisia, which were conducted in cafes. Five interviews in Egypt were conducted over the phone due to political unrest in the country.

The NGO coordinator in each country also assisted in identifying and recruiting key informants (KIs). They contacted KIs over the phone and explained the purpose of the interviews. If the KI was willing to participate, an interview was scheduled based on the availability and preferred place chosen by the participant. All interviews with KIs were conducted in their work premises except one in Egypt, which was conducted over the phone.

In Afghanistan the interviews with women were conducted in a neighborhood of Kabul, which has a harm reduction center for women. In Egypt, the interviews were conducted in Cairo and Alexandria. In Lebanon the interviews were conducted in the catchment areas of participating NGOs (SIDC and SKOUN), In Tunisia they were conducted in Tunis and its suburbs, in Morocco, interviews took place in Rabat, Tangiers and Tetouan and in Pakistan interviews were conducted in Karachi.

The interviewers took notes during the interview and expanded the field notes the same day. In Afghanistan, the interviews were conducted by two persons; one taking notes and another interviewing. In Egypt, some interviews with women were conducted by the principal investigators and in Tunisia and Lebanon principal investigators conducted some KI interviews.

If women expressed discomfort regarding questions, the interviewer either gave her time to answer those questions or they were skipped. The interviews with women lasted from 45 minutes to two hours. Interviews with KIs lasted thirty minutes on average.

Data Analysis

The analysis was conducted by two study investigators. It began with a debriefing session over the phone, via Skype or by email, between the field team members and the study investigators. In these debriefings, investigators probed further for deeper understanding or asked for clarification if needed. The field notes were modified based on the debriefing session and translated from Moroccan, Tunisian, Lebanese or Egyptian dialect, French and Farsi into English. Interviews that were carried out by the study investigators were also discussed by the investigators to share impressions.

The study used a thematic analysis method that aimed to identify the main categories and codes within the narratives (field notes). The analysis used pre-determined categories derived from the conceptual frameworks and based on a literature review that was carried out during the protocol development.

It included a number of categories which were further categorized and coded into smaller sub-categories. These revised sub-categories with relevant codes were organized into a chart, which allowed for the comparison of data across different countries. In the final stage, the codes were reorganized into larger categories and the investigators carried out the final interpretation of the data by consensus.

Ethical Considerations

Investigators of this study are formally trained on research ethics and all those involved in data collection received training on the main principles of research ethics. Interviews were conducted in a closed room and no identifiers were collected. Verbal informed consent was obtained from each study participant before the start of the interview. The study protocol was approved by an Ethical Review Board.

Challenges

The study topic and target audience are culturally sensitive topics in the region, which made it challenging to engage countries with the study. Many countries required long periods of time to discuss the issue with various entities in the country, which created significant delays for the work plan. Several countries also regretted not being able to participate in the study due to political sensitivities that the study topic arose.

As study investigators did not choose the field team members but relied on participating NGOs to select them, the quality of interviews varied from one country to another and between the field team members in countries.

Recruitment of study participants took place through HR centers that typically gather clients of low socio-economic statuses in many countries. Accordingly the study sample includes mainly respondents from low socio-economic statuses.

Political unrest in Egypt and in Afghanistan during the data collection created security risks for the field teams and delays in completing the interviews. In Morocco it was difficult to get data collection started and completed due to lack of coordination between different entities. Delays in obtaining entry visa to Pakistan resulted in severe delays in data collection and required that training be conducted by long distance via Skype. It also created severe confusion for the collaborating NGO in recruiting procedures.

3. Findings



Background characteristics

■ Socioeconomic background of women participating in the study

The study included a total of 57 women: ten women each from Afghanistan, Egypt, Morocco and Tunisia, nine women from Lebanon and eight from Pakistan. Details of participants from each country can be seen in Table 1.

The mean age of the women who participated was 32.2 years, ranging between 27.5 in Pakistan and 42 in Afghanistan. The youngest (18 years) participant was from Pakistan and the eldest (64 years) woman participating in the study was from Lebanon.

Nearly half of the study participants [27/57] were either married (17) or in a relationship (10). In Afghanistan, all the participating women were married; except one participant who was widowed. In Morocco, none of the study participants were married though nearly half of them were in a relationship. Overall, nearly half of the participants [12/27] involved in a relationship/marriage had a partner who was a current injecting drug user. On average, one in six women were either divorced or separated. Divorce and separation were the highest among Moroccan participants. Nearly half of the participants in Egypt and Tunisia were single. Almost half of the study participants had children [26/57] and only one participant (from Egypt) was pregnant during the study period.

The overall educational attainment of the study participants was poor. Half of the participants had never been to school [19/57] or could barely read and write [10/57]. All Afghani participants were illiterate. Nearly one in six women had completed high school or above. University students participating in the study hailed from Egypt, Lebanon and Tunisia [5/57].

The majority of participants were economically disadvantaged. Nearly eight in ten women were unemployed at the time of the study. Out of those who were employed, the majority were involved in unskilled occupations such as working as waitresses, factory workers, hygiene officers or domestic workers. Women from Afghanistan, Morocco, Pakistan and Tunisia reported less employment.

Only one [1/10] Moroccan participant was working as a waitress, one [1/10] Tunisian as a domestic worker and two [2/10] Afghans were working as a hygiene officers and a tailor. At least half of the participants from Lebanon and Egypt had a job. However, the nature of jobs differed as women from Lebanon reported skilled occupations such as graphic designer and medical assistant whereas in Egypt, women were employed as unskilled workers.

The majority of participants either fully or partially depended on the economic support of their families. Families included parents, brothers and sisters and eventually sons and daughters. Women also relied fully or partially on their partners' support or sex work to generate income. While women from Afghanistan, Lebanon and Morocco depended mainly on their families or partners as a source of income, Tunisian and Pakistani participants relied more on sex work to earn money.

The vast majority of study participants [48/57] reported having stable housing conditions. Most of the women stated that they reside in their family homes. Nearly 3 in 10 women lived in a rented house or room either alone or with partners or friends. One participant from Morocco and one from Pakistan reported renting a room in exchange for sex. Family housing conditions were the source of various problems due to interaction with family members or in-laws. Many participants reported that drug use was not acceptable in family settings and hence, if discovered, women could be expelled from the house or experience violence. In Afghanistan, the majority [8/10] of women lived in rented houses; half of them being tenants in government housing and the other half renting from private house owners. Those living in rented houses from the private sector considered their housing situation unstable as convictions were common.

Table 2: Background characteristics of study participants

Country	Afghanistan	Egypt	Lebanon	Morocco	Pakistan	Tunisia	Total	%
	N:10	N:10	N:9	N:10	N:8	N:10	N:57	
Mean age	42 [28-55]	29.8 [21-45]	20.1 [19-64]	34.7 [21-52]	27.5 [18-45]	30.5 [20-43]	32.2 [18-64]	
Marital Status								
<i>Married</i>	9	1	3	0	3	1	17	29.8
<i>Single</i>	0	4	1	0	2	6	13	22.8
<i>In a relationship</i>	0	1	3	4	0	2	10	17.5
<i>Divorced / Separated</i>	0	4	2	6	3	1	16	28.0
<i>Widowed</i>	1	0	0	0	0	0	1	1.7
Partner injecting	3	2	1	0	5	1	12	
Children and pregnancy								
<i>Have children</i>	10	3	1	7	3	2	26	45.6
<i>Currently pregnant</i>	0	1	0	0	0	0	1	1.7
<i>Injected drug during pregnancy</i>	7	3	4	4	2	5	25	43.8
Education								
<i>Never been to school</i>	9	1	3	0	3	1	17	29.8
<i>Primary-can read and write</i>	0	4	1	0	2	6	13	22.8
<i>Preparatory-vocational</i>	0	1	3	4	0	2	10	17.5
<i>High school</i>	0	4	2	6	3	1	16	28.0
<i>University</i>	1	0	0	0	0	0	1	1.7
source of income								
<i>Unskilled work</i>	2	7	2	1	0	1	13	22.8
<i>Skilled occupation</i>	0	0	2	0	0	0	2	3.5
<i>Family and Friends support</i>	5	2	5	5	2	3	22	38.5
<i>Full or partial partner support</i>	4	0	1	3	0	1	9	15.7
<i>Sex work</i>	0	1	1	2	8	5	17	29.8
<i>Drug dealing</i>	0	0	0	0	1	0	1	1.7
Housing								
<i>Reported having stable house</i>	5	9	9	10	8	7	48	84.2
<i>Family/Friend house</i>	1	5	9	3	7	5	30	52.6
<i>Partner house</i>	0	1	0	3	0	1	5	8.7
<i>Rented room /house</i>	8	3	0	3	0	2	16	28.0
<i>Room against sex</i>	0	0	0	1	1	0	2	3.5

■ Drug use patterns

As shown in Table.3, the overall mean age of starting drug use among study participants was 21.4 years, ranging between 16.5 years in Lebanon and Pakistan and 33.1 in Afghanistan. The youngest age of starting drugs was 11 years in a Lebanese and a Pakistani participant and the eldest age was 52 in an Afghani participant.

On average, study participants have used drugs for more than 10 years. The average ranged between 5 years in Egypt and 15.6 years in Morocco. The shortest duration of drug use was one year as reported by an Egyptian participant. The longest period was 48 years that was reported by a 64-year-old Lebanese woman who was still injecting drugs at the time data was collected.

More than half of the participants [32/57] were currently injecting drugs at the time of the study. This included the majority of participants in Tunisia [9/10] and Pakistan [6/8] and half of Egyptian women who took part in the study [5/10].

Heroin was the most commonly used drug by women in all countries except in Tunisia where Buprenorphine (Subutex) was more common. Women from Egypt, Lebanon, Morocco, Pakistan and Tunisia reported having tried, either separately or simultaneously, other drugs with heroin; this included mainly cocaine (basic or crack), cannabis (hash or marijuana) and prescription drugs other than Buprenorphine such as sedatives and pain killers. Afghani participants reported the use of opium.

Table 3: Drug use patterns of study participants

Country	Afghanistan N:10	Egypt N:10	Lebanon N:9	Morocco N:10	Pakistan N:8	Tunisia N:10	Total N:57	%
Mean age of starting drugs	33.1 [23-52]	24.3 [14-41]	16.5 [11-26]	19.1 [12-35]	16.5 [11-27]	19.4 [14-25]	21.4	
Average years of drug users	8.9 [4-20]	4.9 [1-13]	12.6 [1.5-48]	15.6 [4-32]	11 [7-18]	10.1 [4-20]	10.5	
Currently injecting	4	5	4	4	6	9	32	56.1
Type of drugs used								
Heroin	10	10	9	10	8	3	50	87.7
Cocaine	--	1	9	8	2	1	21	36.8
Cannabis	--	1	6	5	4	2	18	31.5
Opium	9	--	--	--	--	--	9	15.7
Buprenorphine	--	--	--	--	--	9	9	15.7
Other prescription drugs	--	5	5	1	--	3	14	24.5

■ Utilization of HR services

The majority of study participants [47/57] have accessed at least one HR service. As indicated in Table. 4, the most used services among women were HIV testing [32/57] and acquisition of needles [27/57]. HIV testing was mainly utilized in Lebanon, Pakistan and Morocco where more than half of study participants were tested. In Tunisia, only 2/10 participants were tested for HIV. All Afghani participants had HIV testing, condoms and needles available to them since these services are part of a routine package delivered to everyone visiting the HR center.

Table 4: Utilization of harm reduction services among study participants

Country	Afghanistan N:10	Egypt N:10	Lebanon N:9	Morocco N:10	Pakistan N:8	Tunisia N:10	Total	%
Used at least one HR service	10	6	8	7	8	8	47	82.4
Average years of drug users	8.9 [4-20]	4.9 [1-13]	12.6 [1.5-48]	15.6 [4-32]	11 [7-18]	10.1 [4-20]	10.5	
Type of service used								
Information	1	3	1	4	7	3	19	33.4
Needles	10	3	2	1	7	4	27	47.3
HIV testing	10	4	5	5	6	2	32	56.1
Psychological Counseling	1	1	3	1	1	--	7	12.2
Detoxification	2	4	6	2	7	3	24	42.1
Referral to other services	1	1	--	--	--	--	2	3.5
STI testing and treatment	10	--	5	--	1	--	16	28.0
Condoms	10	1	4	--	6	4	25	43.8
Drug treatment	5	--	6	4	7	--	22	38.5
Support group	--	1	1	2	--	1	5	8.7

Background characteristic of key informants

Twenty six key informants were interviewed, including 5 experts from Morocco, Egypt, Tunisia and Lebanon, 4 experts from Afghanistan and 2 from Pakistan.

Half of the key informants [13/26] who participated in the study were collaborating with non-governmental organizations. Eight interviews were conducted with governmental representatives and four interviews with representatives of international organizations. Only one healthcare worker from Egypt was working in the private sector. Table 5 lists the number of participants by sector from each country. Areas of expertise of key informants included policy making, project planning, program and project management, outreach, resource mobilization, care and treatment and counseling.

Table 4: Key informants' sectors by country

Country	Afghanistan N:4	Egypt N:5	Lebanon N:5	Morocco N:5	Pakistan N:2	Tunisia N:5	Total	%
Type of service used								
Government	1	0	2	2	1	2	8	
NGO	3	2	3	2	1	2	13	
International organization	0	2	0	1	0	1	4	
Private sector	0	1	0	0	0	0	1	

Experiences and Patterns of Drug Use

The findings of this section describe the experiences and patterns of drug use among women. Thematic differences among countries are described when appropriate.

The section reviews initiation of drug use, drug use habits, financing of drugs, and unsafe injecting practices. Lastly, this section illustrates overdose experiences.

Initiation of drug use

Box #1: key findings on initiation of drug use

- Drug use is frequently initiated by men
- Social networks encourage drug use
- Problems related to breaking gender-based norms and domestic abuse lead to drug use
- Social problems including poverty drive drug use
- Drugs are used as an entertainment



Respondents revealed that drug use was frequently initiated by men who introduced them to drugs, particularly husbands or partners. Women were either invited to use drugs or coerced to use them. Women from all countries except from Pakistan explained that men encouraged them to use drugs as a show of love or commitment to each other. Women from Lebanon, Morocco and Tunisia believed that being young and inexperienced in dealing with men led them to easily agree to their loved ones' requests to use drugs.

"I was crazy about a man, I loved him so much. He introduced me to the group and drugs. He promised that he would marry me and he told me that he wanted to live with me in the European style. We were happy together." 28-year-old woman from Tunisia, 14 years of drug use.

One woman from Lebanon and two women from Morocco explained that they were offered heroin by their husbands to relieve pain, general weakness and as a cure for pneumonia.

"There was a time where I got very sick; I had a high fever and a sore throat for three days. I couldn't perform my duties at home and I was in bed all the time. My husband came home one night and suggested I should sniff a bit of heroin, saying that it would make me feel better." 28-year-old woman from Lebanon, 1.5 years of drug use.

"One day I had terrible back pain and I asked for medicine, my husband gave me heroin." 29-year-old woman from Morocco, 9 years of drug use.

A number of women from all countries described their unwillingness to start using drugs. All participants from Pakistan stated that they started using drugs due to coercion by their husbands or other male family members. One woman from Afghanistan believed that her husband, who was a drug user, did not want to take the blame for his drug alone and forced her to start using drugs as well. Another one explained that her husband made countless, persistent efforts to get her to start using drugs. A woman from Egypt explained that her husband asked her to use drugs to increase his sexual pleasure.

"My boyfriend introduced me to injections, it wasn't my free will. I was scared in the beginning, I didn't like it much." 30-year-old woman from Tunisia, 5 years of drug use.

"My mother and father died I was looked after by my maternal uncle who started me on the habit when I was young I think about 13 years. When I got married my husband made me continue he was an addict too." 20-year-old woman from Pakistan, 7 years drug use.

Respondents also noted that drug use was initiated by friends, except in Afghanistan and Pakistan where women claimed there was minimum involvement of friends in the initiation of drug use. Younger women in particular mentioned "bad company" and peer pressure as reasons that led them to begin using drugs. Women often perceived these friends negatively and considered them as having had intentions to harm them. A Moroccan woman believed that a group of friends pressured her to use drugs out of jealousy.

"... They would invite you to try drugs, they would give it to you for free and after you are hooked, they would let you down." 43-year-old woman from Tunisia, 20 years of drug use.

For others, friends had offered drugs as a friendly gesture to ease depression and sadness. Two women from Afghanistan explained that they started using drugs after moving to a new neighborhood to build friendships with other women.

Respondents explained that their curiosity to begin using drugs increased by living in or visiting neighborhoods that had drugs commonly available, living in or visiting homes in which drug use occurred, and by being around friends who used drugs. In Pakistan women explained drug use among family members; brothers, father and husbands as being common and they described often use of drugs almost as a social norm that made initiation of drug use among women likely. One Lebanese woman mentioned she followed the footsteps of her father who was an injecting drug user. One woman from Morocco and another from Egypt noted that their brothers influenced their initial drug use. Women in Afghanistan frequently explained that families always had someone who was using drugs, which provided them with easy access to drugs. A woman from Egypt and several from Lebanon and Morocco also admitted that they wanted to know what their husbands or partners were going through and how the drugs affected them. A woman from Morocco and another from Tunisia explained that they were curious when they saw others using drugs and wanted to try them. They noted that women were unaware of the consequences of drug use until it was too late and they were addicted to them.

"I started using drugs with my husband. He was smoking heroin and I was curious to see how he feels." 38-year-old woman from Morocco, 15 years of drug use.

"Drug is the easiest thing you can get in some neighborhoods. It's very easy to get pills because dealers are everywhere and you know people who are using them." 30 years old woman from Tunisia, 10 years of drug use.

"I was trapped; I was trapped so soon... nobody told me anything." 25-year-old woman from Tunisia, 11 years of drug use.

"Women in Pakistan in the majority of cases inject drugs because someone in their household injects or is a user." 23-year-old woman from Pakistan, 8 years of drug use.

Problems related to breaking of gender-based norms and domestic abuse lead to drug use. Women from Egypt, Lebanon, Morocco and Tunisia identified factors that lead to history of family problems and there through to drug use including sexual relations without marriage, being left by their partners, unwanted pregnancies and abortions. A woman from Pakistan believed that divorce, delay in marriage or repeated rejections to get married or forced marriages put pressure on women, which lead to drug use. In addition, domestic abuse was believed to drive women to use drugs including verbal and physical abuse as well as other unjust treatment from other family members. One woman from Egypt cited being raped by her step-father and another from Lebanon told of being raped by her fiancée. Respondents from Afghanistan differed slightly as they specifically noted abusive behavior by their husbands as the primary domestic problem that leads to drug use. A woman from Egypt mentioned she began using drugs to cope with sadness following her divorce.

“I suffered from my mom injustice, from my dad before he divorced. I did not have choices in my life.” 27-year-old woman from Egypt, 13 years of drug use.

Poverty and related social problems including unemployment were also mentioned as a cause of drug use in all countries particularly among women from Afghanistan and Pakistan. Women from Afghanistan explained that difficult conditions, especially during displacement and war, led women to start using drugs. Women from Egypt, Tunisia, Lebanon and Morocco discussed hardships created by unemployment that included inadequate housing.

“We had fighting, displacement, unemployment, poverty and lots of sadness.” 43-year-old woman from Afghanistan, 10 years of drug use.

Parties and outings were occasions where women would start using drugs as entertainment. Women from Egypt, Lebanon, Tunisia and Morocco described restaurants, night clubs and private parties as environments where they could easily use drugs to have fun with friends, to increase their sensory experience, to have more energy or increase sexual pleasure. These women did not experience the same hardships as other respondents and used drugs to alleviate boredom, have an adventure and to chase more enjoyment. In Afghanistan, drug use was mentioned as an entertainment with female neighbors or relatives. In Pakistan women mentioned drug use among female friends being rather uncommon.

