

Rapid Situation Assessment of women who use drugs in Egypt



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Forward

*“The achievement of full human potential & of sustainable development is not possible if one half of humanity continues to be denied its full human rights and opportunities.”**

Gender equality and women empowerment are key to achieving sustainable development, peace, and justice. Any assessment of progress towards gender equality requires an understanding of the current context. While the problem of drug use is a global problem, drug use among women is often neglected as a public health issue. The UNODC World Drug Report 2022 highlights trends on drug use among women and youth. The report documents that 284 million people aged 15-64 use drugs worldwide, a 26 per cent increase over the previous decade. The increase in women rate of drug consumption and drug use disorders is evident even more rapidly than men, with almost 1 in 2 users of amphetamine-type stimulants is a woman. Women who inject drugs are also 1.2 times more likely than men to be living with HIV and to be exposed to higher risk for sexual transmission of infections.

Despite this, the treatment gap remains large with women constituting only one in five people seeking treatment, globally. Several factors are responsible to this gap including the stigma associated with drug use problems especially for women. Other factors as gender-based violence, social and economic inequality impede women access to healthcare and other services. Consequently, more resources are needed to address this gap .

“The Rapid Situation Assessment of Women who use Drugs in Egypt” is the first study of its kind bringing together a review of current evidence-based practices in the field and offer practical guidance for clinicians, policymakers, and service providers working to address the complex needs of women who use drugs. It highlights the importance of a gender-responsive approach that considers women’s specific needs and experiences and provides concrete recommendations for integrating gender considerations into drug treatment and prevention efforts. It responds to an existing gap while carrying the potential of help for women who need and seek treatment for drug use.

This study is the result of the joint work of Professor Marie-Claire Van Hout at Liverpool John Moore’s University, and the team of national consultants, including Dr. Heba Elsayed at the National AIDS Program, Dr. Raghda Elgamil at the Addiction Department of the General Secretariat of Mental Health and Addiction Treatment, and Professor Menan A. Rabie at the Ministry of Health and Population, Egypt, and the UNODC team under leadership of Tariq Sonnan. I would like to thank all contributors to the study for their foresight and contribution in addressing and underlining an important public health aspect which often goes unnoticed and neglected. Its recommendations will pave the way for providing public health services for all in equality.

Sincerely,



*Ms. Cristina, Albertin
Regional Representative,
The United Nations Office on Drugs and Crime (UNODC) for the Middle East and
North Africa.*

Abbreviations

ANHRI	Arabic Network for Human Rights Intervention
ART	Antiretroviral Therapy
ATS	Amphetamine Type Substance
CoE	Council of Europe
FSW	Female Sex Worker
GSMHAT	General Secretariat of Mental Health & Addiction Treatment
HCV	Hepatitis C Virus
HIV	Human Immune Deficiency Virus
IDU	Injecting Drug Use
MedNET	Mediterranean Network for Co-operation On Drugs And Addictions Of The Pompidou Group
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MoH	Ministry of Health
MOHP	Ministry of Health and Population
MoU	Memorandum of Understanding
MSM	Men Who Have Sex with Men
NAP	National AIDS Programme
NDO	National Drug Observatory
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Programs
OAT	Opiate Agonist Treatment
PLHIV	People Living With HIV
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RSA	Rapid Situation Assessment
SPT	Subcommittee On Prevention Of Torture And Other Cruel, Inhuman Or Degrading Treatment Or Punishment
STI	Sexually Transmitted Infections
UN	United Nations
UNODC	United Nations Office on Drugs And Crime
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WLHIV	Women Living With HIV
WWID	Women Who Inject Drugs
WWUD	Women Who Use Drugs

Executive Summary

Rationale

Women account for one in every three people who use drugs worldwide. Yet, women suffer severely from the adverse health consequences of substance use. Women who use drugs tend to progress to drug use disorders in a shorter time than men. The health and human rights impact of such invisibility can be very harmful. In many contexts, they remain a particularly hard-to-reach population, even where harm reduction programmes are in place. Stigma and discrimination fuel the covert nature of drug use and injecting and exacerbating their vulnerability within relationships.

In mid-2022, under the project XAMZ96 - HIV and AIDS Prevention, Treatment, Care and Support among people who use drugs and living in closed settings in the Middle East and North Africa, the United Nations Office on Drugs and Crime Regional Office for the Middle East and North Africa conducted a rapid situation assessment on the current situation of women who use or inject drugs as well as the availability of gender-responsive

Methodology

The primary aim was to conduct a rapid situation assessment about women who use or inject drugs in Egypt and the availability of gender-responsive addiction treatment and harm reduction services to generate comprehensive baseline information to:

- Inform policymakers by providing a comprehensive picture of women who use or inject drugs in Egypt.
- Refine a gender responsive national strategy for women who use or inject drugs.
- Inform the harm reduction and drug treatment programmes to plan and prioritize gender-sensitive harm reduction/drug treatment modalities.
- Specific objectives were to:

- Update the available information on women who use or inject drugs in Egypt.
- Describe the characteristics and impact of HIV for women who use or inject drugs who are HIV positive.
- Determine services available for women who use or inject drugs in Egypt.
- Identify harm reduction services availability for women who use or inject drugs in Egypt.
- Document services delivery gaps for women who use or inject drugs in Egypt.
- Determine the knowledge, attitude, behaviors, and practices regarding women who use or inject drugs in Egypt.
- The rapid situation assessment focused on three levels of determinants with possible implications on interventions for women who use drugs in Egypt:
 1. Level of the individual woman who uses or injects drugs and their drug using networks,
 2. Surroundings of the drug users comprising family members, addiction treatment staff, community elites, police, etc., and
 3. Policy and/or programmes available for women who use drugs and the conditions under which these programmes are made available.

A mixed methodology approach collected and analysed primary and secondary data on women who use or inject drugs in Egypt. The assessment was conducted in the period April to June 2022 and consisted of the following four complimentary phases:

Context

A comprehensive desk review was conducted of all extant literature and

government reporting relevant to women who use or inject drugs in Egypt with no limitation on publication date, including a mapping of the current government and private treatment services, and harm reduction services which support women.

Snapshot Profile

An updated profile of treatment and service user characteristics of women who use or inject drugs was sought using the National Drug Observatory reporting sheet circulated to the in/out patient government clinics, private hospitals and clinic settings that support women who use or inject drugs, and to non governmental organisations who provide harm reduction and family support services in the community, and who have women accessing their service.

Multi-stakeholder key informant interviews

In depth interviews were conducted during site visits with a purposive sample of professional key informants involved in the provision of drug treatment and harm reduction, representing the government, NGO and relevant UN agencies (n=21; 12 females, 9 males). Interviews explored the specific needs of substance-dependent women, mental health and co-morbidities, women who use or inject drugs awareness of harm reduction and addiction support services, factors motivating helpseeking, barriers to treatment intake, treatment retention and rehabilitation, and the identified needs of women who use or inject drugs for enhanced gender sensitive services in Egypt, spanning hospital and community settings.

Focus group discussions with women who use or inject drugs

Focus groups were conducted with a convenience sample of women in treatment and accessing community harm reduction (n=75). Discussions explored aspects of female vulnerability, their drug use trajectories and pathways toward drug use disorder, economic pressures, mental health and co-morbidities, awareness of current support services, factors motivating

help seeking, barriers to treatment, experiences of accessing such services, their specific needs around potential provision of gender specific services and programmes, different service responses compared to males, reasons for treatment discontinuation, sexual and reproductive health issues, and opinions around laws, policies and child custody aspects.

Findings with Recommendations

Profile: During the first half of 2022, 142 women were in treatment, representing 2% of the treatment population. The largest proportion are aged 26-30 years (25.40%), followed by 21-25 years (19.7%) and 36-40 years (16.20%). Very few are aged over 46 years. In total 282 were in treatment in 2021ⁱ. 9.9% report injecting drug use with no reported cases of needle sharing. The prevalence of heroin use (54.9%) has reduced compared to 2021, where at a prevalence rate of 68.44%, heroin was the most popular substance among women. Hashish (18.3%) and Tramadol remain popular (14.8%), but lower than reported in 2021 (Tramadol 30.85%; cannabis 28.72% respectively)ⁱⁱ. The use of Strox remains stable at 4.2%.

Drivers and Contexts

Finding: Drivers of women's drug use are often underpinned by trauma in the form of gender and intimate partner violence and bereavement.

Recommendation: Outreach for harm reduction and drug treatment and rehabilitation providers should be trained in and adopt a trauma informed gender sensitive approach.

Finding: Marital discord, fears around divorce and loss of custody of their children cause substantial stress and isolation

Recommendation: Mediation, couples and family therapy should form the

ⁱ National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

ⁱⁱ National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

basis of support and reintegration tactics at all stages of the woman's journey through harm reduction, drug treatment and rehabilitation.

Finding: Women's engagement with drugs is often initiated and facilitated by men (siblings, partners, sex work clients).

Recommendation: Community organisations should consider using women to connect with women who use or inject drugs and support them.

Finding: Social networks in the form of friendships, familial relationships, sexual relationships, and commercial sex transitioning encourage drug use.

Recommendation: Social networks at each level should be leveraged to reach, connect with and support women who use or inject drugs via harm reduction and treatment sensitisation.

Finding: women who use or inject drugs engage in various poverty and drug related crimes to support their drug habit (stealing, sex work etc.).

Recommendation: Sustainable livelihoods programming could form a key component of rehabilitation and aftercare.

Risk behaviours and harms

Finding: Injecting occurs mostly within small groups, in private settings often with injecting facilitated by the male partner.

Recommendation: All harm reduction strategies and responses should prioritise and target women who use drugs not limited to women who inject drugs

Finding: While most women know the risks associated with unsafe injecting, women who inject drugs will share needles or reuse needles if pharmacies do not provide them.

Recommendation: Targeted awareness of risks of unsafe injecting and blood borne virus transmission is warranted at community and hospital levels. Advocacy and sensitisation are warranted at community pharmacy levels to raise awareness around the importance of needle and syringe provision to

women who inject drugs. Community organisations providing harm reduction should prioritise women, particularly in needle and syringe programmes.