“People who inject are all party people. They go out to night clubs, restaurants, cabarets; the list is long. It’s very easy to meet new people to inject with.” 29-year-old woman from Tunisia, 11 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Drug use is often initiated by men.	To reach women : HR programs should use men as entry points to find women drug users.
Social networks encourage drug use.	Social networks should be used to reach out women drug users.

■ Injecting drug use habits

This section outlines injecting drug habits, perceptions related to injecting drugs and the venues in which women commonly inject. It also describes how drugs are acquired and financed.

Box #2: Key findings on injecting drug use habits

- Drug use progresses from oral drugs and smoking to injecting.
- Injecting is a hidden activity
- Injecting occurs mainly in groups, with male partner or alone.

Among respondents, drug use often followed a path that started with using alcohol, cheap prescription drugs, including tranquilizers and/ or smoking cannabis; progressing to smoking heroin and finally to injecting heroin.

“Women usually start smoking cigarettes that leads to trying cannabis. After that they can move to other drugs such as heroin and cocaine. At first they don’t inject heroin but use it “plata”(by heating the drug on the foil and smoking it (inhaling vapors)”. A Moroccan woman explained

In Afghanistan, women frequently mentioned use of opium preceding use of heroin. Only a few women reported having started drug use by injecting heroin. The main reason to switch from smoking heroin to injecting it was lack of money. Women explained having switched from smoking heroin to injecting only after they could no longer afford it. Others explained that injections gave them a better or stronger high and one could get the correct dosage more easily than from smoking.

“Your body is asking more and your money is getting less.”
25 years old woman from Morocco, 4 years of drug use.

Respondents reported the importance of keeping drug use a secret. Women from Egypt, Lebanon, Morocco and Tunisia stressed that the injecting venue could be anywhere as long as it was hidden. Women from Afghanistan and Pakistan, however, explained drug use as hidden only outside their home whereas at home women usually used drugs openly. The injecting venues could be an empty abandoned building, car, house of a dealer or a friend, night clubs and restaurants as well as the bathrooms of these venues. Respondents from Morocco pointed out that once they reached a certain stage of addiction, they did not care any longer of hiding it and could also inject in the street.

“They inject in hidden places. Women are different than men, they cannot inject just anywhere.” 29 years old woman from Egypt, 2 years of drug use.

Respondents explained hiding injecting sites and punctures. Women told that they try to conceal their injection sites and punctures by either injecting in places that can be covered with clothes or by putting makeup on injection sites. Those who were commercial sex workers wanted to hide injection marks from their clients and mentioned injecting themselves in their legs.

“When you look at me, you can’t see anything, you wouldn’t notice that I inject drugs, nothing appears on my body because I don’t inject anywhere.” 30 years old woman from Tunisia, 10 years of drug use.

However, some women explained that others can inject everywhere; in their legs, arms, breast, necks, especially when craving. Respondents frequently reported injecting as unpleasant and complicated. Many women commented the shift from smoking to injecting as a big step as they feared both needles and injecting itself. Women frequently relied on men (husband, partner or dealer) to inject them. Several women reported having an injector who was a male friend or an injector who performs injections for money.

“I was afraid of injecting so my friend introduced me to a male friend who taught me how to inject.” 26-year-old woman from Tunisia, 10 years of drug use.

“I buy mine and go to a guy who injects me. It is like going to a health center.”
52-year-old woman from Morocco, 32 years of drug use.

Often respondents who had injected for several years preferred injecting alone. Many women also injected with their partners and some reported injecting with dealers or with “injecting mates” who injected for them on a friendly basis or against a fee.

“I had a friend that we call “the doctor”, he was a real specialist in findings the veins and injecting for all group members, but then, they learn how to do by their own.” 23-year-old woman from Egypt, 4 years of drug use.

Women in Afghanistan reported drug use mainly occurring with husbands, other close family members or neighbors. Women who reported injecting at parties, night clubs and restaurants often injected in mixed groups with men and women. It was also common for women to join a group of men with whom they inject regularly, except in Afghanistan and Pakistan. Women from Morocco and Lebanon explained that women injection groups rarely exist among women as the dynamics in such a group were difficult. In general, women from all countries reported limited contact with other women injecting drug users.

“Women don’t inject together, there are a lot of problems between women; jealousy and envy so they cannot be friends. Women sit with men to inject or just do it alone.” 27-year-old woman from Lebanon, 9 years of drug use.

“I don’t inject with girls and I usually don’t like to mingle with other drug users.”
32-year-old woman from Morocco, 20 years of drug use.

Respondents reported that drugs are usually first supplied by a male friend, partner or friends who initiated their drug use. Often women relied on first drug contacts for longer periods of time. Later, women start contacting drug dealers themselves who deliver drugs to them. Once finances became scarce, women start to go and get the drugs from the dealers themselves. Some women would regularly visit drug dealers’ neighborhoods to get the drugs either with their friends or partners but often also alone. In Afghanistan and Pakistan, women reported relying only on family members or neighbors who brought the drugs to them at home.

“Usually girls don’t get too adventurous and buy it from the city but when they become really dependent, they can go get the drug from the Bedouins themselves.”
23-year-old woman from Egypt, 4 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Drug use proceeds from oral drugs and smoking to injecting.	All women drug users not only injectors should be targeted with HR interventions Social networks should be used to reach out women drug users.
Injecting is not socially acceptable for women; accordingly they hide this activity more than men.	Protections for confidentiality for HR services should be established. HR outreach should prioritize women.
Women inject alone, in groups in various settings including nightclubs, homes, streets, abandon houses and frequently with men.	Various entry points need to be created for outreach to capture women in different settings.

Means of financing drug use

Box #3: Key findings on financing drugs

- Women can sell their properties, steal or beg to secure financial resources for their dose.
- Sex work is an important financial resource for drugs.

Selling property

Women reported selling valuables such as gold, cars and real estate property when they needed money to finance their drug use. Often property was sold piece by piece before women engaged in other income generating activities.

“In my case, I sold gadgets and gold to get heroin. You would try to do anything to get the drug.” 28-year-old woman from Lebanon, 1.5 years drug use

“In the end I had nothing left, I sold my apartment and I did not even have a place to sleep.” 50-year-old woman from Morocco, 15 years of drug use

Stealing

Stealing was reported as a common activity to finance drug use. Often women first stole money from their homes and later from their friends, public places and shops. A couple of women mentioned engaging in kidnappings to gain money.

“Women would go to all extent to get their drugs, stealing, going out with older men and stealing their wallet, I used to rob gas stations.” 23-year-old, woman from Lebanon, 12 years of drug use

Sex work

Respondents explained that they often engaged in sex work when their regular income was not sufficient to cover their drug use, when their partner or husband stopped supporting them financially, and/or when they had no other way to earn money. Women from Morocco and Egypt explained that over time, financing their drug use became more difficult because they needed a higher dose, which was more expensive. As a result, they began selling sex. Some women from Egypt and Morocco cited selling sex occasionally but for others it was their regular income generating activity. Some women from Tunisia stated being full time sex workers in brothels. Some women in Morocco, Lebanon, Tunisia and Pakistan, reported selling sex to pay for the drugs of their partner as well, while some claimed having been pressured by their partners to sell sex. In Pakistan women also feared abuse, losing housing or being divorced if they did not sell sex to cover the cost of drugs for their partner. Women from Egypt, Lebanon, Tunisia and Morocco also reported that sex with dealers in exchange for drugs was common. Some women from Lebanon, Morocco and Egypt dated drug dealers in order to ensure their supply of drugs. Women from Afghanistan did not discuss sex work.

“I wish there was a shelter where I could sleep without having to sell sex to help my uncle and bothers to get drugs just for a roof over my head” 20-year-old woman from Pakistan, 7 years of drug use.

“I know girls who, for the sake of one injection, sleep with ten men, one after the other.” 21-years-old woman from Morocco, 8 years of drug use.

“I was sleeping from time to time with some guys, but I was not a sex worker, we were just dating and they were paying for my drugs.” 23-years-old woman from Egypt, 4 years of drug use.

■ Begging

Begging was described to be an activity that women engaged occasionally or regularly. Women from Morocco and Lebanon explained that women who did not want to steal or engage in selling sex found themselves going from door to door to beg for money to buy food and drugs.

“I chose to beg rather than become a prostitute.” 21-year-old woman from Morocco, 8 years of drug use.

■ Dealing drugs

Drug dealing could provide enough income to finance drug use. A woman from Morocco and Tunisia mentioned having been drug dealers. Several women from Pakistan admitted being involved in drug dealing to finance drug use.

“I used to deal with my partner who was a dealer. I worked with him for a while.” 20-years-old woman from Tunisia, 4 years of drug use.

“They are used by their husbands and family who inject to push and sell drugs to get more drugs for them.” 23 years old woman from Pakistan, 10 years of drug use.

■ Allowance from family

Allowance from family. Women who attended school or university from Egypt, Lebanon, Tunisia and Morocco reported receiving either regularly or once and while an allowance, “pocket money,” from their parents that they used to buy drugs. Their parents were not aware that the money was used for drugs.

■ Sharing needles

Box #4: Sharing Needles

- Sharing needles was reported as a common practice
- Women have limited awareness of risks of sharing needles
- Unavailability and inaccessibility of needles led to sharing
 - Reluctance of pharmacists to sell
 - Fear of being arrested by police
 - Inadequate financial capacities
- Social and gender context encourages needle sharing:
 - Injecting occurs after partner
 - Sharing with partner is a sign of love, trust and commitment
 - Women do not decide on needle sharing
 - Limited freedom of movement

Among respondents, sharing needles was a common practice.

Only a couple of women claimed not having shared needles ever because their injecting partners (males) insisted on using separate needles or they would inject alone at home.

“I never shared needles with my partner, he has his own equipment to inject and he never shared needles with me or with anyone else.” 21-year-old woman from Morocco, 8 years of drug use.

Respondents had limited awareness of the risks of sharing needles. Often women were not aware of risks from the onset of their drug use and, as a result, shared equipment for years. Women frequently mentioned having learned about the risks of contracting hepatitis and HIV through outreach workers or by accessing HR services.

“For years we did not know that each of us should have our own needle and syringe.” 25-year-old woman from Lebanon, 11 years of drug use.

“We used the same syringe but she washed it first, then she injected for me.” 36-year-old woman from Egypt, 1 year of drug use.

Unavailability and inaccessibility of needles led to sharing. Women frequently mentioned that especially when craving, they did not care if they used shared injection equipment. If they did not have clean injecting equipment available, they would use a needle that was found on the floor or share with anyone around at the time.

“The pain does not let you think. I was aware of the risks but they were not important by then.” 25-year-old woman from Morocco, 4 years of drug use.

“I used to pick up needles from the garbage; I didn’t care what it could do to me.” 43-year-old woman from Morocco, 25 years of drug use

Respondents explained that obtaining needles from pharmacies was a severe obstacle that encouraged the sharing of equipment. Women from Egypt, Lebanon, Tunisia, Morocco and Pakistan explained that in some areas in cities where drug use was common, pharmacies refused to sell needles and syringes without a prescription. Other pharmacies would sell syringes and needles once or twice but after that they would also refuse. Women from Egypt, Lebanon and Tunisia commonly reported obtaining needles from pharmacies located far from their house as they were also afraid that their local pharmacist would disclose their status to their families or police.

Women in Egypt, Tunisia, Lebanon and Morocco feared being arrested by police if found carrying needles and were scared to carry clean syringes.

Lack of money to buy a new needle was one of the most frequently mentioned reasons for sharing injecting equipment. Women from all countries explained that when drug users have money they have higher priorities than buying new needles and syringes such as transportation to go to dealers, extra doses of drugs or food for their children.

Social and gender context also encouraged the sharing of needles. Women from all countries explained that it was common to share syringes and needles with their partner or husband. Usually the partner prepared the drug for himself, injects himself and then prepares the drug for her and injects her using the same equipment. Women explained that sharing equipment was proof of love and it meant that the relation would continue. By sharing, women showed trust. Some respondents also claimed trusting their partner, especially women who were new injectors.

Women from Pakistan explained that sharing needles among family members was a common practice. Women were customarily given leftovers of the drugs remaining from their male family members and expected to inject after them.

“I never thought it was something bad (sharing needles), on the contrary, we were good friends sharing something together.” 50-year-old from Morocco, 15 years of drug use.

“I don’t get to choose the needle; my partner does it for me.” 25-year-old woman from Lebanon, 11 years of drug use.

“We used to use the same needles if he (husband) had a better one.” 28-year-old woman from Lebanon, 1 year of drug use.

Women who depended on men to supply them with drugs were not always sure where to obtain as their friends (male) who supplied them with drugs also brought them injecting equipment. Women also mentioned that dealers with whom they injected were likely to use a used syringe.

“We only give him money and he finds his way to get used syringes.” 21-year-old woman from Egypt, 1 year of drug use.

Some women expressed difficulty buying needles as it was not acceptable for them to leave the house frequently. In Pakistan, a few respondents claimed being locked up in their homes by family members, which made obtaining needles impossible. One respondent also explained that during the time of police crackdowns, drug users in Karachi could not leave their homes.

“They (family) would ask me where I am going so often I did not have a new syringe and needle.” 25-year-old woman from Lebanon, 4 years of drug use.

“I don’t want to make my family suspicious. They don’t think it is good that I go out so I don’t think of going to the pharmacy to get new needles.” 23-year-old woman from Lebanon, 12 years of drug use.

“I am worried that my neighbors may see me buying needles.” 40-year-old woman from Afghanistan, 15 years of drug use.

Women frequently mentioned not having decision-making power regarding sharing of needles. Some women from Lebanon, Egypt, Morocco, Afghanistan and Pakistan explained that they were not able to decide whether to share or to use a new needle as this decision was in the hands of their partner.

Women who inject in groups could share needles as a part of the social setting. Respondents explained that sharing needles brought the group members closer. In nightclubs, injecting and sharing equipment was considered a good entry point to get to know people and a way to socialize. Feelings of trust also played a role in sharing in a group as close friends were likely to share injecting equipment. This was not mentioned among respondents from Afghanistan and Pakistan.

“In a group people can choose after whom they inject. Many people wanted to inject after me because I was considered a clean girl.” 25-year-old woman from Morocco, 4 years of drug use.



Recommendations

Issues to be addressed	Operational Recommendation
Lack of awareness of needle sharing	Targeted awareness on risks of sharing injecting equipment should be promoted
Unavailability and inaccessibility of needles led to sharing of them <ul style="list-style-type: none"> - Reluctance of pharmacists to sell - Fear of being arrested by police - Inadequate financial capacities 	Advocacy and awareness rising on the importance of provision of needles in prevention of infectious disease. Advocacy and awareness about HR among police is recommended.
<ul style="list-style-type: none"> • Social and gender context encourages needle sharing: <ul style="list-style-type: none"> - Injecting occurs after partner - Sharing with partner is a sign of love, trust and commitment - Women do not decide on needle sharing. - Limited freedom of movement 	Raising awareness of needle sharing should target both men and women. Prioritization of women in needle distribution.

■ Drug overdose

Box 5: Key Findings on Overdose

- Witnessed overdoses were common across countries
- Factors inducing an overdose included mixing drugs, consuming a higher dose than usual, relapse after a period of abstinence and trying new drugs
- Women acknowledged the fatal risk of overdose
- Lack of knowledge about overdose management prevailed
- Seeking medical assistance for an overdose was not common mainly due to fear of being arrested

Overdose experiences were reported in all countries. Women had witnessed, heard of or experienced overdose themselves. However, many participants from Pakistan highlighted that overdoses are not common among women as they usually inject after their male partners and hence, receive less doses.

“We do not get overdose as the men take the first share we only get leftovers”
45-year-old woman from Pakistan, 18 years of drug use.

Reported overdoses across countries were mostly accidental, except for one participant from Lebanon who stated having purposively sought an overdose.

“I have had 4 experiences with overdose, 3 of which were done on purpose, when I was with my friends, I mixed heroin and Rivotril®.”
23-year-old woman from Lebanon, 12 years of drug use.

Factors inducing overdose included mixing different kind of drugs, consuming a higher dose than usual, relapsing after a period of abstinence and trying new drugs. Two women from Morocco acknowledged the high risk of overdose from mixing heroin and alcohol. In Afghanistan, women reported the risk due to consuming opium and heroin simultaneously.

“I experienced overdose several times especially that I was mixing different drugs at the same time. I was injecting heroin, smoking cannabis, drinking alcohol, and you know, alcohol and heroin do not go together.” 21-year-old woman from Morocco, 8 years of drug use.

Respondents across countries acknowledged the fatal risk of overdose and recognized its signs among their peers. The most common signs reported by women were the loss of consciousness and lack of responsiveness. Other indicators included difficulty breathing, weak pulse, drooling, low body temperature and shivering. In some cases, women noted that the overdose they witnessed eventually led to death.

The lack of knowledge about overdose management was obvious in all countries. Most respondents did not know how to react or help in the case of an overdose. Witnessed overdoses provoked stress and fear among women. Actions taken to handle an overdose situation varied among countries. For example, some participants from Afghanistan and Lebanon mentioned using cold water as a remedy to wake up overdose sufferers. In Morocco, two women reported slapping their friends. In Egypt, women stated that they made overdose victims smell perfumes or get them fresh air.

“I have seen girls who had an overdose; it’s very scary because I didn’t know what to do. One of the girls had an overdose once, we didn’t know what to do, we were scared that she would die and we were afraid of getting caught by the police.”
26-year-old woman from Tunisia, 10 years of drug use.

“I know someone who was lying down in the yard but recovered quickly when we used cold water.”
40-years-old woman from Afghanistan, 15 years of drug use.



“I know someone who was lying down in the yard but recovered quickly when we used cold water.” 40-year-old woman from Afghanistan, 15 years of drug use.

Two participants mentioned having received previous training on overdose management, yet they did not seem capable to handle such situation.

“I was trying to remember some of the stuff I heard from outreach workers about overdose but in vain. I was also high; I kept asking her boyfriend whether we should lay her on the right or left side. We tried calling an ambulance but we could not remember any number.” 29-year-old woman from Morocco, 9 years of drug use

“I attended a workshop on overdose prevention a few years back but it wasn’t prepared by an organization, I can’t remember much about it.” 25-year-old woman from Lebanon, 11 years of drug use

Although generally perceived as important, respondents noted that seeking medical assistance was not a common reaction to overdose. Women reported fear of being arrested by the police as the main barrier to seeking care. In particular, participants explained that the high risk of death associated with an overdose might get them into trouble. Some of the participants who witnessed overdoses among friends reported having dropped them at a care facility without staying with them. A participant from Tunisia said that her friends abandoned her without helping her seek assistance.

“When my friends saw me like this, they asked me to leave and go to my home; they didn’t want to take me to the hospital. When I went back to my friends and asked them why they let me down, they told me that they got scared; they thought that I would die.” 39-year-old woman from Tunisia, 10 years of drug use.

Overdose cases that occurred in the presence of family members (e.g. parents) were more likely to be taken to a care facility. Two respondents from Afghanistan reported seeking care in a hospital as usually women inject in their homes.

“I experienced overdose from using heroin and opium together and was admitted to hospital.” 55-years-old woman from Afghanistan, 3 years of drug use.

“I experienced overdose from using heroin and opium together and was admitted to hospital.” 55-year-old woman from Afghanistan, 3 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Lack of knowledge about overdose management.	Educate women to recognize overdose signs and involve non drug users surrounding people such as parents / partners and non drug users’ friends in the training.
Lack of healthcare seeking due to fear legal consequences.	Establish a network of friendly health care services where women can seek help for overdose cases. Train healthcare workers , especially ER workers on overdose management and patient confidentiality. Advocate for hospital base policies for proper overdose management and patient confidentiality.

Health status and access to health care

This chapter examines the health problems associated with drug use among WIDUs with a particular focus on reproductive health issues, and access to healthcare services. In addition, unsafe sexual practices are being described.

■ Health problems associated with drug use

Women reported a variety of health issues based on their own experiences or hearsay about other women who inject drugs. The main health problems faced by women were categorized as: reproductive health problems, substance use and dependence related disorders, injection related problems, and infectious diseases.

Box #6: Key findings health problems associated with drug use

- Unwanted pregnancies and unsafe abortions are the main reproductive health problems that women face
- Depression and suicidal attempts were frequent
- Lack of injecting skills engendered vein injuries with risk of severe complications.
- Fatigue and weight loss and teeth problems were associated with drug use among women.
- Withdrawal signs were a major health concern for women
- Reporting of STIs, HIV and hepatitis cases was common

Reproductive health problems

■ Menstrual irregularities

Irregular menstruation was a frequent complaint. Respondents from Morocco, Egypt, Pakistan, Lebanon and Tunisia stated that it occurred very often among women who inject drugs, particularly those who use heroin. Women stated that they can remain amenorrheic for several months or have irregular spotting every two or three months.

“Those who inject heroine have menstruation troubles; the cycle is delayed so they don’t even realize that they are pregnant. Those who inject Subutex have no issues with their cycle.” 43-year-old woman from Tunisia, 20 years of drug use.

Some participants reported that cycle irregularities were a source of anxiety because women feared becoming pregnant.

“My periods stopped so I was always worried that I was pregnant. But thank God I never got pregnant” 23-year old woman from Pakistan, 8 years of drug use.

Women with a longer drug history (5 years or more) seemed more knowledgeable about the effect of heroin on menstruation. However, the majority of women said they wouldn’t seek care for menstrual problems because it was not perceived as an important problem.

■ Loss of sexual desire

Loss of sexual desire was mentioned as a result of heroin use. Study participants from Egypt, Morocco and Lebanon stated that the loss of sexual desire is common among women who use heroin. Nevertheless, participants reported that many women who inject drugs have active sexual lives either through engaging in commercial sex work or having regular sexual activity with their partners.

“Girls who inject use sex as a means, but they have no sexual desire.”
23-year-old woman from Egypt, 4 years of drug use

■ Unwanted pregnancies

Most respondents had heard of, witnessed or personally experienced an unwanted pregnancy. In Egypt, Morocco, Lebanon, Pakistan and Tunisia, this experience was a source of anxiety and stress among women. Many women from Morocco and Egypt described unwanted pregnancies as a trap. A participant from Tunisia described it as the hardest experience she ever had since she started using drugs.



“Many girls get pregnant without even knowing. They are trapped.” 32-year-old woman from Morocco, 20 years of drug use.

“One of my friends is always scared of getting pregnant especially since she has no period.” 21-year-old woman from Morocco, 8 years of drug use.

Respondents from Egypt, Morocco, Pakistan and Tunisia explained that women who inject drugs, particularly those who sell sex, are more exposed to the risk of unintended pregnancies because of frequent sexual relationships and a lack of ability to negotiate condom use.

“Since many of these girls sell sex for money, they are exposed to unwanted pregnancies; I have seen many.” 29-year-old woman from Tunisia, 11 years of drug use.

Unwanted pregnancies occur for various reasons including non use of family planning methods, lack of self-care, and unsafe sex practices.

Most women who use heroin had menstrual irregularities which made it difficult to plan pregnancies with natural family planning methods. In addition, incorrect or non-use of contraceptives were reported frequently. Women across countries mentioned pills and condoms as contraceptive methods. Nevertheless, some participants were not aware of the correct method to use pills, which led to irregular or incorrect use. A respondent from Egypt, who proudly affirmed her use of contraceptives, explained:

“I actually use contraceptive pills, but I don’t get them from the pharmacy myself. My friend buys a box of 30 pills and we share them so she takes half and I take half. Whenever I go to meet a client, I take a pill 5 min before we go into the room. I don’t take the pills daily, I am not married and I only meet clients from time to time, so there is no need that I take the pills on a regular basis; my friend told me that.” 29-year-old woman from Egypt, 2 years of drug use

Additionally, women in Morocco and Egypt reported that pharmacists’ attitudes hindered their access to contraceptives. Women reported being embarrassed by pharmacists who ask whether they were married or not before selling the product.

In Pakistan, participants also underlined the lack of access to contraceptives as a main cause to unwanted pregnancies.

“A friend of mine buys contraceptives from pharmacies. Once the pharmacist asked her what she wants the contraceptives for and whether she is married. She said that she wanted the pills for her mother and he gave them to her.” 29-years-old woman from Egypt, 2 years of drug use.

In Pakistan, participants also underlined the lack of access to contraceptives as a main cause to unwanted pregnancies.

“Most women do not have access to contraceptives so many of these women get pregnant and have unwanted children which they sell to get more doses.” 23-year old woman from Pakistan, 8 years of drug use

Respondents from Egypt and Tunisia explained that commercial sex workers and married women were more likely to use contraceptive pills. In Tunisia, commercial sex workers reported having access to contraceptives in the “official brothels” in which they work.

“I had access to contraceptive pills and condoms in the brothel.” 43-year-old woman from Tunisia, 20 years of drug use.

“Women injecting drug users who are sex workers take precautions not to get pregnant; they buy contraceptive pills from the pharmacy and take them regularly. I heard many saying they’d rather pay EGP 35 per month (~USD 5) – which is the most expensive type of pills – and not get pregnant. This is also because they cannot negotiate condom use with clients.” 23-year-old woman from Egypt, 4 years of drug use

Cost was also reported as a hindrance to contraceptive use. Some women claimed that contraceptives were not affordable and said they preferred to use money to buy drugs instead.

Another important cause of unwanted pregnancies was lack of self-care. Women who use drugs do not care about their health and would not take precautions to avoid pregnancies. Some women reported that repeated unwanted pregnancies are frequent reaching more than seven times, as stated by this Lebanese participant:

“I had seven pregnancies, five of which I aborted using pills; I was alone and at home.” 23-year-old woman from Lebanon, 12 years of drug use.

■ Pregnancy complications

Miscarriage and stillbirth were the most common pregnancy complications reported by participants. A large number of participants reported having used drugs while pregnant which they admitted is a risk factor for miscarriage.

A woman from Afghanistan reported having had three miscarriages; two others from Lebanon and Pakistan reported two lost pregnancies. A participant from Egypt explained that drug use reduces a women's chance of becoming pregnant.

"They have miscarriages because they don't have chances to have children." 27-year-old woman from Egypt, 13 years of drug use.

"I got pregnant and lost my baby because of drugs." 27-year-old woman from Lebanon, 14 years of drug use.

Stillbirth was reported by women in Afghanistan.

"Once I was pregnant, and after 5 months I became aware of pregnancy, but when the child was born, he was dead." 55-year-old woman from Afghanistan, 8 years of drug use.

Fetal health problems were also reported by women as a complication of drug use. Participants cited low birth weight and malformations. A woman from Afghanistan and another from Tunisia stated that women who inject drugs cannot deliver "normal" babies.

"I know somebody whose child was not normal. He did not look like a normal human being; he was weak, cried a lot and had a big head." 48-year-old woman from Afghanistan, 10 years of drug use.

"Those who learn about their pregnancies at a later stage end up delivering babies with malformations, who are handicapped or who have growth problems" 28-year-old woman from Tunisia, 14 years of drug use.

"Those who deliver give birth to very weak, thin babies." 30-year-old woman from Egypt, 5 years of drug use

Participants in Pakistan reported that children born to women who inject drugs suffer from withdrawal symptoms.

"The kids are born badly and no one wants them they cry all the time as they are hooked too." 27-year-old woman from Pakistan, 10 years of drug use.

■ Voluntary abortions

In all countries, participants reported that abortion is a common practice among women who inject drugs, particularly those who have unwanted pregnancies. Respondents stated that fear of taking responsibility for a child; the feeling of worthlessness and the stigma related to extra-marital sex are the main drivers of abortion.

Moreover, participants clarified that the decision to abort is not always a choice; some women are forced to abort because of their partners. Some women revealed that abortions could be performed several times due to repeated unintended pregnancies.

"Oh my dear, I got pregnant several times and I aborted. I didn't have another choice because I was scared of the responsibility. I know many other girls who were in my situation." 39-year-old woman from Tunisia, 10 years of drug use

Across the studied area, the legal status of abortion in the country, financial factors and care providers' attitudes were the main determinants for choosing the way the means to terminate a pregnancy.

Tunisia is the only country where abortion is legal. Women stated that they could have abortions in public health centers and women who inject drugs were considered "social cases" who can receive the service for free.

"If they go there and tell them that they are poor and have no money they would help them. If they tell them that they inject drugs, they would help them because they are worried that these women would give birth to babies with malformations." 43-year-old woman from Tunisia, 20 years of drug use.

However, despite the fact that abortion is legal, Tunisian women may choose to abort at home due to fear of being caught by the police because drug use is illegal in Tunisia.

In other countries, many participants confirmed that women engage in unsafe, illegal abortions. Women from Egypt, Lebanon and Morocco explained that they go to private, "shady" clinics or use traditional methods depending on their financial status. In Pakistan, participants stated that abortions were too expensive. Unsafe abortions result in complications such as excessive bleeding or even death. A woman from Egypt explains:

"I was forced to abort and I was about to die because of it. Some women suggested giving me some herbal recipes, I used them but it didn't help so I went to see a doctor from those who have no morals. He was cheap. I was scared to death; I took a friend with me. He didn't care much about me, neither did his team. I didn't feel I was treated as a human being." 27-year-old woman from Egypt, 13 years of drug use.

"Women mostly cannot afford abortions and the ones that they can afford are unsafe and done by amateurs; one of my friends nearly died from an abortion" 23-year-old woman from Pakistan, 8 years of drug use.



Women network to find a way to have an illegal abortion. Women usually share information about doctors who can perform abortions and participants from Morocco, Egypt and Lebanon stated that it was easy to obtain this information. However, finding money to pay for such practice remains a major barrier. Women explained that they could obtain money from their male partners if the partner is known and not in favor of continuing the pregnancy.

“I know many girls who found themselves pregnant, and had to go for abortion. It’s not a big deal as long as somebody pays for it. When you have money, everything gets easy, even abortion.” 21-year-old woman from Morocco, 8 years of drug use.

Due to menstrual irregularities, many women do not realize they were pregnant until it becomes visible. This poses a problem as many women find themselves unable to terminate the pregnancy by the time they discover it.

“They find themselves pregnant and don’t even realize it because of their messed up cycle. They find out when their belly is too big and of course at this stage of pregnancy it’s too late to do anything.” 38-year-old woman from Morocco, 15 years of drug use.

“I know a friend who didn’t realize she was pregnant until she was 4 months. She wanted to keep the baby but her partner wanted her to abort. The doctor refused because he told her it’s too risky to abort at this late stage of the pregnancy.” 23-year-old woman from Egypt, 4 years of drug use.

Women who do not have an abortion end up delivering and, in some cases, they abandon their new born at the hospital. In Morocco and Pakistan, participants reported that women can also sell their new born.

“What they do is that they keep the baby and find women who cannot have kids. They make a deal: the woman keeps paying her money until she delivers and then she gives her a big sum of money to take the baby. I know of a friend who gave three of her kids to different people. Addiction doesn’t let you have feelings towards your kids, your parents or anyone; you only think of your drug.” 38-year-old woman from Morocco, 15 years of drug use.

Substance use and dependence-related disorders

■ General signs

The majority of participants across countries reported fatigue, headache, and physical weakness as general signs associated with drug use, regardless of the length of their drug history. These symptoms hinder women from engaging in activities involving physical effort due to their constant feeling of fatigue. A woman from Egypt said that even using the stairs became very difficult. Because of these signs, some participants said that women who inject drugs tend to look “sick” and appear older than their age.

“I feel my body got older, as if I became an old woman. I am no longer active. I am 25-years-old but I feel I have the body of 70 year old.” 25-years-old woman from Lebanon , 4 years of drug use.

“You can easily recognize women injecting drug users in the streets because you can see the suffering in their faces, they look very tired.” 39-years-old woman from Tunisia, over 10 years of drug use.

Weight loss was also a common complaint among women as it increased their physical weakness but it was not a cause for concern. According to participants, loss of appetite, particularly due to heroin use, lack of self-care and limited financial resources that push women to prioritize drugs over other needs, such as, food, were the main reasons behind weight loss. Nevertheless, women were not concerned about these changes. A participant from Lebanon reported that she was even happy with it.

“I was very happy that I was no longer fat.” 27-year-old woman from Lebanon, 14 years of drug use.

Women from Lebanon and Afghanistan also reported dental problems, such as teeth falling out.

“I know a woman who lost all her teeth.” 55-year-old woman from Afghanistan, 8 years of drug use.

■ Withdrawal symptoms

Respondents stated that pain associated with withdrawal was their main health concern. Across countries, it was often described as a general, intense pain that alters a women’s ability to think, assess risk situations and can even induce suicide attempts. It’s also a pain that women try to avoid. The pain is too intense that it becomes the center of their lives. A participant from Tunisia explained that with time, women become obsessed with this pain:

“They actually don’t think of anything except the pain they have when they crave. When this happens, they don’t care about anything because all they want is to satisfy their need for the drug.” 29-year-old woman from Tunisia, 7 years of drug use.

“They want to end their lives to end their pain.” 23-year-old woman from Egypt, 4 years of drug use.

Withdrawal pain could also be associated with other signs such as sweating, stomachache and vomiting.

Women adopt certain coping mechanisms to endure withdrawal pain when they cannot access drugs. A woman from Egypt reported using sleeping pills. Another woman in Morocco said she was using medications such as psychotropic pills.

“When I have no access to injections, I use Nordaz®, the red pill, cannabis, and medications; whatever friends would give.” 21-year-old woman from Morocco, 8 years of drug use.

Psychological problems

Women reported many psychological problems. The most frequent complaint was depression, followed by anxiety, stress and sleeping disorders. Respondents in all countries mentioned depression by name or indirectly through symptoms including self-isolation, feeling of worthlessness, sadness and hopelessness. Three women from Lebanon and one woman from Morocco stated that they have attempted suicide at least once in their lives, either through using medication, overdosing or jumping from a balcony. More women have reported having had suicidal thoughts without taking action. Suicide drivers included the will to feel at peace, to escape family problems, the feeling of worthlessness, the inability to face drug addiction and the desire to feel their existence recognized by those around them. Women from Morocco and Egypt mentioned religious concerns and social support as factors that prevented them from committing suicide.

“I wanted to commit suicide. I don’t know how many times I tried, I lost count.” 25-years-old woman from Lebanon, 11 years of drug use.

“I used to walk until I reach the sea and keep contemplating: what if I end this hell? I could jump and it will be all over: no drugs, no humiliation, no guilt, and no regrets; it will be the end. My family will be relieved that people are no longer gossiping about them, I will be gone. But I always had a voice coming from inside saying don’t do, when I will meet God, he would ask me, what did you do in life? I would tell him.” 50-years-old woman from Morocco, 15 years of drug use.

“I wanted to commit suicide. I don’t know how many times I tried, I lost count.” 25-year-old woman from Lebanon, 11 years of drug use.

“I used to walk until I reach the sea and keep contemplating: what if I end this hell? I could jump and it will be all over: no drugs, no humiliation, no guilt, and no regrets; it will be the end. My family will be relieved that people are no longer gossiping about them, I will be gone. But I always had a voice coming from inside saying don’t do, when I will meet God, he would ask me, what did you do in life? I would tell him.” 50-year-old woman from Morocco, 15 years of drug use.

Seeking treatment for depression was rare. Only two women (one from Lebanon and another from Morocco) reported being treated for their depression.

Participants reported that anxiety and stress are common. When they inject drugs, women seem to be easily irritated and angry. Some participants reported not being able to sleep before securing their dose. Others reported frequent shouting at their children and the inability to manage stress and anger.

“When they inject, everything gets on their nerves; they have no patience.”

43-year-old woman from Tunisia, 20 years of drug use.

“I get nervous very quickly and always shout and fight with the kids.”

35-year-old woman from Afghanistan, 8 years of drug use.

Respondents in all countries reported sleeping disorders, namely insomnia and excessive sleepiness. Insomnia was associated with anxiety related to not securing drugs and psychological problems. Some participants from Egypt mentioned that they were oversleeping during the day due to headache and tiredness.

“Mentally I don’t feel well; I am sleepless.” 40-years-old woman from Afghanistan, 14 year of drug use.

“I can’t sleep well at night and when I wake up, my whole body aches. I have back pain, headache, every bone in my body is painful. I can’t sleep before getting money under my pillow to secure my morning dose, otherwise I wouldn’t sleep.”

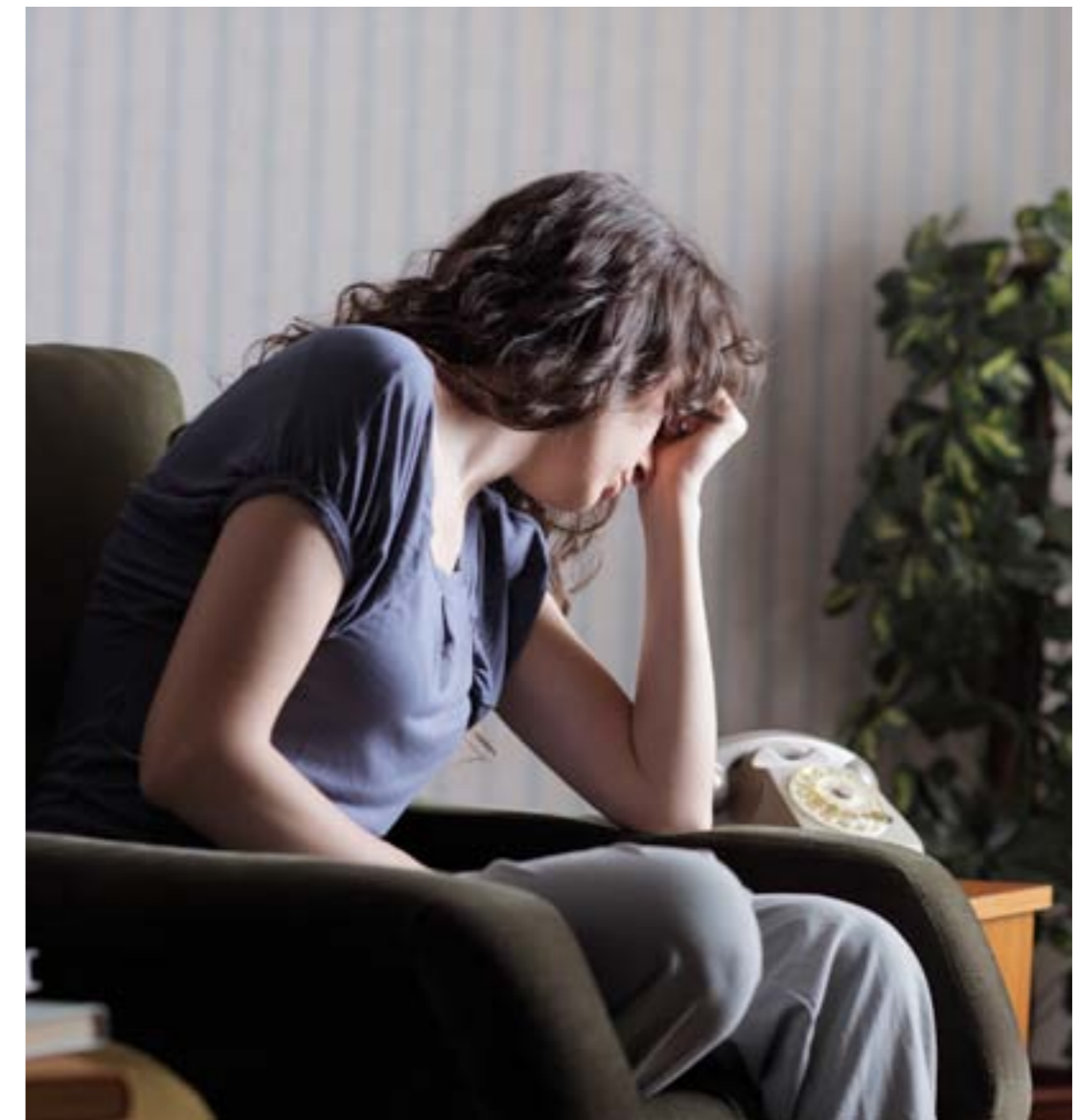
50-year-old woman from Morocco, 15 years of drug use.