Finding: Sexual violations, unwanted pregnancy and unsafe abortions are faced by women who use or inject drugs and contribute to depression, anxiety, and insomnia, as well as risk of acquiring sexually transmitted infections and HIV and other bloodborne virus transmissions.

Recommendation: Harm reduction and drug treatment services should include sexual and reproductive health services underpinned by a gender and trauma informed approach. Alternatively, harm reduction and treatment services can be integrated into existing women's health clinics. Psychiatric and psychological support, and HIV VCT and Hepatitis B vaccination should form part of overall service provision.

Finding: Unsafe sexual behaviours (coerced sex, multiple partners, unprotected sex) fuel the acquisition of blood-borne viruses and sexually transmitted infections, particularly among women who inject drugs and those engaging in sex work. Inability to negotiate condom use is a characteristic of the power differentials in sex relationships.

Recommendation: All community and government services should include awareness raising and sensitisation around unsafe sexual behaviours cognisant of cultural and local dimensions. Women's empowerment programmes should include aspects of safe sex and condom negotiation.

Finding: Women who use or inject drugs are aware of risks of overdose and symptoms (sedation etc) and aware of peer overdoses and fatalities in their networks.

Recommendation: Targeted overdose training regarding signs, symptoms and peer responses should be initiated by community organisations, ideally inclusive of naloxone provision if available in Egypt. Provide local confidential service points for women who use or inject drugs to contact in the event of a

suspected overdose. Ensure that hospital policies include a gender dimension, and that emergency department staff are trained to respond to drug overdose in women in a confidential manner.

Finding: Drug displacement patterns are observed from oral and insufflation to injecting, and in reverse in attempts to reduce harm (switching from heroin to Tramadol or hash, from injecting to insufflation).
Recommendation: Community and hospital level harm reduction awareness raising initiatives should be scaled up to promote evidence-based harm reduction.

Stigma and Help-seeking

Finding: Women experience multiple levels of stigma relating to their behaviours, in terms of their gender, engagement in injecting drug use and sex work. Women who use or inject drugs are uncomfortable in group sessions due to fears of confidentiality and privacy.
Recommendation: The GSMHAT and community actors must continue to work towards reduction of stigma surrounding addiction and increase public awareness of addiction as a mental disorder. Provide outreach workers with skills to encourage women's self-esteem, and empowerment and support healthy coping skills. All efforts should assure the confidentiality of women when accessing services and, where possible, provide individual level counselling and therapy.

Finding: Discriminatory experiences by medical staff and lack of flexibility regarding admission procedures form substantial barriers. Positive service providers are important.
Recommendation: All staff at government and community levels providing drug treatment and harm reduction to women who use or inject drugs regardless of their stage of drug dependence and recovery, must complete anti-stigma (empathy) and human rights training (dignity, respect). All services, irrespective of level should include self-esteem promotion and empowerment initiatives for women. All services should be accessible and affordable to all

requiring treatment or harm reduction.

Finding: Women who use or inject drugs are frequently in contact with the criminal justice system and prison. Denial of treatment and humiliating experiences of women in prison are reported.
Recommendation: Law enforcement training in public health approaches to tackling drug dependence and human rights of women who use or inject drugs are warranted. Harm reduction and hospital settings should include legal clinics to support women. Advocacy against arbitrary arrests and human rights violations of women in detention are advised.

Finding: Harm reduction is perceived to be culturally and religiously unacceptable.
Recommendation: Advocacy to sensitise religious leaders, community elders, and government policymakers/health professionals on the evidence that supports a harm reduction approach is advised.

Finding: Opioid agonist treatment is welcomed
Recommendation: Opioid agonist treatment should be implemented and scaled up for all genders.

Finding: Connecting with women in recovery is important to women who use or inject drugs.
Recommendation: Peer outreach approaches using women as trusted connectors and role models of successful recovery must be encouraged.

Finding: Concerns around childcare hamper efforts to attend drug detoxification and rehabilitation.
Recommendation: Childcare programming and activities should be incorporated on site to facilitate intake and retention in treatment.

Finding: Financial constraints.
Recommendation: Consider mobile health units in the community, including providing take-home OAT when available and supporting transporting women to treatment settings.

Conclusion

The evidence and recommendations generated in this RSA are intended to support further development a culturally sensitive scaled up and sustainable gender responsive approach in Egypt. Gender mainstreaming and enhanced accessibility and affordability must be acknowledged as priority approaches to designing drug policies, services and community and prison-based responses. The routine consideration of the unique needs of women who use or inject drugs in all aspects of the design and delivery of future services and programmes are warranted (accessibility and availability, staffing and training of staff, programme development, and in addressing socio-economic empowerment, legal aid, trauma, and concurrent mental health disorders). A trauma-informed and trauma responsive is imperative given the vulnerabilities and prior exposure to many forms of violence of women who use or inject drugs in Egypt.

Future actions and services must be evidence based and act in accordance with human rights and medical ethics.

Government and civil society efforts to provide tailored services for women, whether in stand-alone facilities or integrated into existing women's health programming should be underpinned by gender-sensitive training for medical, community and criminal justice practitioners and sufficient continuity of care.

All future actions based on this rapid situation assessment are advised to be supported by gender budgets, adequate coverage, regular training and a training cascade, female specialist staff at hospital and community levels and the incorporation of a gender and human rights dimension in routine health surveillance.

Women's access to evidence-based drug disorder treatment in the community is important as part of non-custodial

sentencing and detention.

Gender-oriented programmes or services require sufficient monitoring and evaluation. It is recommended to routinely use the UNODC checklist for assessing the implementation of gender mainstreaming within programming.

Continued research to support practice and that informs evidence-based interventions to respond in a culturally sensitive and effective manner is warranted

Tables

Table One: Proposed best estimate and range for PWID population size estimates

Table Two: Non-governmental organisations (NGO) working with key populations at risk of HIV, including PWID

Table Three: Hospital/Centre affiliated to GSMHAT providing addiction treatment services to women

Table Four: Private centres providing addiction treatment services in different governorates

Table Five: NDO-GSMHAT Profile of female treatment patients January to May 2022

Table Six: Government, UN and Civil Society key informant interviews

Table Seven: Focus Groups with WWUD/WWID

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Figure One: Mapping exercise reflecting dependence and abuse in the governorates of Egypt, the addiction map of Egypt, and services mapping

Figure Two: Substances used by number of females in 2021

Background

Women account for one in every three people who use drugs worldwideⁱ. Yet, women suffer severely from the adverse health consequences of substance use. Women who use drugs (WWUD) tend to progress to drug use disorders in a shorter time than menⁱⁱ. The health and human rights impact of such invisibility can be very harmful. In many contexts, they remain a particularly hard-to-reach population, even where harm reduction programmes are in place. Stigma and discrimination fuel the covert nature of drug use and injecting and exacerbating their vulnerability within relationships.

Women who engage in risky and harmful forms of drug use, particularly women who inject drugs (WWID) face a range of gender-specific barriers to accessing HIV-related services. WWID have a greater vulnerability than men to the acquisition of human immune deficiency virus (HIV), and other blood-borne viruses such as Hepatitis B and C, as well as a wide range of sexually transmitted infections (STI)ⁱⁱⁱ. Many have a male sexual partner who also injects drugs, which hampers efforts to seek help. The convergence of risky injecting practices (for example, using contaminated injecting equipment and using the needle after her partner) and high-risk sexual activity (transactional or commercial sex) creates a further substantial risk for STI, HIV and viral hepatitis transmission in WWID^{iv}. This is especially the case since the COVID-19 pandemic^v.

WWUD use condoms less often with their intimate partners and clients^{vi}, and those who inject are 17 times more likely than other women to be living with HIV^{vii}. Those engaging in sex work are 30 times more likely to be living with HIV than women in the general population^{viii}, and women in prison are 5 times more likely than others to live with HIV^{ix}. There are no recent global estimates of hepatitis C and/or hepatitis B infection rates among WWID, although they are known to be at high risk of infection^x.

There are several identified sub-groups of vulnerable WWUD/WWID. These include women who are affected by violence and trauma, women with co-morbidity, women

i United Nations Office on Drugs and Crime (UNODC). (2022). World Drug Report 2022. UNODC: Vienna. Retrieved from www.unodc.org/unodc/en/data-and-analysis/wdr2022.html

ii Oberleitner, L et al. (2014). Childhood stressors differentially affect age of first use and telescoping across women and men. *Drug and Alcohol Dependence*, 140: e164–e165.

iii United Nations Office on Drugs and Crime (UNODC). (2022). World Drug Report 2022. UNODC: Vienna. Retrieved from www.unodc.org/unodc/en/data-and-analysis/wdr2022.html

iv United Nations Office on Drugs and Crime (UNODC). (2006). HIV/AIDS prevention and care for female injecting drug users. UNODC: Vienna. Retrieved from www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf

v Dannatt et al. (2021). The Impact of Stigma on Treatment Services for People With Substance Use Disorders During the COVID-19 Pandemic—Perspectives of NECPAM Members. *Frontiers in Psychiatry*, 02 March 2021. <https://doi.org/10.3389/fpsy.2021.634515>

vi El-Bassel N. et al. (2014). Drug use as a driver of HIV risks: re-emerging and emerging issues. *Current Opinion in HIV and AIDS* 9, 2, 150-5.

vii UNODC et al. (2014). Women who inject drugs and HIV: addressing specific needs. Policy Brief, UNODC/UNW/WHO/INPUD.

viii UNAIDS (2021). HIV and sex work. Fact Sheet Series, Geneva.

ix UNODC et al. (2014). Women who inject drugs and HIV: addressing specific needs. Policy Brief, UNODC/UNW/WHO/INPUD.

x Dugan E. et al. (2021). Global prevalence of hepatitis C virus in women of childbearing age in 2019: a modelling study. *The Lancet Gastroenterology and Hepatology* 6, 3, 169-84

who are pregnant and/or parenting, ethnic minorities, sex workers and prisoners^{xi}.

Many countries retain a comprehensive, punitive, gender-neutral legal framework to arrest, prosecute and sentence offenders on various drug-related offenses. Women in detention are also a minority prison population, with unique vulnerabilities and distinct pathways into crime and contact with the criminal justice system^{xii}. They are detained for less severe, non-violent crimes, often heavily underpinned by poverty (“crimes of survival”) and drug related offenses (not all of them are using drugs)^{xiii}.