Injection related problems

Health problems related to injections are common. The most cited problems were vein collapses, abscesses and inflammation at injection sites. Women reported that due to frequent injection in the same site, veins become “rigid”, “dead”, “dry” or “fibrotic.” Collapsed veins were reported as a cause of anxiety among women because drugs cannot enter the body properly and this pushes them to inject anywhere else.

“Their veins get blocked.” 26-year-old woman from Tunisia, 10 years of drug use.

Participants also reported that bruises, abscesses and inflammations are common problems associated with vein injuries. Lack of injecting skills was the main cause of these injuries. Some participants named examples of complications due to veins injuries such as lameness, limb heaviness and even amputation.



“My veins are very thin so when I inject, my arm gets inflamed and I stay for an hour without moving. I inject to calm my withdrawal pain but then other pain starts.” 29 years-old woman from Tunisia, 11 years of drug use.

“I know of other girls who are now walking with a cane because they injected in the wrong place and got their legs damaged because of multiple abscesses.” 38-years-old woman from Morocco, 15 years of drug use.

“Their bodies become blue because of a needle stick and if they inject in a wrong place, it gets inflamed.” 64-years-old woman from Lebanon, 48 years of drug use.

■ Infectious diseases

Participants reported that (STIs) and viral Hepatitis were common infections among WIDUs. Women cited symptoms including a burning sensation while urinating, itching and smelly discharge, suggesting urinary infections and STIs. One participant from Egypt reported being HIV positive, a participant from Pakistan reported that her mother died of HIV and many other participants reported having heard of HIV infections among WIDUs.

“I see that 90% have problems and have Hepatitis C, HIV and infections.” 29-year-old woman from Tunisia, 11 years of drug use .

The majority of participants in all countries related STIs with sex work, stating that sex workers who inject drugs were more prone to these infections. Some women were aware that multiple sex partners, unprotected sex and sharing needles were the main risk factors for STIs. Other participants stated that women are often not aware of the risk factors that expose them to such infections.

“Commercial sex workers expose themselves to many health problems, namely HIV and Hepatitis, especially when they don’t use condoms.” 35-year-old woman from Afghanistan, 8 years of drug use

Most respondents acknowledged the serious nature of both STIs and hepatitis and their consequences. Women mentioned low immunity, increased likelihood of infections, constant feeling of tiredness and weight loss as the main problems associated with STIs.

Recommendations

Issues to be addressed	Operational Recommendation
Unwanted pregnancies and reproductive health issues are frequent	HR services should include family planning and reproductive health services
Complications during pregnancy are common	HR services should include follow up for pregnant women
Unsafe abortions put women at risk	HR services should include awareness raising of harms related to unsafe abortions
Psychological problems including depression and suicide are widespread	Psychiatric and psychological support should be included in HR
Injecting related problems cause severe vein damage	HR programs should educate women on safe injecting skills
STIs and HIV are common health problems	HIV and STI services should be integrated as part of HR services

■ Access to healthcare services

Box #7: Key findings on access to care

- Access to care is limited
- Stigma and discrimination in the healthcare setting, lack of self-care, lack of risk awareness and lack of financial resources among women are the main barriers to care.

In all countries, seeking care for health problems was very limited. Reasons underlying this behavior were similar across countries. This section addresses the main factors behind poor access to healthcare services.

■ Stigma and discrimination

Stigma and discrimination in the healthcare setting were the most important hindrances to accessing care. Respondents from all countries have experienced or witnessed stigma from healthcare workers. Women explained that the healthcare setting was the only place where their drug status ought to be known, either because healthcare workers could see injection spots during physical examination or because of the association of health complaint with drug use. For this reason, stigma against women who inject drugs seemed to be the highest in care facilities. Women mostly feared being humiliated and having their drug use status disclosed to family or police.

“Some girls inject in the wrong sites and their arms get inflamed, they can’t find spots to inject so they spend nights in pain and they can’t go to the center or the hospital because of fear. This has to change; people may die because of such problems.” 30-year-old woman from Tunisia, 10 years of drug use.

“The doctor humiliated me also and did not understand the craving the pain that I was going through.” 23 year old woman from Pakistan, 8 years of drug use.

Stigma and discrimination in the healthcare setting manifested in different ways. Participants from all countries reported verbal abuse by healthcare workers including insults, blame and gossip towards them as the most frequent problems. A participant from Tunisia reported being looked at as a “prostitute” because she was using drugs. These practices were widespread, particularly among nurses.

“We can’t go to the hospital as we will be insulted and treated as sinful. They would make us feel guilty.” 55-year-old woman from Afghanistan, 3 years of drug use.

“The only places people know [about her drug use] are hospitals and that’s why I don’t like to go there. I feel that I’m worthless; nurses keep throwing bad words and winking to each other. You feel that you are really nothing.” 36-year-old woman from Egypt, 1 year of drug use.

Equally important were the other manifestations of stigma including denial of care, delayed care, provision of differential treatment or bad quality care, distancing, and disclosure of status to family, police and other patients. Participants reported that healthcare workers treat them with disgust and scorn. Some participants from Morocco and Tunisia related these attitudes to healthcare workers’ fear of HIV infection or other infections associated with drug use. A woman from Tunisia shared:

“They said they should operate on me but they didn’t give me any anesthesia. He cut the vein and started to look for the needle as if he is trying to get a fish in the water. I was in pain and they were telling me: you deserve to die, you are nothing, and you are worthless. Your life is like your death. His [the doctor’s] moves were all nervous; I felt he was disgusted by me, as if he was forced to treat me.”

29-year-old woman from Tunisia, 11 years of drug use.

*“No gynaecologist wanted to touch me I was told to go away and that I did not deserve to be a mother. I was so humiliated that I did not go back and I was scared so much so that I had my baby at home he was born so weak”*34-years old woman from Pakistan, 16 years of drug use.

Physical violence by healthcare workers was also reported by respondents. Women from Tunisia, Lebanon and Morocco shared experiences where they were beaten or tied to a bed by nurses and other healthcare workers. A participant from Lebanon reports:

“I was beaten, and when I was having a withdrawal symptom, I would be strapped in the gown. And once, a nurse even put a sock in my mouth so I would stop screaming.”

25-year-old woman from Lebanon, 11 years of drug use

Participants reported that stigma and discrimination occurred mainly in public and governmental healthcare facilities where services were free of charge. Women who accessed care in the private sector stated that healthcare attitudes were generally different, and did not include blaming or other forms of stigma. However, some participants explained that they did not receive friendly services and had the general feeling that healthcare workers only cared about money and not about their health status. A participant from Morocco commented on her delivery experience saying:

“There [referring to private clinics], it doesn’t matter if you are a drug user or not, what matters is money. You give them money, they shut their mouths. If you are poor, they would make your life hell. It applies to all health services, not only in delivery, you can pay, you can go to the best clinics in Tangiers and get the best care, otherwise, they treat you like a dog.” 43-year-old woman from Morocco, 25 years of drug use.

■ **Health is not a priority**

Many respondents reported that health is not a priority for women who inject drugs. Women would not think of seeking care, simply because they do not care about their health. Participants reported that women may use drugs to ease pain associated with dental or back problems. Women also explained that drug use becomes the central and sole interest in their lives and hence other matters are not prioritized. A participant from Morocco explains:

“They [women who inject drugs] don’t think well, they are able to use their brains or to make decisions. They don’t care about anything in the world except their drug; their health is not important.”
52-year-old woman from Morocco, 32 years of drug use.

■ **Lack of awareness about risks**

Women do not seek care because they are also unaware of the risks and consequences of their health problems. In fact, many participants engaged in high risk sexual and injecting behaviors but were rarely aware of the consequences of their acts. Additionally, women who were infected with STIs, HIV and Hepatitis did not know about the potential complications associated with these diseases, including the risk of maternal transmission during pregnancy. With the exception of Afghani participants, and some participants from Tunisia, seeking treatment for STIs was rarely reported. The exception in Afghanistan and Tunisia was because STI treatment was included in a comprehensive health care package and offered free-of-charge to women with symptoms and who accessed care in a harm reduction center – which was the case with all Afghani study participants - or worked in legal brothels in Tunisia. Also, many respondents reported pregnancy experiences or stories among peers; however, very few reported accessing prenatal care, with the exception of some married participants. Those who followed up with their pregnancies did not attend prenatal visits regularly.

■ **Financial constraints**

The majority of participants from all countries reported that lack of money is one of the most important barriers to accessing care. The services mentioned as unaffordable included medical consultation fees, medications, medical terminations of pregnancies and medical tests. Participants from Tunisia and Afghanistan particularly mentioned the high cost of hepatitis treatment:

“I have Hepatitis C but I can’t afford the treatment, it’s very expensive.”
43-year-old woman from Tunisia, 20 years of drug use.

Some participants from Egypt explained that due to financial constraints, they could consult their peers about health problems and use suggested treatments that had previously worked for some of them.

“Girls consult each other and if one of them knows about a medication, she would share it with the other.” 23-year-old woman from Egypt, 4 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Stigma and discrimination	Anti-stigma trainings towards healthcare workers should be considered Legislation and policy development stating stigma and discrimination should be considered
Lack of self-care/awareness of risks (individual level)	HR service should include self-worth building activities for women to increase their interest to care for themselves
Lack of resources	HR services should consider including financial assistance to cover health costs

■ **Unsafe sexual practices**

Box #8: Key findings on unsafe sexual practices

- Women who inject drugs engage in unsafe sexual practices, such as having multiple partners, unprotected and forced sex.
- These practices are mainly associated with a lack of risk awareness and lack of condom use.
- Gender related factors undermine condom use among women and increases their risk of infections

■ Risky sexual practices

Participants across countries reported that women engaged in unsafe sexual practices. These practices include sex with multiple partners, unprotected sex, and forced sex. The association between sex work and drug use will be discussed in the section “Sex work.”

Sex with multiple partners was reported in all countries except Afghanistan. These partners include sex clients, dealers, and boyfriends who are also typically drug users and involved in high risk injecting or sexual activities. Women explained that the need to secure their dose and in many cases, the one of their partner, was the main factor behind having sex with several partners. Three respondents from Morocco stated that women could have many clients a day:

“The more clients they have, the more money they get. In our area, clients don’t pay much; you should meet with 4 or 5 a day to secure the money you need for your dose.” 38-year-old woman from Morocco, 15 years of drug use.

“I had to sleep with many men during the day and at the night to get money for me and my husband. I was so tired.” 29-year-old woman from Morocco, 9 years of drug use.

Unprotected and forced sex were frequently reported by participants as common among women who inject drugs. In all studied countries, except Afghanistan, participants described various situations where women were unable to negotiate condom use with their partners/clients or forced to take part in risky practices such as anal sex.

■ Underlying causes of unsafe sexual practices

Limited knowledge was a common reason for unsafe sexual practices. Some respondents explained that women are not aware of the risks they are taking. A woman from Morocco did not realize that she was at risk of HIV because she only had sex with one partner:

“Besides being pregnant, I don’t see any risk of sleeping with my boyfriend without a condom. I know there is AIDS but I am not sleeping with anyone else; it was just this guy so there is no risk. As for STIs, I don’t know much about them, but I haven’t seen anything wrong with his penis so I don’t think he had a disease that he could transmit to me.” 21-year-old woman from Morocco, 8 years of drug use.

Lack of awareness about risks in general was associated with myths about transmission risks specifically as a participant from Morocco explains:

“I was not using condoms with them (clients) or contraceptive pills but luckily I never got pregnant. Nobody likes to have condoms, but I was clean, I used to clean myself very well after intercourse.” 43-year-old woman from Morocco, 25 years of drug use.

The most cited reason for not using condoms was the inability to negotiate its use with sexual partners, particularly among commercial sex workers. It was clearly stated, in all countries, that the decision to use condoms was not in the women’s hands.

“If the client doesn’t have one, I wouldn’t bring one myself and ask him to use it. It doesn’t work this way.” 25-year-old woman from Morocco, 4 years of drug use.

“The man with whom she would sleep may not have it in his mind to use a condom; he just wants her to satisfy his needs. He would force her to sleep with him without a condom; he just wants to be satisfied.” 27-year-old woman from Lebanon, 9 years of drug use.

The non-use of condoms was also an expression of love and trust in a relationship. A woman from Morocco explained that she didn’t want to lose her boyfriend.

“My boyfriend was not using a condom, he didn’t like it so I couldn’t argue with him; I didn’t want to lose him.”

21-year-old woman from Morocco, 8 years of drug use.

“I trust him, he was tested.” 23-year-old woman from Lebanon, 12 years of drug use.

Another reason attributed to non-condom use was the fact that many women do not care about their health or the risks of unprotected sex, money was their main driver and what counted more for them is to be able to buy drugs. This lack of care was exacerbated during moments of craving because women only cared about stopping the withdrawal symptoms.

“I was not using condoms; I didn’t care much about getting pregnant or about getting infections. It’s just that I didn’t care much.” 23-year-old woman from Egypt, 4 years of drug use.

Non-condom use was also associated with having sex under the influence of drugs. Many participants reported that they could only have sex when they were “high” because of their low sexual desire or to cope with humiliation. This increased the risk of unprotected sex. A participant from Lebanon explained:

“I cannot have sex now unless I’m high; I do not let anyone approach me. And this is why I do not care about using condoms because I am not really aware of it when I am high.” 24-year-old woman from Lebanon, 12 years of drug use.

Community stigma also highly influenced access and use of condoms. In Pakistan for instance, women reported that they could not buy condoms in pharmacies or shops due to high community stigma. A woman reported that religious leaders and community members would even destroy shops that sell condoms as they are considered immoral. Some participants mentioned that buying condoms was the role of male partner. A participant from Egypt mentioned that it would be perceived peculiar for women to buy condoms.

Two participants mentioned that they started using condoms after one was diagnosed with HIV infection and another got pregnant.

In Pakistan, women reported that fear of being arrested with condoms hindered its use.

Vulnerabilities among women who inject drugs

This chapter describes vulnerabilities associated with women injecting drug users. Women across countries shared experiences and stories about the changes that occurred in their lives since they had been engaged in drug use. They include experiences of violence, loss of social support, sex work, and deprivation of rights.

■ Violence associated with drug use

Box #9: Key findings on violence associated with drug use

- Violence against women who inject drugs is common
- Violence by intimate partners, male drug users and dealers deeply affect women’s lives
- Family, police and community are important violence perpetrators
- Gender roles and stigma associated with drug use are the main drivers of violence
- Perceived lack of legal protection prevents women from reporting violence experiences to authorities

Violence against women who inject drugs is well established. The majority of respondents affirmed the strong link between injecting drug use and violence against women. Across countries, violence was considered a norm that shaped the everyday life of women who inject drugs, as described by this Moroccan woman:

“These women are victims of violence everyday and by everybody.” 29-year-old woman from Morocco, 9 years of drug use.

Participants stated that women are subject to violence by various actors, namely intimate partners, male drug using peers, dealers and sex clients. Women also reported having been subject to violence by family, police, healthcare workers and the community at large. The following paragraphs describe the manifestations of violence that were reported by women in different contexts.

Recommendations

Issues to be addressed	Operational Recommendation
Lack of awareness about unsafe sexual practices	HR services should integrate awareness raising for women on unsafe sexual practices and their consequences
Lack of ability to negotiate condom use	HR services should include empowerment of women and condom negotiation skills Female condom programming should be considered
Careless attitude towards health	HR services should include self worth building activities for women to increase their interest to care for themselves

■ Intimate partner violence

Intimate partner violence was a common finding across countries. Respondents reported their own experiences or shared similar stories of other women. They explained that intimate partner violence manifested in sexual, physical and psychological abuse. Intimate partner violence experiences were not reported as sporadic events, but rather as a normal occurrence in the lives of women who inject drugs.

Sexual violence involved coerced sex with a partner or forced sex with other partners in order to secure money to buy drugs.

“My husband was forcing me to have sex with him; he was not thinking of my pleasure.” 25-year-old woman from Morocco, 4 years of drug use.

Physical aggression by partners was also a common complaint across countries. Women reported that it mainly manifested in beating, hitting and slapping.

“I had fought with my husband that day, and he had been violent with me, he slapped me on my face. This violence has been going on for a while now, since we came to Lebanon.” 28-year-old woman from Lebanon, 1.5 years of drug use.

“He was very violent, he used to beat me and insult me very often. I remember one time, he got very aggressive and he pushed my belly too harshly. I started bleeding from my vagina; it turned that I was pregnant and I lost the baby.” 32-year-old woman from Morocco, 20 years of drug use.

Many participants reported also being frequently insulted and humiliated by their intimate partners. A participant from Tunisia explained that some acts of verbal abuse could take place in public:

“Women who use drugs are exposed to violence by their boyfriends; they beat them, insult them, pour cold water on them, they spit on them in the street and in front of people but they can’t complain.” 43-year-old woman from Morocco, 20 years of drug use.

“They suffer from verbal violence from their partners. Sometimes you would feel you were raped morally and it stays in your memory forever.” 27-year-old woman from Lebanon, 9 years of drug use.



Withdrawal symptoms and being drug users were reported to encourage violent behavior of intimate partners. Many women reported their experiences and explained that their partners became violent when craving drugs. A participant from Lebanon stated that even under the influence of drugs, partners can be violent.

Some participants from Afghanistan, Lebanon, Tunisia and Morocco stated that their injecting partners could be violent for no reason. Others, namely from Tunisia and Morocco, explained that they were beaten if they didn’t bring money home to buy drugs. Some participants reported that jealousy was also a driver of violence:

“Their partners would ask them to go get money for them, but when they see them with other men, they go crazy and beat them.” 43-year-old woman from Morocco, 25 years of drug use.

■ Violence by male drug peers, dealers and sex clients

Drug peers and dealers were responsible for sexual, physical and verbal violence against women who inject drugs. Participants in Morocco, Tunisia, Lebanon and Egypt shared their own experiences of such violence.

Sexual violence was mainly perpetrated by drug dealers and sex clients but also drug using peers including forced sex and group rape. A woman from Tunisia explained that dealers force women to have sex with them to pay for the drugs or to bargain for clean syringes:

“The dealer asks you to sleep with him so that he can reduce the price. He takes you to a garden or even in the street, he doesn’t care, all he wants is to have sex. Of course they don’t like to use condoms, each one has an excuse, some say they don’t turn on, and others say they don’t like it.” 29-year-old woman from Tunisia, 11 years of drug use.

“Drug dealers take advantage of women who inject drugs. They sleep with them and get whatever they want.” 27-year-old woman from Lebanon, 14 years of drug use.

A participant from Pakistan stated that even in HR centers, male IDUs would try to abuse women sexually.

“You really have nowhere to go and when you do go to centers they are full of men who also will try to have sex with you for more doses.” 27-year old woman from Pakistan, 10 years of drug use.

Rape by dealers was also a common form of sexual violence against women who inject drugs. In all countries, women shared their own experiences or those of their peers as humiliating and destroying incidents.

“A woman who injects drugs was raped and left in the street where police picked her up.” 55-year-old woman from Afghanistan, 8 years of drug use.

“I remember a friend who was raped by one of the dealers, she was still virgin. He called her and gave her an appointment at his house to get her the drugs and when she arrived, he forced her to have sex with him.” 21-year-old woman from Morocco, 8 years of drug use.

A woman from Morocco recalled her experience of rape by a man she and others were injecting with:

“He made us take off all our clothes and forced us to have sex. He penetrated me from my anus, it was so painful and he was not using a condom. I couldn’t ask for it by any means, he had a cleaver in his hand and he could’ve killed the three of us. I felt humiliated that day; I felt weak and despised. I couldn’t do anything to this guy. I cried so much after this incident.” 21-year-old woman from Morocco, 8 years of drug use.

Participants also reported frequent episodes of verbal and physical abuse by dealers, drug peers and clients. Many women were subject to theft, beating and humiliation because they were physically unable to defend themselves.

“Male drug users or even dealers would steal their money and give them bad quality drugs; this is because they are females and weak.” 36-year-old woman from Morocco, 20 years of drug use.

Some participants reported being forced to transport drugs as men believed that police were less likely to search girls. Women also reported often being offered bad quality drugs.

“I keep moving from one neighborhood to another so that I am not under their (dealers) mercy. With time I learned how to deal with them, how to take what I want using my own way, now they all know me and I have no problem with them.” 30-year-old woman from Tunisia, 10 years of drug use.

Women reported that sex workers confronted more violence. In all countries, women acknowledged sex workers’ risk of being insulted, beaten or sexually abused by their clients or partners. Women shared stories of group rape, forced anal sex and abuse without payment.

In general, women described that female sex workers have a constant fear of being hurt by clients but have no other choice.

“Many of those I slept with were beating me and kicking me violently. Once, one point a knife at me, I run away from his house and I spent the night in the street” 21-year-old woman from Morocco, 8 years of drug use.

“He took a cutter and introduced it to her vagina. He cut her from anus to vagina and she was full of blood, they threw her naked in the street” 29-year-old woman from Morocco, 9 years of drug use.

Women who inject drugs were also subject to psychological violence by sex workers who do not inject drugs. This manifested in insults and gossip. A woman from Morocco reported that her peers spread rumors about her, stating that she had HIV so that clients do not approach her.

■ Family violence

Family violence was reported by the majority of participants. Family violence was mainly physical (beating), verbal (insults) and economic (deprivation of money). Perpetrators of violence were mostly males such as fathers, brothers, or in-laws.

“My brothers did not accept the fact that I inject drugs; they were beating me and insulting me.” 25-year-old woman from Morocco, 4 years of drug use.

“My parents gave me nothing, they don’t give me 1\$ now. My father even took my car saying that he did it because he is scared for me, but I know he is not, he is just stingy and wants to use my car because it economizes gas.” 25-year-old woman from Lebanon, 11 years of drug use.

In Pakistan, women reported being pushed to sex work by their brothers to secure their doses.

“There are some family members like brother husband who are users and they just use us to sell sex to get more doses for them” 23-year-old woman from Pakistan, 10 years of drug use.

Some respondents from Afghanistan, Lebanon, Morocco and Tunisia reported cases of violence from in-laws. This type of violence, which is mainly physical and verbal, aimed to exert power and control over the women and exacerbated their feeling of humiliation and self-loathing.

“Family tries to control you. When we went to the hospital to treat my anemia, my mother-in-law wanted us to do detox, I made it clear to her that this is my life and you cannot make me. She threatens my husband and I all the time that if we ever use again, she will throw us out of her house and keep the kids with her.” 28-year-old woman from Lebanon, 1.5 years of drug use Violence by police.

■ Violence by police

Police were reported as a major source of physical and verbal violence against women who inject drugs. Sexual abuse by police was only reported by two participants from Pakistan and Tunisia. Women from Morocco, Tunisia, Lebanon, Pakistan and Egypt stated that they have heard of stories or have personally experienced bad and humiliating treatment by police, including insults, harassments, threats and physical harm.

“I don’t want to talk about the police. They’ve done a lot of bad things to me. If this study would do something, it should address the police because they harm us a lot.” 31-year-old woman from Tunisia, 10 years of drug use.

A woman from Morocco explained that the absence of sexual abuse by police is due to their fear of getting infected from women who inject drug:

“They were insulting us, beating us but they never harassed us sexually because they fear getting infections if they touch us.” 29-year-old woman from Morocco, 9 years of drug use.

■ Community violence

Women from all countries underlined the magnitude of community violence against them. Reports of violence were psychological, physical and verbal resulting in the exclusion and marginalization of women who inject drugs. Respondents reported the community expressed feelings of hatred and despise against women who inject drugs. Women stated that they felt humiliated, belittled, insulted and treated with no dignity or respect.

“Once people know that they use drugs, particularly through injections, everything changes. They are exposed to harassment and sarcasm. People make fun of them and despise them.” 30-year-old woman from Tunisia, 10 years of drug use.

“The neighbors always insult me.” 45-year-old woman from Afghanistan, 20 years of drug use.

“Women are subject to violence, especially those who live in the street. They have no one to stand by them, so they can be beaten, raped and insulted by anyone in the street.” 36-year-old woman from Egypt, one year of drug use Conceptual drivers of violence

■ Conceptual drivers of violence

According to participants, violence mainly occurred because women who use drugs broke societal norms and did not “behave as they should.” Moreover, violence also took place due to the social position attributed to men who believe it’s their responsibility to be in control of women’s lives and decisions. With the exception of Pakistani participants, respondents noted that the violence inflicted by parents and brothers was primarily an attempt to make them quit drugs. A participant from Morocco shared:

“My brothers did not accept the fact that I inject drugs; they were beating me and insulting me. They told me that well-behaved girls don’t do these dirty things.” 25-year-old woman from Morocco, 4 years of drug use.

“Parents or brothers in particular wouldn’t accept that their girl goes out at night to buy drugs if she craves, so they beat her.” 23-year-old woman from Egypt, 4 years of drug use.

“In our society, when a man makes a mistake it’s not like when a woman does. Men can do whatever they want, it doesn’t matter, but for us, even our families treat us badly.” 64-year-old woman from Lebanon, 48 years of drug use.

Violence was also driven by stigma towards women who inject drugs. Participants across countries reported that their drug use is perceived negatively by families, healthcare workers and the community which was linked to shame and blame, connotations with sex work and gender.

■ Management of violence

None of the study participants reported their violence to authorities because they all believed that they cannot be protected by the law.

“I was once beaten by a client, he didn’t give me money and he left me in the road. But I couldn’t do anything. I can’t complain to the police, they won’t stand by me.” 29-year-old woman from Egypt, 2 years of drug use.

Women adopted various strategies to avoid violence. One general principle was to hide that they use drugs in order to avoid potential violence from family, the community and police. Some women from Morocco and Tunisia who suffered violence from intimate partners chose to leave their partners and the marital residence. In many cases, those women were already engaged in sex work and found it tiring to generate income for themselves and their partner. Women from Lebanon, Egypt, Morocco and Tunisia reported leaving their parents' houses to escape violence. Some respondents from Morocco, Tunisia and Lebanon stated that despite this violence, women find themselves obliged to stay with their partners for protection against the violence of drug dealers and other drug peers.

Recommendations

Issues to be addressed	Operational Recommendation
Violence against women occurs in various forms and by various perpetrators Intimate partner violence (IPV) and sexual violence are common	Behavior change communication can be used to raise public awareness of violence against women Gender equality training and community-based initiatives that address gender inequality and gender norms are recommended. Trainings that use principles of methods from adult education to target gender and sexual norms should be considered for prevention of IPV Counseling for victims of violence should be integrated into HR services Families and partners should be involved – family counseling and reconciliation sessions HR should build partnerships with institutions working against violence Legislation and policy development against violence towards women drug users should be considered

■ Changes in financial status due to drug use

Box #10: Key findings on changes in financial status due to drug use

- WIDUs lose all their financial resources due to drug use
- WIDUs are more financially burdened than men IDUs

Socio-cultural context creates burdens for women to finance drugs. Women from Egypt, Lebanon, Morocco, Tunisia, and Pakistan mentioned that they often had to secure drugs for their partner, themselves and food for their children whereas men were usually only responsible for financing their own drug consumption.

Women also reported difficulty making money due to socio-cultural restrictions including limitations on working outside the home. This often lead to severe family conflicts and resulted in the confiscation of women's homes. Some women also leave home as their family environment imposes too many restrictions on freedom of movement and makes financing drugs complicated. An exception was Afghanistan where women reported being able to engage in small scale income generating activities such as sewing and selling bread, that were not considered socially unacceptable. Another exception was Pakistan where women reported being coerced by family members to earn money for their drug use and having no restrictions posed on them as regards of freedom of movement.

Respondents reported that drugs were often first introduced for free by partners or friends but within a short period of time, women had to finance it by themselves. In Afghanistan, women reported being supported financially by their husbands or other family members for extensive periods of time. They also reported sometimes receiving drugs from other family members including their children.

“In the beginning, my boyfriend use to give me drugs for free but after a while he stopped. I had to find money to get my dose.” 27-year-old woman from Lebanon, 9 years of drug use.

“My husband buys the drugs for both of us. It is his responsibility. I am using drugs because of him.” 48-year-old woman from Afghanistan, 10 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Drug use makes women more financially vulnerable than men drug users	HR programs should consider income generating activities for drug users and women should be prioritized

■ Changes in social relations

This section summarizes the changes and characteristics of social relations that occurred after the initiation of drug use.

Box #11: Key findings on changes in social relations Drug use results in:

- Social seclusion, marginalization, loneliness
- Rejection by families
- Distancing from children
- Marital and relationship problems
- Loss of friendships

Drug use changes the lives of women resulting in exclusion, marginalization and loneliness. Women from all countries affirmed having been rejected by their families once their drug use was known. Women from Egypt, Lebanon, Morocco, Tunisia and Pakistan referred to the shame that families felt towards women injecting drug users. Some women from Lebanon, Morocco, Tunisia and Pakistan explained having no one to talk to.

"I went on TV and everything just got worse. Everybody knew I was a drug user. My brothers called and insulted me and told me I publicly humiliated them. My daughter called me and said I will never see her face again." 52-year-old woman from Morocco, 32 years of drug use.

Women believed that support could only come from those who were able to understand what they went through. A few women from Lebanon and Morocco described having families, in particular mothers, who had not given up on them.

..."and their families don't stand by them, especially fathers. For them, these women are a shame to the family. In some cases, mothers try to help, and can give money to their daughters to buy drugs. It's the maternal instinct." 25-year-old woman from Morocco, 4 years of drug use.

Relationships with children became distant and stressful. Respondents from Morocco, Lebanon and Afghanistan explained that their children no longer wanted to interact with them. A woman from Morocco reasoned that the distance that was established between the child and a mother who uses drugs was because of the inability of a mother to provide the necessary care for her child. A woman from Lebanon noted that women neglect their children and the children feel neglect; in turn they distance themselves from their mothers. Women from Lebanon and Afghanistan also mentioned being nervous and impatient with their children which caused great distress. Women from Morocco, Lebanon and Afghanistan also mentioned that children often try to convince their mother to stop using drugs.

"If a mother is taking drugs, she has no ties to her son, there is no relationship; the son is in his world and she is in hers. The son grows up without mother." 25-year-old woman from Lebanon, 4 years drug use.

"My children don't accept me and they criticize that if I want to be a good mother I have to stop using drugs", 55-year-old woman from Morocco, 3 years of drug use.

Drug use created great significant marital problems or problems with partners and frequently led to divorce and separation. A woman from Pakistan explained that men frequently divorced women drug users and went to marry other, healthy women. Women from Morocco and Lebanon explained that when drugs became the center of life, a wife and husband start to compete for drugs and develop different needs and priorities that turn into conflicts. Women from Lebanon, Morocco and Egypt explained that marital relations are also influenced by domestic responsibilities and financial stress posed on women who were unable to manage them with their drug use. Women from Pakistan feared losing housing if they did not meet their responsibilities as wives and as financiers of drugs.

"I had to sleep with many men during the day and in the night to get money for both me and him. I decided to leave. I left my husband and moved on." 29-year old woman from Morocco, 9 years of drug use.

"I didn't have any support from my husband. It was the opposite; I discovered drugs because of him and then he divorced me and left me with my kids." 35-year-old woman from Egypt, undisclosed number of years of drug use

Relationships with husband or partner depended on whether he was an active drug user or not. Women from all countries frequently mentioned that a husband or a partner who used drugs was rarely able to support women psychologically. An exception was in Afghanistan where women mentioned the husband as the only one who could support them. Support of husbands and partners who did not use drugs themselves was described as conditional; with a request to stop woman's use of drugs. Respondents from Pakistan believed that men who wanted women to obtain drugs for them were supportive and encouraged women drug use.

"Women cannot rely on a partner who does not use drugs. All he tries to do is to get her stop using drugs and finally he will get fed up." 24-year-old woman from Lebanon, 12 years of drug use.

"My husband is the only one who can understand me; he is the only one who knows of my drug use." 35-year-old woman from Afghanistan, 8 years of drug use.

Friendships were broken. Women from all countries explained that friends and neighbors distanced themselves from them as they did not want to be associated with drug users and especially with women who inject drugs.

"My neighbors no longer talk to me. Everyone thinks that I don't deserve their friendship." 28-year-old woman from Egypt, 8 years of drug use.

"They (neighbors) told everyone to stay away from me." 26-year-old woman from Tunisia, 10 years of drug use.

Friendships with other drug users could be established but they were based on benefits rather than genuine friendship. Women from Egypt, Lebanon, Tunisia and Morocco clarified that in friendships between drug users, everyone was looking to secure their own drugs. This was not mentioned among respondents from Afghanistan or Pakistan.

"No matter how close the friendships could be, this substance keeps them apart. Each one seeks to steal; there is no friendship any longer, just business." 64-year-old woman from Lebanon, 38 years of drug use.

Recommendations

Issues to be addressed	Operational Recommendation
Women injecting drug users live in social seclusion, marginalization and loneliness	Family mediation and reintegration strategies should be considered to be integrated into HR services HR services should include psychological support, support groups, couple counseling

■ Sex work

Box #12: Key findings on sex work

- Association between drug use and sex work is established
- Sex work is a major consequence of drug use
- Despite selling sex, many women do not identify themselves as sex workers
- Women perceive sex work as humiliating
- Sex work exposes women to sexual health problems, violence and stigma more than those who inject drugs but don't sell sex

The association between women injecting drug use and sex work was highlighted in all countries but Afghanistan where, due to cultural sensitivities, the issue of sex was not discussed during the interviews.

■ Survival sex

In general, sex work was reported as being a consequence of drug use. Given the poor socio-economic conditions of women, their social instability and the lack of support, many women found themselves left with no other choice but to sell sex to secure their drugs. The majority of respondents reported that women sell sex in exchange for money, but some women explained that they could also do it in exchange for drugs or free housing.

“Most women sell sex to get drugs. In my opinion, this is the worst violence they go through. When you reach the level of selling your meat to calm your pains, you open your legs to whoever just to get money, isn’t it justice.” 38-year-old woman from Morocco, 15 years of drug use.

A few women reported that sex work could be an entry point for drug use. Respondents explained that women who sell sex are at risk because clients may force them to use drugs.

A woman from Morocco shared:

“Sex workers are more likely to use drugs. Many clients ask them to use drugs with them, and because they are paid, they should do what the client says - to smoke with them, to inject, or whatever.” 52-year-old woman from Morocco, 32 years of drug use.

■ Denial of being a sex worker

A few women reported that sex work could be an entry point for drug use. Respondents explained that women who sell sex are at risk because clients may force them to use drugs. A woman from Morocco shared:

“From time to time I was sleeping with some guys, but I was not a prostitute. We were just dating and they were paying for my drugs.” 23-year-old woman from Egypt, 4 years of drug use.

■ Perceptions of sex work

Sex work was perceived negatively by respondents who referred to it as “selling one’s meat,” “selling one’s soul,” “doing immoral work,” “prostituting” and “being dirty.”

However, two participants from Morocco believed sex work was an advantage for women compared to men injecting drug users. One of them explains:

“Men cannot prostitute, sometimes I feel pity for them because they can’t do much to get drugs. Women can sell their bodies and they will, by any means, manage to get money.” 29-year-old woman from Morocco, 9 years of drug use.

■ Higher exposure to sexual risk, violence and stigma

Participants from Morocco, Tunisia, Lebanon, Pakistan and Egypt believed that women injecting drugs who sell sex were exposed to more risks than drug users who did not. This included sexual risks, inability to assess risk situations, violence and stigma.

Respondents reported that sex workers are at increased risk of contracting STIs including HIV/AIDS. Some women acknowledged that having multiple sexual partners and lack of condoms were important risk factors.

“They sleep with anyone, with dealers, they don’t protect themselves and hence they can get sexually transmitted diseases and other infections.” 27-year-old Lebanese woman, 14 years of drug use.

Respondents also reported that sex work was generally street based and as a result exposed women to more risks. They explained that women based in the streets were more vulnerable to rape, violence and sexual abuse, which increased the likelihood of unprotected sex. These factors were exacerbated by a general state of recklessness and lack of self-care among women.

“They can sleep with anyone to get their drugs. They just don’t care about protecting themselves.” 30-year-old woman from Tunisia, 5 years of drug use

Participants from Pakistan explained that having sex in the street reduced their chances of using a condom because they feared being arrested by the police.

Stigma against women who inject drugs was also reported to be higher towards those known to sell sex. A woman from Egypt said:

“For the community you are just garbage, you are cheap!” 27-year-old woman from Egypt, 4 years of drug use.

Across all countries, stigma towards sex workers is driven by social values and negative attitudes regarding extra marital sex. A woman explained that this was related to the “conservativeness” of society. Participants reported that stigma associated with drug use remains even after women stops using drugs. This was mainly linked to the strong social association of drug use with sex work. Sex workers were also exposed to stigma by women who inject drugs but do not sell sex.

Recommendations

Issues to be addressed	Operational Recommendation
Women do not identify themselves as sex workers	Personal risk assessment approaches should be used to increase risk perceptions of women engaging in sex work
Women engaged in sex work reported more sexual health problems than those women drug users who did not report selling sex	HR should prioritize women who inject drugs and sell sex
Violence against women who use drugs and sell sex is frequent	HR should prioritize women drug users who sell sex in gender trainings and counseling for victims of violence Income generating activities should target women who inject drugs and sell sex.

Legal consequences

Box #13: Key findings on legal consequences

- Women drug users are frequently in police custody and prison
- Women are unable to defend themselves against false accusations

Many respondents shared their experiences of being in police custody or in prison. Women feared being accused of drug use, dealing drugs, sex work and stealing, which could lead to arrest and imprisonment. An exception was in Afghanistan where most women explained that their drug use status was not known outside of their home and they had only limited interaction with people outside their houses, accordingly, they had little contact with police. Women from Morocco and Lebanon mentioned that once police arrested them for drug use, they were likely to get arrested over and over again. However, several women from Tunisia, Morocco and Lebanon pointed out that police were often more interested in arresting drug dealers than users and therefore, users were likely to be released shortly after their arrest. A woman from Morocco feared being arrested for sex work as she was married and believed the legal consequences of sex work would be more severe than for her than for an unmarried women. A woman in Egypt explained that one could get arrested for simply carrying injecting equipment. Women from Lebanon, Egypt and Morocco also described being accused of stealing and were sometimes subject to false accusations. One woman from Morocco claimed having had minimum troubles with police as she was a heroin and cocaine user who usually has money whereas police are often keen to arrest those without money. In Pakistan, women described large scale police crackdowns that targeted drug users and dealers alike.

“I was arrested several times by the police for sex work or drug use. Once I got jailed for 6 months and then for 2 years.” 45-year-old woman from Morocco, 25 years of drug use.