The United Nations (UN) Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) has described a range of concerns regarding the situation of women in detention. Many are especially relevant to WWUD/WWID, including the detention of women in compulsory drug treatment centres, the punitive denial of opiate agonist treatment (OAT) causing withdrawal whilst detained (including in pre-trial detention), excessive prescription of psychotropic drugs as control measure by authorities and the lack of other gender sensitive health and mental health supports for women^{xiv xv}.

National and international research, services, guidelines, training programmes and surveillance concerning people who use drugs (PWUD) remain overwhelmingly gender-neutral or male-focused. Partly as a result, limited data exist on WWUD/WWID, and their specific challenges and needs are rarely recognized or understood. Despite all the risks of substance use in women, only one in six people in treatment are women^{xvi}. Women face numerous barriers in accessing drug treatment services, which may include the fear of possible legal sanctions and social stigma relating to their drug use, lack of childcare or the fear of losing custody of children while in treatment, or because of other family responsibilities related to the prescribed role of women as mothers and caregivers in general^{xvii}.

Hence, the initiation and development of gender sensitive services which address the unique needs of WWUD and WWID are warranted^{xviii}. Key components

xi European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2017). Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice. Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European guide. Retrieved from www.emcdda.europa.eu/document-library/women-who-use-drugs-issues-needs-responses-challenges-and-implications-policy-and-practice_en

xii Penal Reform International (PRI) (2021). Women in the criminal justice system: key facts. PRI: London. Retrieved from <https://www.penalreform.org/issues/women/key-facts/>.

xiii United Nations Office on Drugs and Crime (UNODC). (2008). Handbook for prison managers and policymakers on women and imprisonment: women and imprisonment. UNODC: Vienna. Retrieved from <https://www.unodc.org/documents/justice-and-prison-reform/women-and-imprisonment.pdf>.

xiv Penal Reform International (PRI), Linklaters LLP, International Drug Policy Consortium (IDPC) (2020). Sentencing Of Women for Drug Offences PRI: London. Retrieved from <https://www.penalreform.org/resource/sentencing-of-women-convicted-of-drug-related-offences/>.

xv Van Hout, MC., Fleißner, S., Stöver, H. (2021). “# Me Too”: Global progress in tackling continued custodial violence against women. The 10-year anniversary of the Bangkok Rules. Trauma, Violence, & Abuse: A Review Journal Early online. doi: 10.1177/15248380211036067.

xvi UNAIDS. (2019). Women who inject drugs more likely to be living with HIV, based on data from Global AIDS Monitoring 2103–2017, 11 June 2019. UNAIDS: Geneva. Retrieved from www.unaids.org/en/resources/presscentre/featurestories/2019/june/20190611_women-who-inject-drugs

xvii International Narcotics Control Board (INCB) (2016). Report of the International Narcotics Control Board for 2016. INCB: Vienna. (E/INCB/2016/1).

xviii United Nations Office on Drugs and Crime (UNODC). (2006). HIV/AIDS prevention and care for female injecting drug users. UNODC: Vienna Retrieved from www.unodc.org/pdf/HIV-AIDS_fmaleIDUs_Aug06.pdf

centre on gender responsiveness in service design and delivery, the importance of non-judgemental supportive and safe environments, and comprehensive and holistic programmes, cognisant of healthy connections with children, family, and the community, and which address socio-economic and health inequality^{xix}.

Rationale

In mid-2022, under the project XAMZ96 - HIV and AIDS Prevention, Treatment, Care and Support among people who use drugs and living in closed settings in the Middle East and North Africa, the United Nations Office on Drugs and Crime (UNODC) Regional Office for Middle East and North Africa (ROMENA) conducted a rapid situation assessment (RSA) on the current situation of WWUD and WWID, as well as the availability of gender-responsive services for the drug and harm reduction centres in Egypt.

xix Council of Europe (CoE) (2022). Implementing a gender approach in different drug policy areas: from prevention, care and treatment services to law enforcement & the criminal justice system. Pompidou Group: Strasbourg. Retrieved from <https://rm.coe.int/-/2022ppg-implementing-a-gender-approach-in-drug-policies-a-pg-handbook/1680a66835>

Methodology: The Rapid Situation Assessment

Purpose

The primary aim was to carry out an RSA on the situation of WWUD/WWID in Egypt and the availability of gender-responsive addiction treatment and harm reduction services to generate comprehensive baseline information to:

- Inform policymakers by providing a comprehensive picture of WWUD/WWID in Egypt.
- Refine a gender responsive national strategy for WWUD/WWID.
- Inform the harm reduction and drug treatment programmes to plan and prioritize gender-sensitive harm reduction/drug treatment modalities.

Specific objectives were to:

- Update the available information on WWUD/WWID in Egypt.
- Describe the characteristics and impact of HIV for WWID who are HIV positive.
- Determine services available for WWUD/WWID in Egypt.
- Identify harm reduction services availability for WWUD/WWID in Egypt.
- Document services delivery gaps for WWUD/WWID in Egypt.
- Determine the knowledge, attitude, behaviors, and practices regarding WWUD/WWID in Egypt.

Focus

The RSA looked at all three levels of determinants that have implications for future intervention development to support WWUD/WWID in Egypt:

1. Level of the individual WWUD and their drug using networks.
2. Surroundings of the drug users comprising family members, addiction treatment staff, community elites, police, etc. and.
3. Policy environment and schemes or programmes available for WWUD/WWID and the conditions under which these schemes are made available.

The RSA Approach

A mixed methodology approach collected and analysed primary and secondary data on WWUD/WWID in Egypt. The RSA was conducted in the period April to June 2022 and consisted of the following four complimentary phases:

Context: A comprehensive desk review was conducted of all extant literature and government reporting relevant to WWUD/WWID in Egypt with no limitation on date of publication, and including a mapping of current government and private treatment services and harm reduction services that support women.

Snapshot Profile: An updated profile of treatment and service user characteristics of women was sought using the National Drug Observatory; department in GSMHAT-MOHP-Egypt (NDO-GSMHAT) reporting sheet (Annex One) which was circulated to the in/out patient government clinics, private hospital and clinic settings who support WWUD, and to non governmental organisations (NGO) who provide harm reduction.

Key areas of interest were socio-demographic aspects (age, marital status, living environment, employment status, source of income); treatment and medical history, current treatment episode, substance abuse profile, and mode of intake, frequency and nature of use.

Multi-stakeholder key informant interviews: A series of in depth interviews (Annex Two) were conducted during site visits with a purposive sample of professional key informants involved in the technical support and provision of drug treatment and harm reduction, representing government, NGO and relevant UN agencies. Interviews explored the specific needs of substance-dependent women, mental health and co-morbidities, WWUD/WWID awareness of harm reduction and addiction support services, factors motivating helpseeking, barriers to treatment intake, treatment retention and rehabilitation, and the identified needs of WWUD/WWID for enhanced gender sensitive services in Egypt, spanning hospital and community settings.

Focus group discussions with WWUD/WWID: A series of focus groups (Annex Three) were conducted with a convenience sample of WWUD/WWID in treatment and accessing HIV VCT and NGO providing community harm reduction. Discussions explored aspects of female vulnerability, their drug use trajectories and pathways toward drug use disorder, economic pressures, mental health and co-morbidities, awareness of current support services, factors motivating helpseeking, barriers to treatment, experiences of accessing such services, their specific needs around the potential provision of gender specific services and programmes, different service responses compared to males, reasons for treatment discontinuation, sexual and reproductive health issues, and opinions around laws, policies and child custody aspects.

While the data collection focused largely on urban areas, the RSA included attention on rural aspects of drug use and drug injecting and accessing services, and where possible, probed into the experiences of WWUD who had been in prison (El Kanater). Governorates reached represent North Egypt (Delta), South Egypt (Upper Egypt) , Coast governorates and Cairo (the Capital and largest city)ⁱ.

The design was refined during training of the national consultants before entering the field. Points that were covered during finalisation of the design included:

- » Team decision on sources to be utilised for collecting secondary information.
- » Mechanism for accessing different types of secondary data.
- » List of key informants to be interviewed.
- » Mechanism for approaching key informants and conducting interviews.
- » Number of WWUD/WWID to be interviewed from treatment centres and NGO.
- » Ways to build rapport with WWUD/WWID and conduct interviews.
- » Guides to be used during interviews and focus group discussions.

Ethical considerations

National consultants adhered to professional research ethics considerations. Verbal informed consent was obtained from each study participant before the interview or focus group discussion. Interviews and focus groups were conducted in a conversational tone in a closed room and no identifiers were collected.

ⁱ Alexandria, Aswan, Assiut, Beheira, Beni Suef, Cairo, Dakahlia, Damietta, Fayoum, Gharbia, Giza, Ismailia, Kafr el-Sheikh, Matrouh, Minya, Menofia, New Valley, North Sinai, Port Said, Qalyubia, Qena, Red Sea, Al-Sharqia, Soha, South Sinai, Suez, Luxor.

Triangulation and data analysis

Data collection, analysis and triangulation was conducted concurrently. Special attention was paid to an unbiased and objective approach and the triangulation of sources, methods, data, and theories. Secondary data sources were cross-checked and triangulated through the collected primary research data. The RSA findings are subsequently presented with a coherent focus on potential responses.

Dissemination and communication

The RSA used a participatory methodology that involved key sectors (Ministry of Health and Population: MoHP, relevant UN counterparts and NGO) and consulted WWUD/WWID. The idea was to encourage all participants to contribute to promoting strong internal advocacy for issues of WWUD/WWID in Egypt following the RSA dissemination.

The Team

The team consisted of one international consultant expert in addictions, public health and human rights law responsible for drafting the design, analysis and RSA reporting, and two national consultants, both experts in public health, HIV and drug use responsible for data collection and RSA review.