Most women showed no ability to protect themselves against arrests, false accusations and unlawful arrests. However one woman from Lebanon believed that being self-confident and strong saved her from trouble with the police. Another woman from Tunisia explained that women could make deals with police by identifying dealers and thereby, avoid getting arrested for drug use.



Recommendations

Issues to be addressed	Operational Recommendation
Women drug users are frequently in police custody and in prison	Police custody and prison can be good entry points for HR services
Women are often falsely accused and experience unlawful arrests	HR services should include legal counseling and trainings on “know your right” for women Training of police and law enforcement on human rights is recommended

■ Violations of rights

This section outlines the types of rights violations women experience due to their drug use. It does not include violations of rights in the healthcare setting as this is described in detail in this report in the section on access to care services.

Box #14: Types of rights violations

- Deprivation from children
- Denial of family inheritance
- Evicted from homes
- Denial of right to work or schooling
- Rejection of civil protection

Women reported fear of losing their children and shared their experiences of having being forced to give up custody of their children. In all countries, a woman’s husband, in-laws or family members were those who forced women to give up custody of their children as they did not believe they would be able to take care of them themselves. Some women from Tunisia, Morocco and Lebanon stated that they had not been able to see their children ever since they were taken away from them. A woman from Afghanistan noted that she had not only lost her children but also her legal rights in divorce due to drug use.

“Women are scared of losing their kids. The husband or parents usually take the kids from her and she knows it’s a lost battle.”
25-year-old woman from Lebanon, 4 years of drug use.

“Our children can be taken away from us by our husbands or mothers as they say we do not deserve to have kids.” 27 year old woman from Pakistan, 10 years drug use.

Denial of family heritage violated women’s rights. Women from Morocco Tunisia and Pakistan reported being denied family inheritance.

“They (brothers) even told me that they want to remove me from official documents as their sister so that I am out of the family.”
25-year-old woman from Morocco, 4 years of drug use.

“My brothers also deprived me of my share in the house. They kicked me out although it’s my right to be there.”
25-year-old woman from Morocco, 4 years of drug use.

Loss of housing created instability. Respondents from Tunisia, Morocco and Afghanistan shared their experiences of being evicted from rented apartments. In Afghanistan, women also explained that landlords used techniques such as cutting electricity and the water supply to force tenants to leave the house. In addition, women mentioned that finding a landlord that rented apartment to a family with drug users was challenging.

“I know girls who were kicked out of their houses because they inject, the owner of the house put their stuff in the street and told them you can’t live here because everybody knew that they inject drugs.” 29-year-old woman from Tunisia, 11 years of drug use

Losing government protection was critical. Women from Egypt, Lebanon, Tunisia, Morocco and Pakistan frequently mentioned that they were unable to protect themselves against various rights violations as police protection was not available to them.

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Losing government protection was critical. Women from Egypt, Lebanon, Tunisia, Morocco and Pakistan frequently mentioned that they were unable to protect themselves against various rights violations as police protection was not available to them.

“If they lose their children, they can’t go and complain because the police won’t stand by them. On the contrary, they may arrest them.” 36-year-old woman from Egypt, 1 year of drug use

Right to work or schooling can be revoked if a women’s drug use status is known. Women from Lebanon, Morocco and Egypt feared losing their job if their drug use status was disclosed.

“I lost my job because of my withdrawal symptoms. It was very hard for me to work if I was craving.” Moroccan woman, 25-year-old woman from Morocco, 4 years of drug use

“These experiences make women reluctant to seek care. They start thinking that it is better to die this way since nobody is helping.” 64-year-old woman from Lebanon, 38 years of drug use

Recommendations

Issues to be addressed	Operational Recommendation
<ul style="list-style-type: none"> • Family members can deny women’s rights to children and inheritance. • Women may face evictions from homes. • Women can be denied right to work or schooling. • Women are rejected civil protection . 	<p>HR services should include right based approaches to create awareness of human rights among women, families and police and enhance law enforcement.</p>

■ Stigma

Stigma has been described in detail throughout this report revealing how it manifests in different contexts. This section aims to show a collective picture of stigma by presenting it in a framework model that outlines the key domains of stigma, including drivers of stigma, manifestations of stigma and outcomes of stigma. The framework is built based on experienced and anticipated stigma against women who inject drugs. Experienced stigma is the discrimination based on drug use status. Anticipated stigma is the fear of ramifications should one’s drug use status become known. - See Figure 2: Stigma Framework.

Actionable drivers of stigma against women drug users

The drivers of stigma are an important domain of the stigma framework because changing these drivers is the key to reducing stigma.

Box #15: Drivers of stigma against women drug users

- Social judgments
- Intersecting stigmas with sex work and gender
- Lack of trust
- Fear of infection

■ Social judgments

Respondents believed that the values and social judgments connected to them as women drug users included being deviant, different than other people, shameful, immoral, disgusting, worthless and sinful.

Women explained that these thoughts were present among the community at large including police and healthcare workers as well as among family members and friends. They explained that the most painful feeling was having their own family despise them, especially their mothers. Many women felt they had brought shame to their family and explained that their family wished they had never existed.



■ Sex work related stigma

Respondents explained that as long as a woman was injecting she was believed to engage in immoral sexual behaviors. They also highlighted that people believed that all women who inject have sex with anyone to get their drugs.

■ Gender related stigma

Respondents explained that being a woman injecting drug user was worse in the eyes of society than being a man who injects. They believed that a man can inject drugs and still be accepted by society and family whereas women cannot. Women from Morocco and Tunisia mentioned that men who inject drugs could also be selling sex but people rarely link them to sex work. Some women also noted that they were considered bad mothers.

“My mother said that even her son did not do all that although he is a man and I am a woman” 29-year-old woman from Morocco, 9 years of drug use

Respondents believed that the way people looked at them would not change even if they stopped using drugs. Many women who had stopped using drugs claimed that stigma followed them. They believed that they would be rejected and marginalized regardless of what they did, whereas the community was more forgiving of male drug users and more willing to allow them to integrate back into society.

“If you’re a girl in our society, you will be labeled, no matter what.” 31-year-old woman from Tunisia, 10 years of drug use.

“God can forgive, people don’t.” 45-year-old woman from Morocco, 20 years of drug use.

■ Lack of trust

Respondents believed that the stigma of fear against them was caused by perceptions that women who inject drugs do not have morals and are capable of crimes including stealing anything from anyone. Moreover, several women mentioned that people feared them, believing they would encourage those around them to start using drugs.

“They think we are thieves; that’s why nobody wants to interact with drug users.” 33-year-old woman from Afghanistan, 4 years of drug use.

■ Fear of contracting infections

Respondents from Morocco, Egypt, Tunisia and Pakistan mentioned that people also often believed that women who inject drugs have infections, particularly AIDS. Women from Tunisia explained that clients feared to have sex with prostitutes who were known to inject drugs.

■ Manifestations of stigma

Manifestations of stigma are thoroughly described earlier in this report and occur in different settings. They include:

■ Distancing

People surrounding women distanced themselves from them. Everyday interactions with the community were short and for some women, the only interactions they had were with other drug users or dealers.

■ Rejection

Women were rejected, particularly by families. Male family members were especially harsh towards women. Women were evicted from their homes. Some women were no longer considered members of the family.

■ Humiliation

Women felt humiliation in various settings. They felt embarrassed when rejected food or shelter. They also often felt humiliation in healthcare facilities by being denied care or by not being offered quality of care due to their drug use. Women also experienced humiliation from the police and other government officials.

■ Denial healthcare

Denial of health services was widely reported by women from all countries.

■ Verbal abuse and gossiping

Continuous gossiping and harsh words was experienced by women in communities where their drug use was known.

■ Physical violence

Women experienced various forms of violence in a variety of settings by family members, police, neighbors and the community at large.

■ Sexual violence

Perpetuators of sexual violence included sex work clients, partners, dealers and police. Experiences of sexual violence included rape.

■ Loosing rights

Women feared losing their right to inheritance and to their children. Women also feared being expelled from universities and schools, losing their jobs or being evicted from their homes.

Stigma outcomes

Stigma resulted in the following

1. Reluctance to seek health services, enter drug treatment or seek harm reduction services.

Women reported fear of disclosure of drug use status, humiliation, verbal abuse, denial of care and violence, all of which made them unwilling to seek services.

2. Loneliness

Rejection by families and communities at large led women to cut ties with the community and often they were left alone with no one or only limited contact with other people.

3. Marginalization

Rejection and verbal abuse that labeled women drug users as “bad mothers” and “bad women” resulted in self-pity and the belief that they no longer had a place in society.

4. Negative feelings toward people

Verbal and physical abuse, humiliation and deprivation of rights resulted in negative feelings toward people.

5. Negative feelings towards men

Those who had experienced continuous physical and sexual violence by men felt acute negative feelings toward them including fear and reluctance to interact with men in their everyday lives.

6. Reluctance to stop drug use

Manifestations of stigma also resulted in feelings of desperation and hopelessness that made women unwilling to stop drug use.

7. Self-stigma

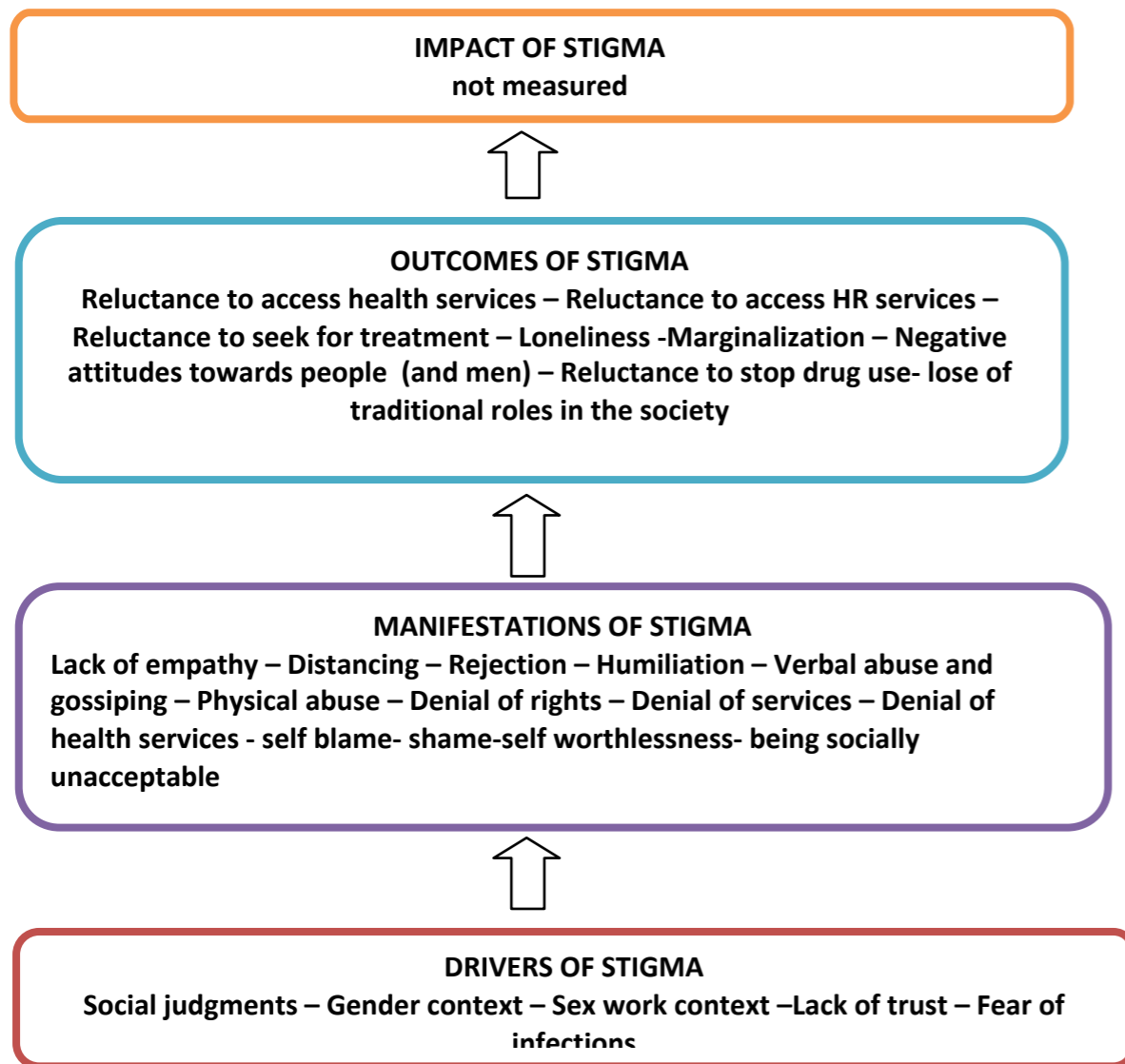
Feelings of blame, shame and worthlessness were common among women injecting drug users. Shame was linked to a feeling of being different than women who do not use drugs and a feeling of being socially unacceptable. Some women also mentioned that they felt guilt toward their children and considered bad and insufficient mothers. Some women felt guilt toward their parents whom they saw suffering due to their drug use. Women also believed that they had lost their feminine side and nobody appreciated them as women. They did not think that they could build a socially acceptable future as wives and mothers again. Some women expressed hating themselves and others expressed feelings of anger towards themselves. Some women also felt they were victims and being drawn to drug use due to life circumstances or other people. These feelings led to depression and suicidal thoughts.

"I blame myself every day because of my children; they don't have normal life because of me." 43-year-old woman from Tunisia, 20 years of drug use.

"I wish I would be a better person." 36-year-old woman from Egypt, 1 year of drug use.

"I felt ashamed of myself all the time I know I have done something wrong I deserve that my son was taken away from me, I was a bad mother." 20-years-old woman from Pakistan, 7 years of drug use.

Figure 3: Framework of perceived and experienced stigma



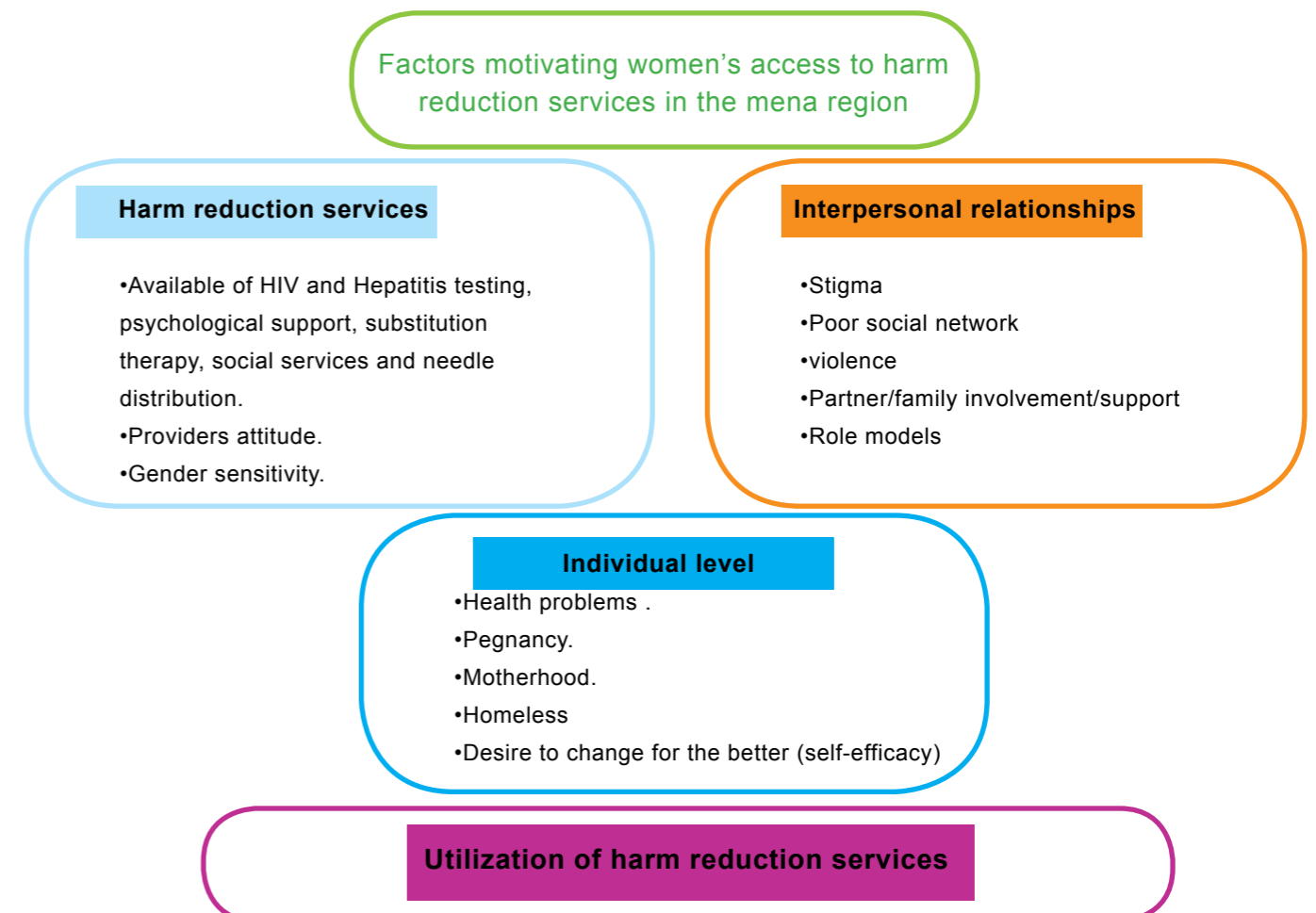
Recommendations

Issues to be addressed	Operational Recommendation
Stigma and discrimination towards WIDUs is widespread and occurs in multiple settings .	Anti-stigma advocacy efforts should be considered Legislation and anti-stigma and discriminatory laws should be encouraged .

Factors motivating women to access HR services

This section describes perceptions of women and key informants regarding factors that motivate access to HR services among women injecting drug users. The section outlines motivators in individual level, interpersonal level and HR service level.

Figure 4: Summary of factors motivating women access to HR services



Women's views

■ Individual level factors

Health status and, in particular, frequent illness and general weakness were reported as conditions that encouraged women to access HR services. Women from Pakistan, Morocco and Lebanon also believed that psychological problems, specifically depression, motivated women to seek HR service.

Motherhood was also reported to motivate women to seek HR services. A woman from Afghanistan explained that she wanted to be a better mother. In Lebanon and Morocco, several women expressed feeling guilt regarding their children, which encouraged them to seek HR services. A woman from Morocco explained that her children motivated her and supported her to seek services and continue using them. A woman from Afghanistan cited the frequent requests of her children to seek help for her drug problem was a strong motivator for her to finally access services. A woman from Pakistan explained not wanting her 3 year old child to grow up with a mother that is humiliated and mistreated.

Homelessness was mentioned by one woman from Lebanon as a motivating factor noting that without a home, women could be easily encouraged to enter HR services. She had lived in a car with her husband until they decided to access HR services which provided them with shelter as well.

Willingness to change lifestyle was one of the most frequently mentioned reasons to seek for HR services. Women from all countries believed that when one reached a condition of being "tired" and did not want to continue with the same life time, they were willing to access HR services. Women frequently expressed their desire to be "normal" and lead a "normal life" as a "normal" mother and wife. Women from Afghanistan, Egypt, Lebanon, Tunisia and Pakistan expressed hope that HR services would improve their health and help them become accepted by the community again.

Two women from Morocco explained that once earning money through prostitution became difficult, they had the desire to change their entire lifestyle and were more likely to seek HR services.

■ Interpersonal factors

Lack of social contacts also drove women to seek services. Women from Morocco and Egypt cited loneliness and the desire to have someone to talk to and who would listen. A woman from Egypt believed that having another woman in the service center to talk to would encourage women to seek services.

Family and partner support was considered essential. Women from all countries believed that a supportive partner or husband was a crucial motivator. Similarly, encouragement by other family members was believed to positively influence HR service seeking behaviors.

Role models were powerful tools to encourage women to access services. Several women mentioned being motivated after seeing a peer on substitution treatment. A woman from Tunisia said that she had not believed in HR services until she met a friend who had done so.

■ HR service related factors

The attitude of service providers was mentioned by respondents from all countries as important to encourage women to enter services. Women in Egypt, Tunisia and Pakistan explained that service providers needed to be understanding. In Morocco and Tunisia they also mentioned that respect toward women was an important motivator.

HIV and hepatitis testing were considered important motivators. Women in Egypt, Lebanon and Tunisia explained that the availability of HIV and Hepatitis testing was the initial motivator for women to access HR services. Respondents from Lebanon explained that many women had engaged in risky practices and they were keen to know their HIV status.

Services of psychologists were believed to be important. Women from Lebanon and Morocco explained that drug users – particularly those that have been using for years - were often depressed and the hope of treatment for it, more than other type of health problem, encouraged women to access HR services.

Female friendly logistics: A woman from Lebanon explained that an outpatient treatment model was often the only possible way for women to enter treatment services. She also believed that women with children could be encouraged to seek treatment through more convenient hours and locations.

Needle distribution was reported to motivate the uptake of HR services among women in Lebanon, Afghanistan and Pakistan.

Substitution treatment was considered essential. Women in Morocco, Lebanon and Pakistan mentioned that access to treatment was the ultimate motivator.

Social services were mentioned by women in Morocco. They believed that legal assistance and employment services were great ways to encourage women to access services.

Gender specific services were mentioned by all respondents in Pakistan. They believed that services for pregnant women, family planning, and STI screening and treatment and child health would encourage the uptake of HR services.

Key informants' views

Individual level facilitators

Willingness to change lifestyle was mentioned by key informants from Egypt and Morocco and Pakistan who believed that when women become tired with their lifestyles, they are more willing to try HR services.

Experiences of violence were mentioned by one key informant from Morocco who believed that when women felt they were being overly-abused they sought access HR services.

Pregnancy was also believed to motivate the uptake of HR services. Key informants from Afghanistan, Morocco, Lebanon, Egypt and Pakistan agreed that pregnancy often motivated women to look for services. Key informants explained that women who sought HR services during pregnancy did not want to lose their baby.

Motherhood was mentioned as a factor in the uptake of HR services. One key informant from Egypt believed that it was a great opportunity for women to change their lifestyles. A key informant from Pakistan believed that women with children were keen to get support as they want better life for their children. A key informant from Morocco did not think that motherhood motivated women to access services but it did provide an opportunity for outreach workers to offer various health services.

Awareness of risk practices were pointed out by a key informant in Afghanistan as motivator to access HR services

HR service related facilitators

Gender-sensitive services were considered a powerful way to encourage the uptake of HR services among women. Key informants from all countries agreed that current HR services are not “female friendly”. Key informants from different countries gave suggestions to make services more appealing for women. Key informants from Pakistan believed that services for pregnant women, family planning and STI screening and testing would be a strong motivator for women. Those from Tunisia and Morocco stressed the importance of creating a safe and stigma-free environment where women do not have to fear disclosure of their status. Key informants from Egypt considered it essential to include women in outreach work. Key informants from Morocco and Pakistan believed that centers for women only would serve them the best whereas key informants from Lebanon believed that services adapted for women in mixed centers would encourage the uptake of services. Key informants from Morocco also believed that opening hours should adjusted to fit women, that services provided should cover both women and children health, and that child care should be provided.

Shelter was believed to be an essential encouragement for many women in Pakistan who are often reliant to husband or other male family members who are drug users and who push her to use drugs and finance usage by sex work.

Substitution treatment was encouraging. Key informants from Lebanon and Morocco agreed that the availability of treatment made the uptake of services more likely. A key informant from Pakistan believed that MMT would be a powerful motivator for women to seek for HR services.

Interpersonal motivators

Relationships were strong motivators. Key informants in Egypt, Tunisia and Lebanon mentioned that women often gained a strong desire to change when they had someone in their life. The new relationship provided hope for a new start that encouraged women to seek HR services.

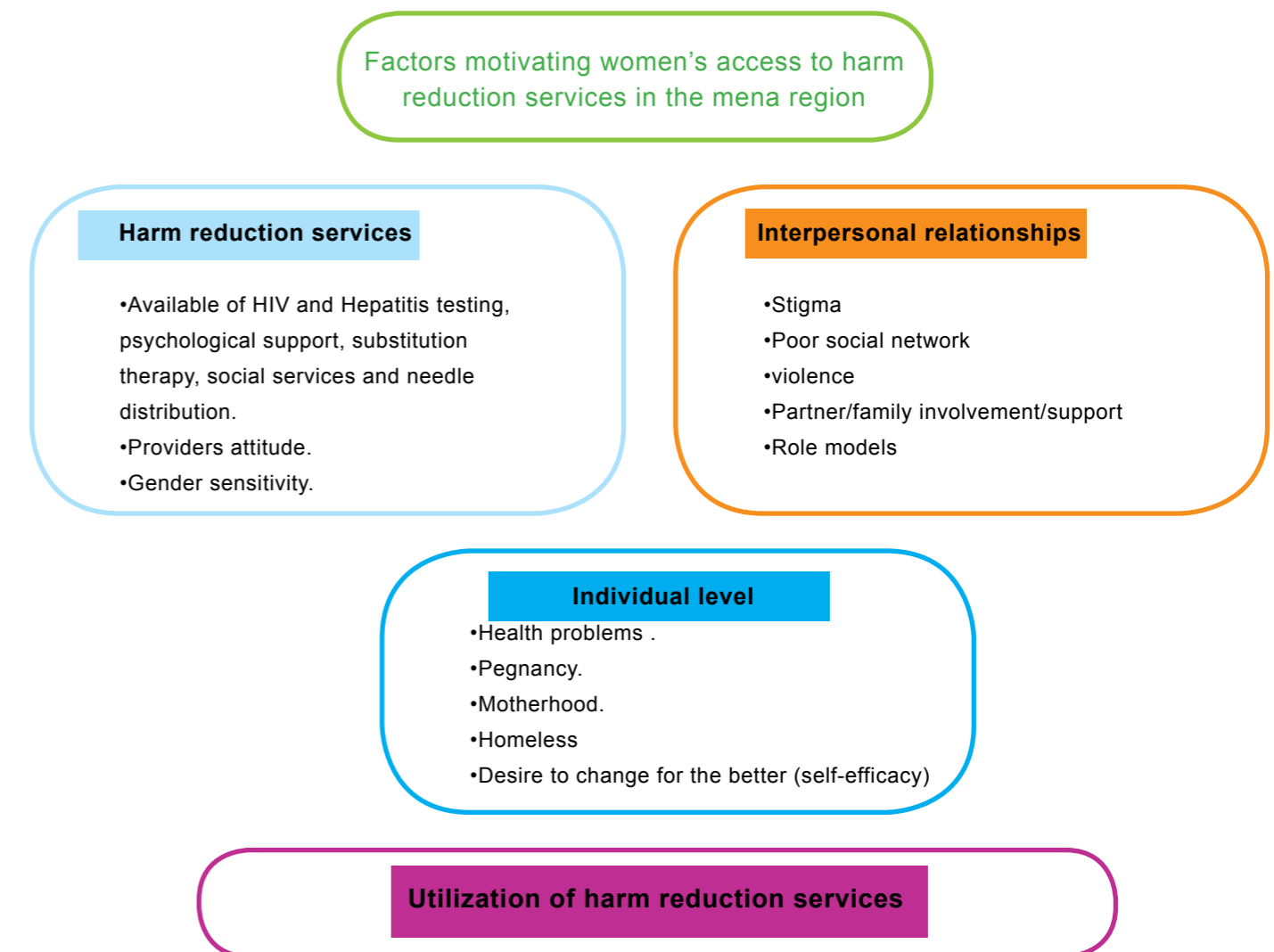
Recommendations

Issues to be addressed	Operational Recommendation
Individual level motivators	
Women are likely to seek services for health problems	Gender based health services should be integrated into HR services
Motherhood encouraged women to seek HR services	Mother and child health services should be linked to HR services
Awareness of risk practices motivates women to seek HR services	Awareness of risks related to drug use should be intensified
Interpersonal level motivators	
Lack of social contacts drove women to seek HR services	Ensuring gender sensitive psychosocial support including counseling and support groups is recommended
Husband/partner support is an important motivator for women to seek HR services	Outreach strategies should include partners
Positive examples encourage women to seek for HR services	Peer outreach approaches should be supported
Interpersonal level motivators	
Positive service provider attitude was encouraging	Extensive training to sensitize outreach workers should be considered
HR services - HIV testing, psychological services, substitution treatment, needle distribution and social service encourage women to access HR services	Creating demand and awareness of HR services should be intensified
Gender sensitive services have the potential to encourage women to seek for HR services	Gender sensitive services should be considered in design, staffing, location and services provided.

Barriers to accessing HR services

This section describes the perceptions of women and key informants regarding barriers to accessing HR services. The section is structured by following an ecological framework that divides barriers into individual levels, community-interpersonal levels, government-policy level, HR service level, and wider socio-cultural level. Respondents in this section discuss barriers related to different types of HR services and treatment options based on their knowledge, experiences and the availability of services in their setting.

Figure 5: Summary of barriers that hinder women’s access to HR services



Women's views

Individual level barriers

Self-stigma created barriers to accessing services. Women from Tunisia and Afghanistan described being ashamed to seek HR services. A woman from Morocco and another one from Lebanon explained that they did not want to admit to being drug users. Finances were repeatedly cited as a barrier to accessing services in all countries. Women explained that sometimes the transportation cost alone hindered them from accessing HR services. One woman explained that she needed to secure enough money to last for a few days before she could think of visiting a HR center.

Logistics were only mentioned as a barrier by a couple of women. Two women from Lebanon explained that their work and other commitments did not allow them to access HR services. A woman from Morocco knew that it was not possible to enter methadone maintenance treatment immediately because there was a waiting list and her fear of craving made her unwilling to access HR services. Some respondents from Pakistan believed that service location that was not conveniently close and within easy access was not likely to be used.

Community-interpersonal barriers

Fear of stigma was the most common barrier to seeking HR services. It was the strongest and most frequently mentioned barrier in all countries.

Social relations impact service-seeking behaviors

Attempts by family members to force women to seek treatment were reported to have an adverse effect on them. Respondents in Egypt, Lebanon and Morocco also believed that women with a partner or husband who was not supportive regarding HR services were unlikely to access services. Women from Pakistan feared greatly for losing their social support system including their homes if they accessed services. These women were all highly dependent on their male drug user family members.

In Afghanistan and Pakistan it was also described impossible to access services without permission of husband.

HR service related barriers

Service related barriers to seeking care included previous negative experiences with various drug treatments with relapses, fear of withdrawal symptoms when entering treatment, and beliefs that services are not beneficial.

Key informants' views

Individual level barriers

Internal stigma influences HR service seeking behavior including feelings of shame and unworthiness. Key informants from Afghanistan, Lebanon and Tunisia explained that women often lacked self-confidence and found it hard to admit being a drug user, which led to resistance to access HR service. A key informant from Pakistan believed that women who felt themselves worthless and guilty did not feel they deserve the services and accordingly they did not seek for them.

Little knowledge of services and negative beliefs related to them discouraged women from seeking HR services. Key informants from all countries believed that many women were not aware of HR services. Those from Egypt, Morocco and Tunisia also mentioned that women were often not convinced about the benefits of services.

Financial capacity was considered a problem. Key informants from Morocco and Tunisia explained that women often do not have money for transportation. In addition, they noted that women's financial priorities put drugs and food over HR services.

Community-interpersonal barriers

Perceived and experienced community stigma towards women drug users was agreed to be one of the strongest barriers to women accessing HR services with an exception of Pakistan.

Fear of lack of confidentiality regarding drug use was considered a main obstacle for women. Key informants from Lebanon and Morocco noted that stigma is especially high toward women who use drugs compared to men drug users.

Family influence was discussed at length with a key informant from Lebanon who believed that women, especially those that are younger, are often not autonomous and are unable to make decisions about accessing HR services. He believed that girls that are able to access HR services are independent and typically do not live in the family home anymore. A key informant from Afghanistan believed that fear of reactions of family and fear of losing social support are the major obstacle for accessing HR services.

Violence toward women was considered a barrier. A key informant from Afghanistan and Pakistan mentioned that attempts to access HR services may lead to domestic violence if the husband does not agree with her. Key informants in Afghanistan, Tunisia and Egypt discussed the fear of police violence as a serious barrier to accessing care. In Morocco, key informants were concerned about violence toward women in HR centers by men drug users, which they believed kept women away from the centers.

■ HR service related barriers

Services are not adapted for women's needs was frequently mentioned by key informants from all countries. A key informant from Lebanon believed that it was essential to have separate services for women even if they used the same center as men. In Morocco, Tunisia and Pakistan, key informants strongly believed that women did not only need their own services but also separate centers to avoid violence toward them to make them comfortable and likely to access services in the first place.

Health services that link women with drug use (HIV, HEPATITIS C and HEPATITIS C testing) were considered discouraging by one key informant from Afghanistan.

■ Government-policy level barriers

Fear of being arrested due to drug use that is criminalized in all countries was considered a barrier to accessing HR services.

Fear of being arrested due to possession of needles was believed to hinder needle distribution efforts as mentioned by key informants from Egypt, Lebanon, Morocco and Tunisia.

■ Socio-cultural environment

HR services are not perceived to be culturally and religiously acceptable. Key informants from Afghanistan, Egypt, Morocco and Tunisia explained that HR services were perceived by society as a form of encouragement to use drugs and have sex. One key informant from Egypt explained that many policy makers look at substitution treatment as religiously forbidden. Key informants from Lebanon, Egypt, Morocco and Tunisia believed that such perceptions towards HR hindered the political commitment of governments to support such services.

Social context related to accessing HR services was also considered problematic. Key informants from Lebanon and Morocco agreed that the marginalization of women drug users and gender based restrictions that limited freedom of movement made it difficult for women to seek HR services.

Recommendations

Issues to be addressed	Operational Recommendation
Individual level challenges	
Self stigma	Providing outreach workers with skills to alter self-stigma of women and to provide women with skills for coping with self-stigma is recommended
Financial capacity	Provision of transportation or financial compensation to HR service should be considered. Location of HR services should be convenient taking into consideration limited financial capacity of women
Interpersonal level challenges	
Stigma	Anti-stigma awareness raising campaigns can reduce stigma against drug users. They should target also police and law enforcement bodies, and religious leaders. HR services need to setup safeguards for privacy and confidentiality. Home based HR services could be considered in settings where women fear stigma or where it is culturally unacceptable for them to access services outside their home.
Lack of partner/husband and family support	Outreach should include reaching out partners and include spouse counseling and family education on HR
Violence	Providing outreach workers with skills to empower women against domestics and intimate partner violence.
Service related barriers	
Lack of gender sensitive services	Context specific gender based services should be considered to include types of services, location and timing
Government / policy level barriers	
Arrests due to drug use Arrest due to carrying needles	Advocacy against arbitrary arrests and breaches of human rights with police and ministry of interior.
Socio-cultural environment	
HR is perceived culturally and religiously unacceptable	Advocacy to sensitize religious leaders and health and government officials on HR is needed

4. Discussion



This study provided important insights into drug use among women injecting drug users in five countries in the region: Afghanistan, Egypt, Lebanon, Morocco and Tunisia. The findings highlight many similarities across the region and the need for gender-specific harm-reduction strategies.

Women and drug use are related in multiple ways to the social and gender context. Initiation of women drug use is related to relationships with men who inject drugs, which is further characterized by violence and abuse due to uneven gender balances. Initiation of drug use is also highly related to a history of physical and sexual abuse and linked to problems stemming from women breaking traditional gender norms, such as having sex outside of marriage. Intimate partner violence was especially prominent. This is in line with literature that indicates that intimate partner violence among women injecting drug users is very common and often includes physical, sexual or psychological aggression (Moore et al, 2008). Previous studies in other regions have also found intimate partner violence to be significantly higher among women who use drugs compared to non-drug-using women in the general population (Wechsberg et al, 2008; El-Bassel et al, 2011; Braitstein et al, 2003).

Study findings also highlighted the underlying gender-specific determinants of needle sharing. Women tended to use the same needle after their partner and were therefore more likely to use contaminated needles than their partners. The findings were concordant with available data from the region and elsewhere (Rafiey, 2009).

The study also showed that women frequently inject with their sexual partners. Multiple studies have found that women who inject drugs have greater overlap between sexual and injection social networks than men do, and that they are more likely than their male counterparts to have a sexual partner who injects drugs (UNODC, 2006; Doherty et al, 2000; Latkin et al, 1999; MacRae et al, 2000; Roberts A et al, 2010; Des Jarlais et al, 2012; European Monitoring Center for Drugs and Drug Addiction, 2012; Needle & Zhao, 2010; Stoicescu, 2012).

Findings also highlighted that it was socially unacceptable for women to ask for a new needle from partner, needle-sharing was thought to reflect care, trust and love, as has been seen in studies done elsewhere (UNODC, 2006). Moreover, men who injected with women decided on what needle was used.

The study revealed that women face important health hazards associated with gender. Women were exposed to unwanted pregnancies, carried out unsafe abortions and had difficulties accessing healthcare services. STIs, HIV and hepatitis B and C infections, meanwhile, were found to be common among WIDUs particularly those who engage in commercial sex. The findings confirmed the existing evidence from international literature about women's risk of unplanned pregnancy and higher exposure to hepatitis and HIV infections compared to their male counterparts (Black et al, 2012; HAARP, 2010; Naimi et al, 2003; Shapoval & Pinkham, 2011; Pinkham & Malinowska-Sempruch, 2007; Burns, 2009).

Many participants confirmed that pregnancies were discovered at a late stage due to menstrual irregularities associated with heroin use. This is known to limit women's chances to access prenatal care services and increase the risk of unsafe abortions (Shapoval & Pinkham, 2011). A lack of access to family-planning services puts women at greater risk of repeated unplanned pregnancies and increases the risk of morbidity and mortality associated with unsafe abortions. A study carried out in Iran found that pregnant women who use drugs were significantly less likely to have had access to prenatal care (Gargari et al, 2012). This was confirmed by our findings, as most participants did not have access to care services in general due to stigma, lack of self-care and financial constraints.

The study findings further highlighted that unsafe sexual practices among participants are shaped by gender determinants, hindering women from negotiating safe sex and adding to their vulnerability to HIV infection. These findings confirm the available data on WIDUs worldwide, which state that they are likely to engage in various sexual risk behaviors, including sex with multiple partners and unprotected sex (Shapoval & Pinkham, 2011). The lack of risk awareness was an important determinant for engaging in unsafe sexual practices. Data from the region suggests that it is associated with women's limited mobility, lack of education and social gender roles (UNAIDS, 2012). The study also showed that condom use was low and linked to gender vulnerabilities. Women do not have the decision-making power to use condoms whether they have sex with regular sexual partners or with sex work clients. Accordingly, condom distribution in HR centers has little benefits. These findings strongly suggest that to improve condom use, women must be empowered and/or gender-sensitive approaches should be adopted, including the promotion of female condoms.

Sex work was a common income-generating activity for women in our study. Although only a little data is available from the MENA region, they confirm linkages between injecting drug use and commercial sex in many countries, such as Egypt (FHI/ NAP, 2012), Lebanon (Mahfoud et al, 2010) and Morocco. Although study participants from Afghanistan did not discuss sex work, national drug surveys in the country in both 2005 and 2009 highlighted the alarming rates of high-risk behavior among IDUs who exchange sex for money and drugs (Country progress report-Islamic Republic of Afghanistan, 2012). In our study, engagement in survival sex – which was frequently street-based – further emphasizes the need to find safeguards to protect these women.