Context: Desk Review

Drug use trends in Egypt

Egypt is classed as a transit country for drugs but is experiencing an increasing drug problemⁱ. In 2005, the UNODC reported on a concerning rise of drug abuse (cannabis herb known as Bango, and hashish), amongst young malesⁱⁱ. Currently, the main drugs consumed in Egypt are cannabis, pharmaceutical opioids (mostly Tramadol), amphetamine type stimulants (ATS) and heroinⁱⁱⁱ. Novel psychoactive substances have emerged in Egyptian drug markets, as elsewhere in the Middle East and North Africa (MENA) region^{iv}. In 2021, studies report on using the 'Voodoo' a synthetic cannabinoid among Egyptian youth, reported to be causing a range of acute toxicity symptoms including altered states of consciousness, agitation, and hallucinations^v. Studies also report on a similar compound, in the use of 'Strox', a synthetic herbal mixture^{vi} (a green marjoram type, or a tobacco type sprayed with active compounds) which has rapidly spread in popularity in Egypt in recent years, creating significant social and health problems^{vii}.

Most research on substance use in Egypt focuses on secondary school and university populations. Studies on secondary school students in Egyptian villages document that substance use among youth is common, and correlated to use of electronic devices, smoking, alcohol use, risky sexual activity, risky driving, and suicidal ideation^{viii}. In 2020 a study on Egyptian adolescents reported that female students had a higher family history of cannabis and benzodiazepine use^{ix}. Studies in 2021 on Egyptian university students reported on the common use of hashish (96.5%), Strox (41.3%), Bhang (cannabis) (34.4%), Voodoo (synthetic cannabinoid) (34.4%), and Tramadol (31.1%). They observed that a family history of the conflict is significantly associated with risk of illicit drug use (mainly in young males of low or moderate socio-economic status^x. Khafagy et al. (2021) reported on the low prevalence of substance use among female Egyptian university students, possibly due to social stigma, or more excellent social tolerability of substance

i El-Kouny, N. (2015). Outcast: Egypt's growing addiction problem. Ahramonline. Retrieved from <https://english.ahram.org.eg/NewsContent/1/151/133715/Egypt/Features/Outcast-Egyptys-growing-addiction-problem.aspx>

ii United Nations Office on Drugs and Crime (UNODC). (2005). Egypt Country Profile. Retrieved from http://www.unodc.org/pdf/egypt/egypt_country_profile.pdf

iii MENAHRA (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2021. Retrieved from 2021 Assessment of Situation (menahra.org)

iv Ibid.

v Hussien, R et al. (2021). Acute Toxic Effects of the New Psychoactive Substance "Voodoo" among Patients presented to the Poison Control Center of Ain Shams University Hospitals (PCC-ASUH), Egypt, during 2017. Substance Abuse Treatment, Prevention, and Policy, 16:71.

vi A potent synthetic narcotic that is mixed with tobacco and smoked.

vii El-Masry, M., Abdelkader, S.I. (2021). Clinical profile of designer drug "Strox" intoxicated cases presented to Poison control center Ain Shams University, Egypt from first of January 2017 to end of January 2018. Ain Shams Journal of Forensic Medicine and Clinical Toxicology 36: 98-105.

viii Shaheen HM et al. (2021). Substance use disorder and risk behaviors among secondary school adolescents in a rural area in Egypt. Menoufia Medical Journal, 34:544-9.

ix Rabie, M et al. (2020). Prevalence updates of substance use among Egyptian adolescents. Middle East Current Psychiatry 27:4.

x Naguib, Y.M. et al. (2021). Prevalence and associated risk factors of cannabinoid abuse among Egyptian university students: a cross-sectional study. Environmental Science and Pollution Research 28:68706–68716.

use among males^{xi}.

Levels of drug use disorder and addiction, particularly of Tramadol, heroin and cannabis, have risen steeply in recent years in Egypt, with an estimated 9 million people using drugs in 2018 (10% of the domestic population and largely male)^{xii} ^{xiii}. The Freedom Drugs and HIV programme now estimates that 2.8% of all Egyptians (around 2.4 million people) have significant problems with drug use and dependence.

Preliminary results of the “National Addiction Survey- 2021”^{xiv} for the general population were:

- The prevalence of alcohol and addictive substance use: 5.9%.
- The prevalence of alcohol and substance use disorders according to the DSM-5 diagnostic criteria: 2.4%.
- 98.2% of those who met the criteria for addiction were males and 1.8% were females.
- The percentage of using drugs by injection was 0.2%.

In terms of fully understanding the needs and documenting the profile of WWUD and WWID in Egypt, few studies explicitly focus on this gender dimension of drug use. Media reports have publicised that in 2017, 28% of drug addicts in Egypt were female, with substantial barriers to accessing help due to stigma^{xv}. Low help-seeking and uptake of women’s treatment services is likely due to the significant cultural stigma of female addiction^{xvi} ^{xvii}. One study in Egypt has reported on the generally lower socio-economic status of WWID compared to men, along with the strong association of drug use with mental health issues, poverty, and violence^{xviii}. A study in 2022 documented the correlation between adverse childhood experiences and substance abuse among Egyptian patients with schizophrenia, particularly females^{xix}.

Drug related health consequences in Egypt

Egypt has the fastest-growing HIV epidemic in the MENA region, with evidence of a growing HIV epidemic among people who inject drugs (PWID)^{xx}. Hepatitis C is a common

xi Khafagy et al. (2021). Substance use patterns among university students in Egypt. *Middle East Current Psychiatry* 28:59

xii Balha et al. (2021). Assessment of Psychological Symptoms and Cravings among Patients with Substance Related Disorders *Egyptian Journal of Health Care*, 2 (3):751 to 763.

xiii Mneimneh, R. (2018). Ten percent of Egypt’s population is addicted to drugs. Retrieved from <https://step-feed.com/ten-percent-of-egypt-s-population-is-addicted-to-drugs-8667>

xiv Personal communication, Dr Raghda ElGamil, Director of Addiction Treatment, Egyptian Ministry of Health.

xv Egypt Today (2017). 28% of Egyptian drug abusers are female: Minister. Retrieved from www.egypttoday.com/Article/1/4729/28-of-Egyptian-drug-abusers-are-female-Minister

xvi Balha et al. (2021). Assessment of Psychological Symptoms and Cravings among Patients with Substance Related Disorders *Egyptian Journal of Health Care*, 2 (3):751 to 763.

xvii Fathy et al. (2021). Effect of Educational Program for Reducing Self Stigma and Shame among Substance Abuser Women. *Ilkogretim Online* . 2021, 20 (5):2278-2288. 11p.

xviii El-Sawy, H et al. (2010). Gender differences in risks and pattern of drug abuse in Egypt. *Egyptian Journal of Neurology, Psychiatry and Neurosurgery*, 47(3), 413-418.

xix Yousef et al. (2022). Prevalence and clinical implication of adverse childhood experiences and their association with substance use disorder among patients with schizophrenia. *Egypt Journal of Neurology Psychiatry Neurosurgery*. 58:4.

xx Mumtaz, C. R. et al. (2014). HIV among people who inject drugs in the Middle East and North Africa: systematic review and data synthesis. *Plos Medicine*, 11(6), e1001663.

co-infection among people living with HIV (PLHIV) in Egypt due to the extremely high background of Hepatitis C (HCV) prevalence in the general population, and due to the sharing of non-sterile drug injecting equipment. UNODC estimates that the prevalence of HCV among PWID in Egypt is 55%, meaning that 55,000 people who inject drugs are living with HCV^{xxi}.

Women are especially vulnerable to acquisition of HIV and other blood borne viruses. Many studies on injecting drug use (IDU) in Egypt have however excluded women due to their small numbers^{xxii}. A study by Oraby in 2013 reported on the convergence of risks across key groups of injecting drug users; men who have sex with men (MSM), and female sex workers (FSW), and documented how WWID are married to men with substance use disorders and have children^{xxiii}. There are case studies of women living with HIV (WLHIV) who report that WLHIV in Egypt often have husbands that are involved in high-risk behaviours (extramarital sex, same sex relations or IDU), and who are reported to be hesitant to seek support from their community for fear of stigmatization^{xxiv xxv xxvi}. Some studies report on low HIV knowledge among WLHIV before testing positive^{xxvii}.

An Integrated Bio-Behavioural Surveillance Survey (IBBSS) was conducted in 2010 which primarily focused on MSM and male IDU. Regarding females, only targeted street girls and FSW due to the difficulties in reaching WWID^{xxviii}. In 2007, UNAIDS estimated the number of PWID in Egypt to be 57,000- 120,000^{xxix}. In 2014 a national population size estimate of PWID was conducted in collaboration between the National AIDS Program (NAP) and UNODC in three governorates. See Table One.

xxi United Nations Office on Drugs and Crime (2015). Feasibility Study Opioid Substitution Treatment in Egypt. Retrieved from www.unodc.org/documents/middleeastandnorthafrica/drug-prevention-health-publications/OST_Feasibility_Study_in_Egypt.pdf

xxii Anwar et al. (2021). Association of sociodemographic factors with needle sharing and number of sex partners among people who inject drugs in Egypt, *Global Public Health*, Early Online DOI: 10.1080/17441692.2021.1950798

xxiii Oraby, D (2013). Harm reduction approach in Egypt: the insight of injecting drug users. *Harm Reduction Journal* 10:17.

xxiv Khattab, H. et al. (2007). All Alone: The Stories of Egyptian Women Living with HIV, Stigma and Isolation. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

xxv Khattab, H. et al. (2010). The agony of AIDS: A qualitative study of the experience of AIDS in Egypt. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

xxvi Khattab, H. El-Geneidy, M. (2014). Living with AIDS: Suffering and Courage. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

xxvii Oraby, D., Abdel-Tawab, N. (2016). Understanding Married Women's Vulnerability to HIV Infection in Egypt: An Exploratory Study. Cairo: Population Council.

xxviii FHI/Ministry of Health (MOH) Egypt (2010). HIV/AIDS Biological & Behavioral Surveillance Survey; Round Two Summary Report, Cairo, Egypt 2010. FHI in collaboration with the Ministry of Health and support from the Global Fund.

xxix UNAIDS (2007). Joint United Nations Programme on HIV/AIDS (UNAIDS) and AIDS Project Management Group: Recommendation for interventions addressing IDU and related HIV infections in Egypt. UNAIDS: Geneva.