In addition, women in our study did not always identify themselves as sex workers, which has been identified in studies elsewhere as a hindrance to adopting safe sex (Oinam et al, 2008; Kermode et al, 2013; Kyrychenko & Polonets, 2012; Benotsch et al, 2004; United Nations Office for Drugs and Crime, 2006). This is likely to result in higher prevalence of HIV among women who use injecting drugs and who sell sex than their peers who do not (Estebanz et al, 2000). Harm-reduction programs should therefore take into account the linkages between drug use and sex work when developing services for WIDUs.

Social instability highly influenced the lives of women in our study. Women often lost their social networks and interactions with the community at large, leaving them prone to marginalization and social exclusion. Drug use negatively influenced marital life, relationships with partners and ties to children, further aggravating women's sense of loneliness. Existing literature underlines the need to provide women with social support, as they are likely to have greater social problems than their male counterparts (EMCDDA, 2006; Zilinska, 2012). Women in our study believed that drug-using men could be forgiven and reintegrated into their families, or their drug use could be overlooked by family members – but this was not the case with women drug users.

Our study did not explore housing conditions in depth, but findings revealed that some women from Morocco lived in the street for extensive periods of time, while others from Lebanon, Egypt and Tunisia had experienced periodic homelessness. However, many women in our study seemed to have found temporary shelter with partners, dealers or other drug-using friends, although it was often an unstable arrangement. HR programs should consider housing conditions when developing strategies to improve the social stability of women drug users. Homelessness has been identified elsewhere as a prominent feature among women drug users (Nair et al, 2003). It has also been associated with higher HIV risk (Wolitski et al, 2007).



Stigma greatly affected the lives of women drug users in our study. The findings highlighted the main drivers of stigma, including social judgments and intersecting stigmas to sex work and gender. In addition, stigma was driven by a lack of trust toward women injecting drug users and fears of infection. Stigma in our context was particularly high in the healthcare setting, as many women sought to reveal their drug-use status to healthcare workers to seek proper care. Stigma in the healthcare setting manifests in various ways, including humiliation, intimidation, denial of care and moral judgments against women who use drugs (Eurasian Harm Reduction Network, 2012; Myers et al, 2009). Drug users who are pregnant are more prone to stigma and discrimination, the study found. Our study provides important evidence on the outcomes of stigma among women drug users. It shows that stigma highly influences healthcare, HR services and treatment-seeking behaviors of women drug users. It was also associated with a reluctance to stop drug use. This confirms available data from international literature.

Attitudes on the part of healthcare workers remain an important barrier to care-seeking (Pinkham et al, 2012). Stigma also influences the quality of life of women, leading to severe psychological and social problems. Our findings strongly indicate that stigma-reduction strategies that address health providers, families and communities are of high public health importance.

Our study confirmed existing evidence regarding the influence of gender-specific determinants in the course of drug use among women. Harm-reduction approaches should take into account women's vulnerabilities and design targeted and gender-specific activities that aim not only at reducing physical harm associated with drug use, but which also heal the social and economic problems they face because of their drug use.

5. Conclusion notes



Harm-reduction efforts for women who inject drugs in the MENA region should be integrated within larger efforts to promote gender equality and women empowerment at different levels. Women's experiences of drug use were shaped by various gender-specific risks and barriers to access care and services. Also, poverty, the lack of education and social vulnerability put them at higher risk of infection, violence and rights violations. Interventions to reduce harm associated with drug use should therefore take into consideration larger social determinants that expose women to injecting drug-related hazards. Efforts should be redoubled to improve women's education, ensure their economic independence and increase their awareness of their rights and how to defend them.

As women's experiences of drug use differ sharply from their male counterparts, there is a need to dissociate the planning and development of women's harm-reduction activities and services from those of men. Harm-reduction approaches should prioritize women in all their activities. More financial and human resources within existing programs, meanwhile, should be dedicated to reaching out to women injecting drug users and responding to their health and social needs.

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ANNEX A- SUMMARY OF OPERATIONAL RECOMMENDATIONS

This section summarizes recommendations by dividing them into HR service related, healthcare setting related, and advocacy, legislation & policy development related recommendations. Lastly, this section summarizes recommendations how to encourage uptake of harm reduction service.

HR service related recommendations:

HR outreach

- To improve outreach of women HR programs need to use men and social networks and various entry points need to be created for outreach to capture women in different settings.
- HR outreach should prioritize women due its hidden nature.
- Protections for confidentiality for HR services should to be established.
- Police custody and prison can be good entry points of HR services.

HR target

- All women drug users not only injectors should be targeted with HR interventions.

To improve needle programming:

- Targeted awareness on risks of sharing injecting equipment should be promoted for both men and women .
- Women should be prioritized in needle distribution
- Women need be provided with knowledge to recognize overdose signs non drug users surrounding people such as parents / partners and non drug users' friends should be involved in such educational efforts.

To improve health status of women:

- HR services should include family planning and reproductive health services, follow up for pregnant women . awareness raising of harms related to unsafe abortions, Psychiatric and psychological support, and HIV and STI services.
- HR programs should educate women on safe injecting skills.
- HR services should integrate awareness raising for women on unsafe sexual practices and their consequences.
- HR services should include empowerment of women and condom negotiation skills (structural interventions).
- Female condom programming should be considered.
- HR service should include self worth building activities for women to increase their interest to care for self.

To address violence against women:

- Gender equality training and community-based initiatives that address gender inequality and gender norms are recommended.
- Trainings that use principles of methods from adult education to target gender and sexual norms should be considered for prevention of IPV
- Counseling for victims of violence should be integrated into HR services
- Families and partners should be involved – family counseling and reconciliation sessions

To improve WIDUs' rights

- HR services should include legal counseling and trainings on “know your right” women
- Training of police and law enforcement on human rights is recommended
- HR services should include right based approaches that would create awareness of human rights among women, families and police and enhance law enforcement.

To reduce vulnerabilities of WIDUs

- HR programs should consider income generating activities for drug users and women should be prioritized.
- HR services should include psychological support, support groups, couple counseling, family mediation and reintegration strategies
- HR services need to prioritize women who inject drugs and sell sex

Healthcare setting related recommendations:

To improve overdose management:

- Establishment of a network of friendly health care services where women can seek help for overdose cases should be considered to improve overdose management
- Advocate for hospital base policies for proper overdose management and patient confidentiality is crucial to facilitate access of WIDUs to medical care during overdose cases.

To improve access of WIDUs to healthcare

- Anti-stigma trainings towards healthcare workers should be considered
- Development of hospital based anti stigma policies are recommended
- HR services should consider including financial assistance to cover health costs or advocate for lower costs of services for WIDUs

Advocacy related recommendations

- Advocacy for rights of WIDUs in different settings
- Advocacy on provision of needles among police and pharmacists

Legislation, policy development and coalition building related recommendations

- HR should build partnerships with institutions working against violence
- Legislation and policy development against violence towards women drug users should be considered
- HR should advocate for policy development of human rights

Encouraging uptake of harm reduction services

To motivate access to care HR programs should consider the following strategies:

Individual level motivators:

- Health services should be integrated into HR services including mother and child health services.
- Awareness of risks related to drug use should be intensified
- Providing outreach workers with skills to alter self-stigma of WIDUS
- Provision of transportation or financial compensation to HR service should be considered.
- Convenient location of HR services

Interpersonal level motivators:

- Ensuring gender sensitive psychosocial support including counseling and support groups
- Ensuring partner support
- Using peer to reach out WIDUs
- Having stigma free services
- Providing outreach workers with skills to empower women against domestics and intimate partner violence

HR service level motivators:

- Having service provides well trained and sensitized on gender based issues
- Creating demand and awareness of HR services
- Gender sensitive services in design, staffing, location and services provided.
- Home based HR services could be considered in settings where women fear stigma or where it is culturally unacceptable for them to access services outside their home
- HR services need to setup safeguards for privacy and confidentiality

Government policy level motivators:

- Advocacy for human rights among policy makers
- Advocacy against arbitrary arrests and breaches of human rights with police and ministry of interior

Socio-cultural level motivators:

- Advocacy to sensitize religious leaders and health and government officials

ANNEX B – TOOLS AND CONSENT FORMS

Informed consent

My name is _____. I am working in a research project that aims to understand barriers to access harm reduction services of female drug users. The project is commissioned by an international nongovernmental organization MENCHARA that is based in Lebanon. The study is conducted in collaboration with xxxxx in your country.

You are kindly asked to volunteer to participate in this study by volunteering in an interview that will collect information about your background characteristics, your experiences in drug use and your opinions about factors that hinders and facilitates your access to services that are provided for female drug users in your country. There will be approximately 80 volunteers participating in this study from six countries that include Afghanistan, Egypt, Lebanon, Morocco, Tunisia and Pakistan.

Your input is very important because it will help us to think of appropriate methods to improve access to the services.

The investigators of the study believe that there are no risks from participating in this interview; it will take maximum one hour from your time.

The benefits of enrolling in the study is to help organizations and governments to know more about drug use and barriers to access to services that helps them to develop services to meet the needs of female drug users.

No information that identifies you will be disclosed in any report or publications that result from this study. Your confidentiality during the study will be ensured by using a research identification number. Your name will not appear nay paper or report and you cannot be linked to this study.

Your participation is voluntary, there will be no penalty if you do not want to participate; you are free to skip questions, or stop the interview at any time.

By your verbal approval, you give your voluntary informed consent to participate in the research as it has been explained to you. Do you agree to participate in this study?

In-depth interview guide for WIDUs

Date _____

Interviewee code _____

Name of interviewer _____

A. Ground rules

- As explained in the consent form, this interview is confidential. Everything you say in this discussion will be kept private. Your responses may be used in the report, but your name will ever be used. It is important to us that you give us your honest opinions.
- There are no rights or wrong answers. We are interested in hearing different opinions and you do not have to agree with one another.
- Do you have any questions?

B. QUESTIONS

Q1 First, I'd like us to talk about women who use injecting drugs in your country?

KEY PROBES

==>PROBE Why do they use drugs? Where do they inject drugs? With whom do they inject? What kind of drugs do they use? In what kind of situations needles might be shared? Do you know about any experiences of overdose with women injecting drug users in your country? Do you know what kind of drug treatment and service experiences women injecting drug users have in your country?

Q2. What do you know about services provided for women injecting drug users in your community?

==>PROBE: treatment, detoxification, distribution of needle, distribution of condoms, health services, HIV testing.

Q3. Now, I'd like to get some of your thought about problems that women who use injecting drugs face in your community?

KEY PROBES

- What kind of health problems they face?

==>PROBE: Unwanted pregnancies, abortions, problems during and after delivery, healthy / unhealthy babies.

==>PROBE: Infectious diseases like hepatitis B or C or HIV

==>PROBE: Psychological problems since you stated using drugs? Do they get help? Are they hospitalized? Do they receive treatment?

==>PROBE: Problems with urinary tract infections, discharge (STIs)

==>PROBE: Do they have access to health services to get help to your health problems?

- How do you think they feel about themselves?

==>PROBE: What kind of negative feelings do they have towards themselves?(feeling ashamed, feeling guilty, blaming self, blaming others, feeling that I should be punished, don't deserve being mother, feeling suicidal) (internalized stigma).

- How do you think people in your community think about women injecting drug users?

==>PROBE: From your opinion, what kind of negative feelings and ideas people may have about you because of your injecting drug use?

- What kind of experiences women who inject drugs have when dealing with the community members?

==>PROBE: Are they differently because they use drugs?

==>PROBE: Are their rights that are taken away from you because of drug use? ==>PROBE: Do health-care providers or police treat them differently than other people?

- How do negative experiences or attitudes of the community influence women who use injecting drugs?

==>PROBE: Delay in seeking care, do not seek care, get depressed, isolate, and make crimes

- How does drug use influence in friendships and relations with people?

==>PROBE: Who are the people with whom they are in contact and from they can get support for problems?

==>PROBE: Do they get family support? Do families know that they take drugs? Do they help them if you have problems? What kind of changed drug use brings to family relations?

==>PROBE: How are husband/ and or partner supporting and influencing in them? Do they support in problems? Can they talk about problems? Does the support has conditions

==>PROBE: Are there other people from whom they can get support or with whom they can talk? (Other WIDUs, friends) are in your life that provides them with support? Are there other people to whom they can talk to? (Peers, friends etc)

==>PROBE: What about relationship with children?

- What kind of violence women who use injecting drugs can confront?

==>PROBE: Beating, sexually abusing, insulting, harassing, threatening

- How does drug use influence economical status of women?

- How about related risks to drug use? What kind of risks they relate to drug use?

==>PROBE: What kinds of fears related to risks of drug use they have? Can you describe any practice that put them at risks of HIV? (Multiple partners, irregular, none condom use, commercial sex etc)

- What kind of legal consequences women may fear when they start using injecting drugs ?

==>PROBE: drug use, motherhood, custody of children, pregnancy

Q4 Tell me about your own experiences with injecting drug use?

KEY PROBES

==>PROBE: How did you start? Why did you start? With whom do you/ did you inject drugs? Any experiences with overdose? Any experiences with treatment or other services for IDUs?

Q5 what can you tell about changes in your life after starting to take injecting drugs?

Q6 (A) We want to talk about factors that influenced your decision to seek for services and or treatment?

Q6(B) We want to talk about reasons that would motivate you and factors that make it difficult for you to seek for services and or treatment?

KEY PROBES

- How specific health related problems could influence care seeking?

==>PROBE: motherhood, pregnancy, infectious diseases, depression

- How people around you can influence seeking services?

==>PROBE: Fear of changes in relationship after accessing services? Fear of losing friends and social support? Fear of reactions of husband/ partner? Fear of violence?

- How the way other people think of you influence your desire to seek for services?

==>PROBE: Fear people knowing about drug use and using against them? Fear losing access to other services, losing rights or being treated badly by authorities? Being looked as bad mother or bad wife? (Anticipated stigma, discrimination, gender norms)

==>PROBE: Motivation to be better mother, motivation to be a good woman, motivation not to have bad looks from the people

- Can you think if the way you think about yourself can influence seeking services?

==>PROBE: shame, blame, does not believe in deserving to get services or feel better (internalized stigma)

- How about different risk practices such as sharing needles or having unprotected sex? Do they influence your interest to access services?

- Could there be fear of any legal consequences when seeking for services?

- Can financial situation or location of services influence uptake of services?

- What kind of services can encourage and discourage uptake of services?

==>PROBE: mixing men and women, provider attitudes , women only services, HIV testing , treatment , availability of needles, availability of condoms, health information, location.

Q7 Are there any other issues or concerns you would like to share with us?

C. BACKGROUND INFORMATION

I would like to ask some background information before we end up the discussion. It will only take a few minutes.

1. How old are you? _____ Years
2. What is your nationality? _____
3. if non national, ask-) What is your resident status?
 migrant tourist refugee no status (visa expired) other _____
4. What is your marital status
- married divorced separated single / never married widowed
 in relationship
5. How old are your children (if any) _____
6. Are you currently pregnant yes no
7. Have you been pregnant while taking injecting drugs? yes no
8. What is your education level cannot read and write can read and write/ some schooling
 completed primary school completed preparatory school completed high school
 completed vocational/ institute level school completed university degree
9. What is your occupation?
10. What are the sources of income
- Full time employment part time employment casual work family support friend/peer support partner/ boyfriend support refused
 other _____
11. Do you have a permanent house/ home? yes no if no ask Q 11
12. Describe your housing situation partner house family house friends house shelter institution/ charity organization housing in the street hotel other refused
- Drug using history**
13. How long you been taking drugs? _____
14. Are you currently injecting drugs? yes no
15. What types of drugs do you use OR you used to use? _____

16. What type of services you have used
 drug treatment detoxification information needles condoms
 HIV testing STI testing and/or treatment psychosocial counseling support group referral to other health services/ providers other services _____

Partner / husband background characteristics (ask if husband or partner is mentioned in Q 3)

17. What is your partner/ husband educational level

D. CLOSING

OK, great. I enjoyed listening to your thoughts and ideas. They will be very helpful for our research and for improving access for WIDUS to services and treatment. We appreciate you all for coming and thank you.

In depth interview for key informants

Date _____

Interviewee code _____

Name of interviewer _____

A. GROUND RULES

As explained in the consent form, this interview is confidential. Everything you say in this discussion will be kept private. Your responses may be used in the report, but your name will never be used. It is important to us that you give us your honest opinions.

- There are no rights or wrong answers. We are interested in hearing different opinions and you do not have to agree with one another.
- Do you have any questions?

B. QUESTIONS

Q1 Tell me about harm reduction services for injecting drug users in your country.

==>PROBE: treatment, health services, HIV testing, needle distribution

Q2 What kind of specific harm reduction services if any your country has for women who inject drugs ?

Q3: Who is referring WIDUs to harm reduction services? How do they find their way to the services?

==>PROBE: health providers, family members, friends, husband

Q4 Do you have policies that may hinder access to harm reduction services for women injecting drug users?

==>PROBE: mandatory testing for HIV, custody laws, pregnancy, motherhood

Q5: What do you know about women injecting drug users in your country?

==>PROBE Why do they use drugs? Where do they inject drugs? With whom do they inject? What kind of drugs do they use? In what kind of situations needles might be shared? Do you know about any experiences of overdose with women injecting drug users in your country? ==>PROBE Why do they use drugs? Where do they inject drugs? With whom do they inject? What kind of drugs do they use? In what kind of situations needles might be shared? Do you know about any experiences of overdose with women injecting drug users in your country? Do you know what kind of drug treatment and service experiences women injecting drug users have in your country?

Q6 Describe the kind of WIDUs who access harm reduction services or treatment in your country?

==>PROBE Age, socioeconomic level, urban, rural, with children, single.

Q7 What kind of factors influence women uptake of harm reduction services? What factors hinder and what factors facilitate?

- Are there specific health problem that either motivate or discourage women?

==>PROBE: motherhood, pregnancy, infectious diseases, depression

- How people around women may influence women in seeking harm reduction services?
==>PROBE: Fear of changes in relationship after accessing services? Fear of losing friends and social support? Fear of reactions of husband/ partner? Fear of violence?

- How the way other people think of women who use injecting drugs influence desire to seek for harm reduction services?
==>PROBE: Fear people knowing about drug use and using against them? Fear losing access to other services, losing rights or being treated badly by authorities? Being looked as bad mother or bad wife? (Anticipated stigma, discrimination, gender norms)
==>PROBE: Motivation to be better mother, motivation to be a good woman, motivation not to have bad looks from the people

- Sometimes women may have negative feelings about themselves because of drug use? How would you evaluate the impact of these feelings to their willingness to seek for harm reduction services?
==>PROBE: shame, blame, does not believe in deserving to get services or feel better (internalized stigma)

- How about different risk practices such as sharing needles or having unprotected sex? Do they influence women's interest to access services?

- Could there be fears of any legal consequences when seeking for services?

- How do you evaluate financial situation of woman or location of services influencing in uptake of services?

- What kind of services can encourage and discourage uptake of services?

==>PROBE: mixing men and women, provider attitudes , women only services, HIV testing , treatment , availability of needles, availability of condoms, health information, location,

Q8. Are there any other issues or concerns you would like to share with us?

C. BACKGROUND INFORMATION

We would like to ask you next some background information about you. It will only take a few minutes.

1. What is your job title? _____
2. Your work is related to government NGO International organization private sector.
 other
3. How long have you been working with injecting drug users _____ Years
4. How long have you been working with AIDS response _____ Years
5. What are your role and responsibilities related injecting drug users
 policy making strategic planning resource mobilization program management
 project management project planning outreach
 care and treatment counseling others

5. CLOSING

OK, great. I enjoyed listening to your thoughts and ideas. They will be very helpful for our research and for improving access for WIDUS to services and treatment. We appreciate you all for coming and thank you.

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