Table One: Proposed best estimate and range for PWID population size estimates

Suggested Range ⁱ	Cairo-Giza	Alexandria	Menya
Best estimate	22701	6969	1005
Population percentage	0.58%	0.51	0.37
Lower bound (all deflation factors, no inflation factors)	21555	6376	910
Population percentage	0.55%	0.47%	0.34%
Upper bound (all inflation factors, no deflation factors)	44424	7396	1116
Population percentage	1.13%	0.54%	0.41%

In 2015, according to the NAP and General Secretariat of Mental Health and Addiction Treatment” (GSMHAT- MOHP Egypt), there were an estimated 100,000 PWID in Egypt. In 2022 UNODC estimated that 50,000 PWUD need OAT in Egyptⁱⁱ. The latest size estimate of PWID in Egypt generated by Mahmud and colleagues in 2020 is 90,809 (71,485 – 119,633)ⁱⁱⁱ. The National AIDS Program is planning to conduct new Population Size Estimate (PSE) and IBBSS in September of 2022 to update those national figures. Dissemination is expected in March 2023.

Harm Reduction Coverage in Egypt

Harm reduction is referred to in the Egypt National HIV Strategic Plan 2021 - 2025, with PWID identified as a target group for HIV prevention. Needle and Syringe Programs (NSP) have been scaled up^{iv}. Latest UNAIDS data on Egypt from 2015 estimates using sterile injecting equipment at last injection at 31.5%^v.

A wide range of other services are offered through a drop-in centre, including health, legal, and psychosocial support, referral for health services, and voluntary counselling and testing (VCT). Whilst prevention activities for key populations at risk of HIV in Egypt include targeted education, comprehensive condom promotion, VCT, there is the insufficient systematic tracking of care^{vi}. In terms of harm reduction at the community

ⁱ United Nations Office on Drugs and Crime (UNODC) (2014). Estimating the size of key affected populations at elevated risk for HIV in Egypt. UNODC Regional Office of the Middle East and North Africa (ROMENA): Cairo.

ⁱⁱ United Nations Office on Drugs and Crime (2022). Terms of Reference. Rapid Situation Assessment (RSA) on women who use and inject drugs in Egypt. UNODC Regional Office of the Middle East and North Africa (ROME-NA): Cairo.

ⁱⁱⁱ Mahmud, S. et al. (2020). The status of hepatitis C virus infection among people who inject drugs in the Middle East and North Africa. *Addiction* (Abingdon, England), 10.1111/add.14944.

^{iv} Middle East and North Africa Harm Reduction Association (MENAHR) (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2020. MENAHR: Beirut. Retrieved from 2021 Assessment of Situation (menahra.org)

^v UNAIDS. (2019). UNAIDS Data 2019. Geneva: Joint United Nations Programme on HIV/AIDS; 2019. UNAIDS: Geneva. Available from: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^{vi} MENAHR (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2020. MENAHR: Beirut. Retrieved from 2021 Assessment of Situation (menahra.org)

level several NGOs are providing condom promotion, HIV testing and counselling and NSP for PWID in large cities^{vii}. The main challenge is the limited number of NGOs working in HIV prevention and the lack of geographical coverage of those activities which is one of the national priorities in the upcoming period to scale the coverage of these interventions. See Table Two.

Table Two: Key Non-governmental organisation (NGOs) working with key populations at risk of HIV, including PWID

NGO ^{viii}	Targeted KPs	Geographical area
Al Shehab	PWID, FSWs	Greater Cairo
Caritas	PWID, MSM	Alexandria and Gharbia
Befrienders	PWID, MSM	Cairo and Giza
Friends	PWID, MSM	Menia (upper Egypt)
Freedom	PWID, MSM	Cairo and Giza
S4D	PWID, MSM	Alexandria
Al Daherya	PWID, MSM	Alexandria

A National Task Force for implementing the OAT strategy was established in 2013 and UNODC supported the developing of a detailed plan and protocol for methadone and buprenorphine maintenance treatment. Service providers were trained, and the plan was to establish OAT services in six governorates by an NGO.

In 2020 a MoHP ministerial decree was issued to adopt the use of OAT as one of the harm reduction interventions and addiction treatment approaches in Egypt^{ix}, with a decree for a national committee for OAT and harm reduction program to include members from the NAP, mental health, UNAIDS, UNODC and the World Health Organization (WHO), as well as civil society. The decision issued to implement the OAT program approved the first implementation phase only in the centres and hospitals affiliated with the General Secretariat of Mental Health & Addiction Treatment (GSMHAT). Accordingly, according to the criteria and standards of harm reduction centers, special units are currently being prepared for the implementation of the OAT program within the GSMHAT hospitals.

Egypt has started the procurement of OAT medication (both methadone and buprenorphine) and is expected to receive the first shipment of methadone in July 2022. The national scientific guidelines are in place, and a study tour was conducted to Morocco to benefit from their experience in OAT implementation. At the time of writing, the standard operating procedures are under finalization to be reviewed by the

vii Ministry of Health and Population (MOHP) (Egypt), El-Zanaty and Associates (Egypt), and ICF International. (2015). Egypt Demographic and Health Survey 2014. Cairo and Rockville, MD: Ministry of Health and Population and ICF International.

viii Personal communication. Dr Heba ElSayed NAP Manager Ministry of Health.

ix United Nations Office on Drugs and Crime (2022). Terms of Reference. Rapid Situation Assessment (RSA) on women who use and inject drugs in Egypt. UNODC ROMENA: Cairo.

OAT and harm reduction scientific committee.

Drug use disorder treatment and rehabilitation in Egypt

Various drug treatment services, including inpatient and outpatient detoxification and residential rehabilitation, are available to PWUDs in large cities. See Table Three/Four (following page).

Table Three: Hospital/Centre affiliated to GSMHAT providing addiction treatment services to women

Hospital/Centre	Outpatient	Outpatient
Heliopolis Psychiatric Hospital	+	+
Abbasiyah Psychiatric Hospital	+	+
Helwan Psychiatric Hospital (adolescent only)	+	
Khanka Psychiatric Hospital	+	
Tanta Psychiatric Hospital	+	
Mamoura Psychiatric Hospital	+	+
El Menia Psychiatric Hospital	+	

Table Four: Private centres providing addiction treatment services in different governorates

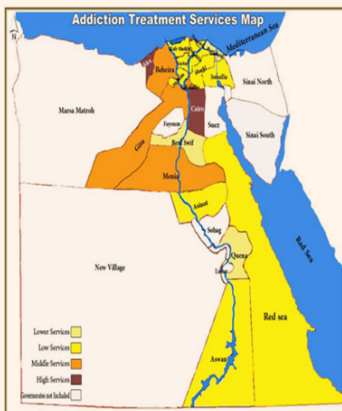
Governorates	Number of private centres providing addiction treatment services
Cairo	91
Giza	38
Kaliubeya	8
Alexandria	18
Al Sharkeya	4
Al- Monofeya	4
El- Dakahleya	2
Kafr El- Sheikh	2

Governorates	Number of private centres providing addiction treatment services
Damietta	3
El- Ismailiah	2
El- Fayoum	1
Beni- sweif	8
El Menia	5
Assiut	4
Suhag	1
Qena	2
Luxor	2
Red Sea	3
Aswan	3

The General GSMHAT conducted a mapping exercise of addiction and available services in 2018 . See Figure One on the following two pages provides cartographical detail from 2018^x.

- » Addition services mapping.
- » Addition map of Egypt.

Figure One: Mapping exercise reflecting addiction treatment services and the addiction map of Egypt^{xi}



x General Secretariat of Mental Health & Addiction Treatment (GSMHAT). (2018). Mapping Addiction in Egypt Size of the Problem and Available Services GSMHAT report 2018. Research Unit General Secretariat of Mental Health & Addiction Treatment Ministry of Health & Population: Cairo.

xi General Secretariat of Mental Health & Addiction Treatment (GSMHAT). (2018). Mapping Addiction in Egypt Size of the Problem and Available Services GSMHAT report 2018. Research Unit General Secretariat of Mental Health & Addiction Treatment Ministry of Health & Population: Cairo.

The 2018 report by the GSMHAT indicated a ratio of male to the female rate of substance dependence was 7:1 (females 0.7%)ⁱ. This report showed that there was a substantial proportion of women (especially in large cities) with a drug use disorder problem and that they required dedicated treatment servicesⁱⁱ. Empirical studies in 2011 and, more recently, 2022 have documented that whilst female patients are in the minority, Egyptian males commence drug use earlier and have a longer trajectory of addiction^{iii iv v}. The 2019 NDO-GSMHAT Annual Report reported that all treatment seekers were males (98.7%), while females composed only a minute portion of 1.3%^{vi}. In 2019, it was reported by the NDO that women in treatment in Egypt have a different profile compared to men, with Tramadol (48.75%) the most popular substance among women, followed by heroin (44.84%) then hashish (32.38%). Pregabalin was more common among females (11.03%) than males (7.62%)^{vii}. Strox was not as popular among females as males; it was reported by only 2% of the female patients (6 cases)^{viii}.

In 2020, the percentage of women in treatment increased to 1.9%^{ix}. The gender treatment profile in 2020 revealed a heroin prevalence rate of 40.95%, followed by Tramadol, then Hashish, at prevalence rates of 23.46% and 19.28% respectively. Pregabalin (had reduced since 2019) was also relatively more common among females (5.57%) than males (2.52%). Strox was like the previous year in that it is not as popular among females as males; it was reported by only 2.58% of the female patients (13 cases). The most popular mode of intake for women was snorting (34%), followed by injection (23%).

In 2021 this remained stable with 282 women were in treatment (2%)^x. In 2021, at a prevalence rate of 68.44%, heroin was the most popular substance among women, followed by Tramadol, then Cannabis, at prevalence rates of 30.85% and 28.72% respectively^{xi}. A minority of women used Strox (4%) and pregabalin (5%). See Figure Two).

i General Secretariat of Mental Health & Addiction Treatment (GSMHAT). (2018). Mapping Addiction in Egypt Size of the Problem and Available Services GSMHAT report 2018. Research Unit General Secretariat of Mental Health & Addiction Treatment Ministry of Health & Population: Cairo.

ii Ibid.

iii Hamdi, E (2011): The national addiction survey-final report. Egypt: Research Unit of General Secretariat of Mental Health, Ministry of Health.

iv Abd Allah et al. (2022). A study of co-morbidity between opioid addiction and major depressive disorders in El Hussein University hospital. Al-Azhar Medical Journal. 51 (1): 397-408

v Ebrahim et al. (2022). The Effectiveness of Life Skills Training on Assertiveness, Self-Esteem and Aggressive Behavior among Patients with Substance Use Disorders. International Egyptian Journal of Nursing Sciences and Research (IEJNSR), 2(2): 413-431.

vi National Drug Observatory Annual Report (2019). National Drug Observatory Egypt.

vii Ibid.

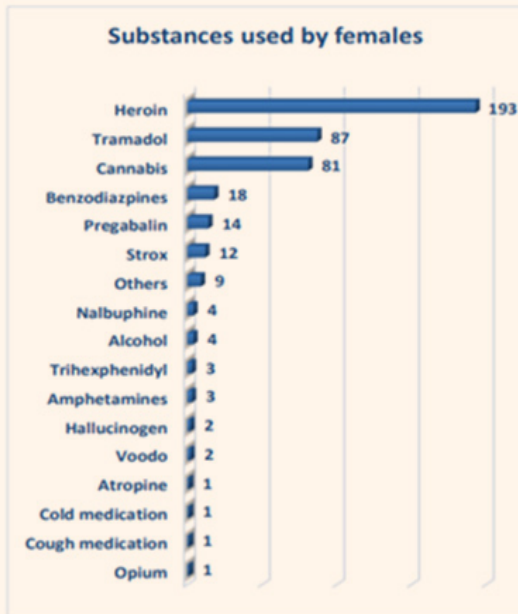
viii Ibid.

ix National Drug Observatory Annual Report (2020). National Drug Observatory Egypt

x National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

xi National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

Figure Two: Substances used by number of Females who come for treatment in 2021ⁱ



During COVID-19 in 2021 it was reported that social stigma of drug use in Egypt contributed to inequality in accessing medical care, due to the cultural and community views that drug users are morally responsible for their conditionⁱⁱ.

Prisons

Prisoners especially female prisoners are identified in the Egypt National HIV Strategic Plan 2021 – 2025 as being at risk of being left behind in the domestic HIV response. As of April 2021, the Arabic Network for Human Rights Intervention (ANHRI) has estimated there are 120,000 prisoners in Egypt, with most recent data from 2006 estimating that 3.7% are womenⁱⁱⁱ.

The HIV VCT project in prisons was launched in 2014 in 3 prisons and then scaled up to 7 prisons and finally to 10 prisons in 2021, This project is under the Memorandum of Understanding (MoU) between Ministry of Interior, NAP and UNODC.

ⁱ National Drug Observatory Annual Report (2021). National Drug Observatory Egypt.

ⁱⁱ Dannatt et al. (2021). The Impact of Stigma on Treatment Services for People With Substance Use Disorders During the COVID-19 Pandemic—Perspectives of NECPAM Members. *Frontiers in Psychiatry*, 02 March 2021. <https://doi.org/10.3389/fpsy.2021.634515>

ⁱⁱⁱ Prison Studies (2022). Egypt. Retrieved from www.prisonstudies.org/country/egypt

The UNODC ROMENA implemented the first-ever prison health project with the support of DROSOS Foundation from 2016-2020 in Egypt^{iv}. The UNODC Prison HIV project was officially opened by H.E. Assistant Minister of Interior of Egypt on 25 February 2019. The Assistant Minister formally announced the expansion of the UNODC Prison Health Programme from three prisons to seven, including to the first-ever female prison. Currently, UNODC provides VCT Services in ten prisons, including Borg-Al-Arab, Wadi Nartroon, Fayoom, Gamasa, El-Marg, Minya, Katta, Lyman Abo Zaabal as well as Damanhour and El Qanater female prisons. This project has reached more than 7,000 female prisoners in Egypt.

Encouraging Initiatives to date

There have been efforts by several organisations to document and respond to the need of WWUD/WWID in Egypt. Firstly, in 2013, the Middle East and North Africa Harm Reduction Association (MENAHRHA) identified WWUD/WWID in the MENA as a vulnerable group and underscored concern around the lack of research and limited understanding of their situation^v. Their report on WWID in the MENA region (which included data collection in Egypt) describes them as hidden, encountering substantial stigma compared to males who inject drugs, resulting in low uptake of harm reduction services^{vi}. It highlighted the need to address stigma and discrimination, prioritise women in harm reduction activities, especially NSP and awareness on safe injecting practices, and the need to incorporate aspects of sexual and reproductive health education and care.

Secondly, Egypt is part of the Council of Europe (CoE) International Cooperation Group on Drugs and Addictions, the Mediterranean network for co-operation on drugs and addictions of the Pompidou Group (MeDNET)^{vii}. As part of its involvement in this network, Egypt has engaged in several encouraging drug cooperation activities which include a gender dimension^{viii}. The Egyptian Observatory on Drugs and Addiction (NDO-GSMHAT) which was developed in 2014, created a data collection system on treatment and published its first report in 2018. Egypt was one of the MedNET countries which participated in a Rome seminar in 2017 on “Women and Drugs: from policy to good practice”. In 2017 Egypt further developed several MeDNET initiatives; its gender responsive services for WWUD, the development of care addiction services for adolescents and pregnant women who use drugs, and the continuation of addiction treatment services for HIV positive patients. In 2020 through MeDNET Egypt continued the development of a community-based model of care for substance abuse project; and extended the training and building capacity phase for developing specialized addiction services for pregnant females^{ix}.

iv DROSOS (2020). Final Report of the Final Evaluation of the Drosos Funded HIV and AIDS Prevention, Treatment, Care and Support Project in Prison Settings of Egypt, Morocco, and Tunisia. DROSOS: Geneva.

v MENAHRHA (2013). Women injecting drug users in the MENA. MENAHRHA: Beirut. Retrieved from www.menahrha.org/images/pdf/MENAHRHA_OR_Women_Injecting_Drug_Users_2013.pdf

vi Ibid.

vii MedNET site internet <https://www.coe.int/fr/web/pompidou/activities/MedNET>.

viii Van Hout MC (2021). Evaluation Report of the Impact of 15 years of MedNET. Mediterranean cooperation network on drugs and addictions of the Pompidou Group. P-PG/MedNET (2021) 36 16 November 2021.

ix Ibid.

The most recent assessment of the need for gender responsive services for women with drug use disorders in Egypt was conducted in 2016 within MedNET¹. This assessment revealed the strong gender-based disparities in the areas of health, economic participation, and overall empowerment of women. It underscored the efforts of the GSMHAT in undertaking continuous efforts to remove the stigma surrounding addiction and increase public awareness of addiction as a mental disorder. There is a national project to provide sexual and reproductive health services for women living with HIV which is implemented in nine governorates in collaboration between NAP and UNAIDS.

The MedNET assessment noted the lack of willingness among these women to declare their problem and access treatment, the under-development of services for them, and the lack of in-depth studies of addiction problems affecting women in Egypt. The report noted at the time that services available for treating women with substance abuse problems in Egypt were quite limited, consisting of mostly residential facilities, with most beds in the private sector. Inpatient wards have been developed only very recently in public hospitals. Whilst community-based services are mixed-gender, men exclusively attend them. They are all run by private sector establishments. Public mental hospitals run clinics open to women but are not geared specifically to their treatment needs.

2022 National Drug Observatory Snapshot Profile: Female Treatment Characteristics

During the RSA data collection, an updated profile of treatment and service user characteristics of women using the NDO-GSMHAT reporting sheet (Annex One) was circulated to the patient and out patient government clinics and private hospital and clinic settings who support women, and to NGOs who provide harm reduction and family support services, and who have women accessing their service. See Table Five.

**Table Five: NDO Profile of female treatment patients
January to May 2022**

Gender	Number	Percentage
Males	6929	98%
Females	142	2%
Age group	Number	Percentage within female cases
16-20	13	9.20%
21-25	28	19.70%
26-30	36	25.40%
31-35	22	15.50%
36-40	23	16.20%
41-45	13	9.20%
46-50	2	1.40%
51-55	2	1.40%
56-60	2	1.40%
Above 60	1	0.70%
Total	142	100%

During the first half of 2022, 142 women were in treatment, representing 2% of the treatment population. The most significant proportion are aged 26-30 years (25.40%), followed by 21-25 years (19.7%) and 36-40 years (16.20%). Very few are aged over 46 years. In total, 282 were in treatment in 2021ⁱ.

1ry substance	Number	Percentage within female cases
Hashish	26	18.3%
Bango	2	1.4%
Tramadol	21	14.8%
Heroin	78	54.9%
Nailbuphine	1	0.7%
Amphetamines	1	0.7%
Strox	6	4.2%
Others	7	4.9%
Total	142	100%

2ry substance	Number	Percentage within female cases
Hashish	18	17.2%
Bango	1	0.7%
Tramadol	17	12%
Heroin	4	2.8%
Opium	1	0.7%
Amphetamines	1	0.7%
Benzodiazpines	6	4.2%
Pregabalin	2	1.4%
Strox	2	1.4%
Others	3	2.1%
Total	55	38.7%

IDU was reported by 9.9%, with no reported cases of needle sharing. The prevalence of heroin use (54.9%) has reduced compared to 2021, where at a prevalence rate of 68.44%, heroin was the most popular substance among women. Hashish (18.3%) and Tramadol remain popular (14.8%) but lower than reported in 2021 (Tramadol 30.85%; cannabis 28.72%, respectively)ⁱⁱ. The use of Strox remains stable at 4.2%.

i National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

ii National Drug Observatory Annual Report (2021). National Drug Observatory Egypt

Understanding multi-stakeholder key informant perspectives

In depth interviews (Annex Two) were conducted during site visits with a purposive sample of health professionals involved in the delivery of drug treatment, representatives of UN agencies, and senior staff at non-governmental organisations providing harm reduction services. A total of 21 key informant professionals were consulted.

Six females and seven males were interviewed in the government cohort, mostly nursing staff, psychiatrists and drug counselors with a broad range of experience working with PWUD (ranging from one to 20 years). Of note is that two drug counselors were former users. All responsibilities included assessment, treatment, follow up outreach and programme management. See Table Six.

Six women and two males were interviewed representing UN agencies and NGOs involved in harm reduction and community support of PWUD. Length of experience in working with PWUD and WWUD/WWID was longer, on average 16 years. All had a broad range of responsibilities, including policy making, strategic planning, resource mobilization, programme management and referral for treatment. See Table Six.

#	Institution and Role	Gender	Length of time working with PWUD (years)
Key Informant Interviews Government			
1	Nursing Specialist	Female	4
2	Nursing Specialist	Female	1
3	Nursing Specialist	Female	1
4	Nursing Specialist	Female	2
5	Psychiatrist	Male	2
6	Psychiatrist	Male	3
7	Psychiatrist	Male	2
8	Psychiatrist	Male	20
9	Drug Counsellor	Female	10
10	Drug Counsellor	Female	3
11	Psychiatrist	Male	7
12	Psychiatrist	Male	17
13	Special Assistant	Male	7

Key Informant Interviews UN agencies and NGOs

1	Befrienders NGO	Female	20
2	UNAIDS	Male	14
3	Friends NGO	Female	10
4	UNDP Global Fund Unit	Female	14
5	HIV Unit in Caritas NGO	Female	19
6	Sehaaty Beauty NGO	Female	15
7	El Shehab NGO	Female	20
8	Freedom NGO	Male	19

WWUD/WWID profile and settings for use

Key informants employed in government services observed that WWUD and WWID accessing treatment in Egypt are from urban areas and of lower socio-economic status, often middle aged, single and with children. UN agencies and NGOs working in community harm reduction observed similar patterns in that they felt that WWUD and WWID are between 18 and 45 years old, from lower socio-economic backgrounds and most commonly single. A broad range of ages of women accessing harm reduction and treatment was observed by all stakeholders, mostly from cities, and mostly unmarried or divorced.

A key informant from NGO

"Scope is really widened nowadays from 13 years to old women. Normally from the cities Rarely from countryside unless she chooses to say."

Both government, NGO and UN sectors observed that common drugs used by women in Egypt are heroin, Tramadol, hash, cannabis, synthetic cannabis, and cocaine. They observed drug consumption by women to occur primarily through inhalation and swallowing tablets/powders, with some reports of IDU. Most key informant stakeholders reported that WWUD do not reach the drug dependence levels attained by men. They observed that the proportion of WWID was low compared to women using tablets or inhaling drugs for recreational purposes. There was one report by an NGO about tropicamide [Mydrapid] injecting.

Drug use settings were with husbands, partners, sex work clients and friends, and rarely alone. An NGO informant said.

“They use drugs when their partner or someone in the family is using drugs or working as sex worker or have been prisoned before.” (NGO)

Another key NGO informant illustrated the varied pathways toward drug use among women and the relative lack of awareness around the dangers of drug use and the potential for overdose.

“The conditions of drug abuse differ among women, some of whom went to drugs due to problems, and some of them engaged in sex work and the clients made them use drugs. They inject drugs with clients or friends, most of whom do not know anything about overdoses.” (NGO)

Dimensions of stigma, risk-taking and help-seeking

“NO POLICIES ARE HINDERING THEIR ACCESS TO TREATMENT, BUT THE CULTURE OF THE SOCIETY IS STIGMATIZING ADDICTION IN FEMALES AND LACK OF AWARENESS IN THEIR FAMILIES ARE HINDERING THEIR ACCESS TO TREATMENT.” (GOVERNMENT)

The majority of key informant stakeholders described cultural norms and values in the conservative Egyptian society as heightening stigma of drug use among women and subsequent experiences of discrimination, isolation, and marginalisation.

Government level key informants also repeatedly mentioned the lack of awareness of families around drug use and dependence and where to seek treatment.

All described the substantial levels of self-perceived, familial and community level stigma of WWUD, resulting in discriminatory experiences and poor mental health of WWUD, and hindering their attempts to enter treatment and receive support.

“They always have shame, blame, depression, self-stigma and this what keeps them from seeking help.” (NGO)

“The stigma and discrimination from society towards women who use drugs prevents women from requesting health services and health support, and in some cases, arbitrary measures are taken against them.” (NGO)

Stigma is particularly exacerbated if the woman is living with HIV, injecting drugs and engaging in commercial sex work. A UN agency key informant said.

“Triple stigma (Women who inject drugs/people living with HIV/sex worker) (UN Agency)

Several NGO informants observed the stigma of female drug use to exacerbate high-risk activity and amplify trauma in the form of domestic violence, loss of relationships and children, and consequent poor mental health.

“Women are always stigmatized (may lose their family or partners), violence, abuse, traumatized or depression...May share needles.” (NGO)

Elevated risk behaviours such as sharing of injecting equipment and having unprotected sex were observed to hamper efforts to seek help and to complicate treatment entry and retention.

NGO key informants working in the community observed.

“If she still practices those risky behaviours, she wouldn’t seek treatment.” (NGO)
“Female sex workers always suffer if the client refuses to use condoms to protect herself. So, this really affects her seeking help.” (NGO)
“Dangerous practices and unprotected sex affect women’s exposure to transmitted diseases, and when becoming an infected person, things get complicated and put women in a state of refusal of services, seeking death and salvation from their problems.” (NGO)

The power of their intimate partner relationships, their place within an existing network of PWUD, and their clients of sex work, compound efforts of WWUD/WWID to seek help. This was especially the case where husbands introduced wives to drug use, injecting of drugs and consequent co-dependencies.

“Their sexual partners prevent them from seeking help. To overcome those risky behaviours, even those surrounding them, especially if addicts, they stop them from seeking treatment or seeking harm reduction tools.”
“Most of the cases I witnessed started using with the husband, which makes it difficult for them to seek treatment or even maintain their abstinence unless the husband is also seeking treatment.”

The government, UN agencies and NGO key informants provided a range of narratives illustrative of individual internal stigma, hopelessness, and lack of ability to change behaviours.

“Yes those negative feelings may stop her from seeking help since she is used to this negative feeling and has learned to cope with this bad feeling and those risky behaviours so she may not change easily. So she will have to change her inner feelings” (NGO)

“Sometimes these feelings are motivating them, and sometimes they feel hopeless, and no one can help so they don’t seek treatment or support.” (Government)

“It is necessary to collaborate with women who use drugs on self-acceptance and how to combat their internal stigma.” (NGO)

Additional barriers to service uptake and reluctance to seek help centre on the lack of awareness of appropriate services to go to, but also around fears of losing custody of children and exposure to gender-based violence (including intimate partner violence) in the home. Some key informants reported on the fears of WWUD/WWID of loss of confidentiality. For young women using drugs, for example, the parental consent for HIV testing in minors represented a specific barrier to service uptake.

Current addiction services and role of civil society organisations

According to all key informant stakeholders, a range of government and community harm reductions services are provided using a “gender neutral” approach and

which includes women's health services (HIV testing, Hepatitis B and C testing), harm reduction (condom provision, NSP), counselling, reproductive and mental health referrals, outreach care, detoxification, and rehabilitation. OAT was observed by all consulted to come soon, and this was very much welcomed by all participants.

Many government-level key informants described mixed services for men and women and the location of centers as discouraging to women seeking help. Geographic coverage across the country was also observed to be inadequate.

Both government and NGO key informants said:

"We have an increasing number of injecting drug users, but there are difficulties in reaching them, especially in Upper Egypt." (NGO)

"Geographical distribution of cases on admission, while centres are not available in all governorates." (Government)

NGOs were deemed a vital lifeline and crucial in engaging with WWUD to encourage help-seeking and build trust.

» *"Secrecy, Trust, Safety. The thing that influences the women is the services provided by the NGO without any stigma or discrimination." (NGO)*

» *"The support community is the important point... we have to emphasize on it." (UN Agency)*

» *"Self-stigma makes herself not keen on seeking help. But this should be overcome with the help of the community around them, and with psychological support." (UN Agency)*

NGO key informants observed referral to treatment to occur mainly via the 'inner circle' of partners, family, and friends. Self-referral and via outreach were also described.

"The most important point is getting help from people around her and the community, either from family or work." (UN Agency)

"The role of civil society and the AIDS program is very important." (UN Agency)

Future development of gender sensitive services, capacity building and reinsertion efforts to support women

Government level key informants observed the need to address the gaps in service coverage in Upper Egypt and the hinterland, the geographic distribution of centres mainly in big cities and lack of centres in some governorates (mainly the Upper Egypt governorates (Assiut, Aswan, Qena) and some delta governorates (Sharqeya, Gharbia), the lack of trained staff, lack of specialist centers for women, and lack of social integration initiatives for women within rehabilitation and aftercare.

For a better response to women needs:

Sensitize and reduce stigma.

More services for women and for minors.

Service for HIV and STI testing.

Integration of clinics within existing women's health services.
Strengthened NGOs.

Deployment of women only led services.

Specialized staff.

Assertiveness skills and combating violence.

Government staff also felt the stigma of those working in the field of addiction.

“As service providers in the field of addiction treatment in general and the field of WWUD in particular, we are facing a stigma that is never less than the stigma of patients themselves.” (Government)

A range of suggestions to achieve a better response to the needs of women were documented during interviews and included the following:

- Efforts to sensitise and reduce stigma and discrimination against WWUD.
- More government places for free services and specialised units for women and for minors.
- A distinct service for women inclusive of HIV and STI testing and treatment separated from male facilities. Integration of clinics within existing women’s health services.
- More strengthened role by NGOs working in the community and greater syringe and condom distribution.
- Deployment of women only led services to support initial outreach in the community, encourage uptake, support retention, and enhance gender sensitive care.
- Specialized staff for operating gender sensitive treatment to support a confidential and professional gender and trauma sensitive approach.
- Wrap around services to support special trainings for WWUD/WWID on safe injection, refusal skills, and combating violence, counselling for trauma and gender-based violence, legal supports, and community packages (day care / transportation fees for low-income level women, childcare), and sustainable livelihoods for when in aftercare.

Key quotes from NGO key informants

- ◆ “Women only services at least for the first period since they may have been subjected to rape or violence from men so they may not be encouraged to deal with men at this time.” (NGO)
- ◆ “I think that women who use drugs need special services directed toward them, such as “fieldwork teams made up of women.” (NGO)

Community NGO and HIV VCT Settings

Focus Groups Location	Number of WWUID	Organization	Age range	Marital Status	Education	Employment	Range of Drugs Used
Cairo-Greater Cairo	5	Freedom Rehabilitation NGO	32	Divorced	Illiterate	Fulltime employment	Drugs not detailed in interview with exception of tablets
			27	Separated	University degree	Full time employment	
			43	Single	University degree	Full time employment	
Cairo-Greater Cairo	5	Freedom Rehabilitation NGO	25	Single	University degree	Fulltime employment	Tablets, marijuana and crystal
			23	Single	High school	Fulltime employment	
			25	Divorced	University degree	Unemployed	
Ismailia Suez Canal	5	HIV VCT centre	35	Married	University degree	Housewife	Powder, Crystal, Carnabis / powder
			27	Divorced	High school	Unemployed	
			39	Widow	Illiterate	Unemployed	
AI Charbia Delta	5	HIV VCT centre	50	Divorced	University degree	Fulltime employment	Hash, tablets, powder
			31	Married	Literate	Street worker	
			35	Married	High school	Unemployed	
Cairo-Greater Cairo	5	AI Shehab NGO	42	Divorced	High school	Unemployed	Hash, Strax, Vodo Powder, Tablets
			42	Divorced	High school	Unemployed	
			25	Single	Literate	Unemployed	
Minya -Upper Egypt	3	HIV VCT centre	21	Married	High school	Unemployed	Tablets, Mydrapid drop, injections, Methamphetamine Powder, Analgesics.
			23	Married	In university	Unemployed	
			36	Married	University degree	Unemployed	
Minya -Upper Egypt	4	At Friends NGO	32	Divorced	High school	Unemployed	Heroin, hash, tablets, Mydrapid
			29	Single	University degree	Part time employment	
			31	Married	University degree	Part time employment	
AI Charbia Delta	3	HIV VCT centre	45	Married	University degree	Housewife	Nalufin injection / Tramadol Powder inhalation injections (Heroin - Morphine)
			45	Divorced	University degree	Housewife	
			35	Married	University degree	Housewife	
Cairo	3	Sahaaty Mn Beaaty NGO	45	Separated	University degree	Unemployed	Mydrapid oral injection
			65	Widow	Literate	Unemployed	
			48	Divorced	Illiterate	Street seller	
Alexandria	4	Caritas NGO	30	Married	Literate	Unemployed	Heroin
			31	Separated	University degree	Unemployed	
			79	Widow	Illiterate	Unemployed	

Understanding the experiences and needs of WWUD/ WWID

Focus groups (Annex Three) were conducted with a convenience sample of WWUD/WWID in treatment and those accessing HIVVCT centres and NGO providing community harm reduction (n=75). Detailed profile characteristics are presented in Table 7.

Table Seven: Focus Groups with WWUD/WWID

Government Hospital Settings

Focus Groups Location	Number of WWUID	Organization	Age range	Marital Status	Education	Employment	Drugs Used
Suhaq - Upper Egypt	6	Suhaq Psychiatric Hospital	28	Married	High school	Full time employment	Tramadol
			32	Divorced	High school	Casual work	Pregabalin
			33	Married	University	Full time employment	Heroin/Naufin
			40	Married	Literate	Housewife	Hashish
			33	Married	Vocational school	Housewife	
35	Married	High school	Housewife				
Cairo	7	Abbasiyah Psychiatric Hospital	33	Divorced	University	Casual work	Alcohol, sleep aid,
			25	Divorced	University	Casual work	Hashish , cocaine,
			32	Divorced	Primary School	Casual work	heroin Tramadol,
			30	Married	High School	Unemployed	Metamphetamine
			30	Divorced	Vocational School	Casual work	(X3).
36	Divorced	High School	Housewife				
25	Single	High School	Casual work				
Cairo	3	Abbasiyah Psychiatric Hospital	36	Divorced	Highschool	Full time employment	Tramadol
			39	Divorced	Literate	Unemployed	Hashish
			41	Married	University	Casual work	
Cairo	5	Heliopolis Psychiatric Hospital	39	Married	University	Full time employment	Hashish, Heroin,
			26	Single	University	Temporary work	Tramadol, Cocaine
			50	Married	University	Full time	
			21	Single	High school	Unemployed	
			23	Married	Primary school	Unemployed	
Cairo	5	Heliopolis Psychiatric Hospital	27	Divorced	University	Full time employment	Hashish, Tramadol,
			28	Single	University	Temporary work	Naro vet and
			25	Single	University	Full time	tramadol, Heroin,
			36	Divorced	High school	Unemployed	Tramadol,
			25	Married	Primary school	Unemployed	Cystal meth (!)
Alexandria	7	Al Mamora-Psychiatric Hospital	39	Divorced	University	Low level	Alcohol, heroin,
			27	Married	--	Unemployed	benzodiazepines,
			32	Married	--	..	hashish
			23	Married	--	..	
			28	Single	--	..	
			36	Divorced	--	..	
			30	Married	--	..	

Trauma, stigma, and the drivers of the use of drugs among women

A broad range of motives for the use of drugs were illustrated by the women consulted and included self-medication for physical pain due to work duties, the self-medication of symptoms of psychological stress (anxiety, depression, and insomnia) due to marital stress and bereavement, for recreational intoxication purposes, due to boredom and for the enhancement of sexual activity. At the Freedom Rehabilitation Centre NGO, several women reported acute depression due to bereavements and loss of children. At Al Mamora Psychiatric Hospital, one woman reported inter-familial addiction when her father was an addict.

- » *"I faced a great shock when I lost my son. He was 22 years old and died in an accident, my husband was taking drugs and I tried with him to pass my depression and mental suffering" (Caritas NGO)*
- » *"I was depressed and sad since my husband got prisoned for 5 years and when he got out, he left me." (Al Minya VCT Centre)*

There were some reports of progression toward iatrogenic dependence for menstruation pain management, with subsequent displacement to IDU.

"I began with taking unprescribed menstrual sedative then it progressed to Adol and Tramadol [both synthetic opioids] and I got used to it ..then I tried injection with my sister." (Al Gharbia VCT Centre)
income level women, childcare), and sustainable livelihoods for when in aftercare.

Several women at the Abbasiyah, Heliopolis and Suhag Psychiatric Hospitals reported using and injecting drugs with and often under coercion from their husband (heroin). At the Al- Minya at Friends NGO, several women reported that husbands coerced them to use drugs during sexual intercourse.

Many women reported marital difficulties and exposure to intimate partner violence.

- » *"My fiancé was takings drugs, so he made me try it a couple of times, then I became addicted." (Al Minya VCT Centre)*
- » *"I used drugs due to refusal to continue my life with my husband, I don't love him however, my family forced me to continue this life for the sake of my children." (Caritas NGO)*

At the Al- Minya at Friends NGO, several women reported that close family relatives introduced them to drugs to relieve emotional distress and trauma due to physical and sexual abuses in the home and to stimulate aborted pregnancies.

"Due to problems in the family since my stepfather was molesting me and made me take drugs with him and then my mother saw us together in an unpleasant situation and she kicked me out." (Al- Minya at Friends NGO)

Perceptions of individual, familial and community stigma and gender discrimination are pervasive in the narratives of the women consulted across the hospital, HIV VCT and NGO settings.

- » *"People always stigmatize me." (Ismailia VCT centre)*
- » *"For women, being divorced in our community is stigmatizing just like using drugs." (Abbasiyah Psychiatric Hospital)*

- » *“The community is unfair and racist as it differentiates between men and women in everything, so in terms of abuse, it might be accepted for men to use cannabis - while it’s not acceptable for women, even if the reasons for the use are the same.” (Abbasiyah Psychiatric Hospital)*
- » *“Nobody in my family wants to deal with me.” (Al Gharbia HIV VCT Centre)*

Levels of trauma and guilt were relayed in many interviews, including awareness of their children’s exposure to drug use and intoxication. Many women across the hospital, VCT and NGO settings experienced substantial stigma and discrimination and voiced their fears about being a poor role model, and fears around legal consequences and loss of custody of their children.

- » *“My son used to see me smoking hash, he is 13 years old and now he has started smoking hash with his friends, I do not want him to be an addict. I am blaming myself for being a bad role model for my son.” (Abbasiyah Psychiatric Hospital)*
- » *“People cursed my children for being having a mother addict.” (Al Gharbia VCT Centre)*
- » *“The community and my neighbours stigmatized me, and they began to curse my children... so I wanted to stop using drugs for them “(Sehaaty Mn Beauty NGO)*

One woman described network level stigma regarding type of drug used.

“Stigma between users themselves according to the type of drug the woman is using.” (Freedom Rehabilitation Centre)

Settings and forms of drug use

Settings for the use of drugs by women centred on home, particularly regarding IDU with partners, friends, and siblings (often brothers), and on the street. Access to drugs was viewed as easy via user networks. One woman observed.

- » *“I had the drugs delivered to my doorsteps.” (Freedom Rehabilitation Centre)*
- » *“Someone taught me to use drugs since it was free although I knew it was wrong.” (Al Minya VCT Centre)*

Few women reported using or injecting drugs alone. Of the minority reporting experience of IDU, they did not share needles with others, indicative of some risk awareness. Several, however, reported using the same needle twice, particularly when pharmacies did not provide clean syringes. Several women reported needle sharing at the Al-Minya VCT centre to save money. Similar reports were documented at the Al- Minya at Friends NGO.

“When I can’t get a clean one from the pharmacy or the dose is there, and I can’t wait to get a clean syringe.” (Al- Minya at Friends NGO)

At Al Gharbia HIV VCT centre one woman described how she used to share with her sister but then her sister was infected by her husband with HIV, and so she stopped sharing with her. She then shared with her husband and became infected with HIV. One woman at Sehaaty Mn Beauty NGO reported her experience of sharing needles in prison.

"I have been to jail for 4 months and that's what helped me to stop using drugs." (Caritas NGO)

Across the sample of women consulted there was some awareness and experience of overdose, both personally and that of peers and husbands. At the Abbasiyah and Heliopolis Psychiatric Hospitals, one woman reported that three of her friends had died from a drug overdose, and another reported awareness of overdose deaths in her network. Several women at Al Minya at Friends NGO described personal experiences of overdose.

"A couple of times I overdosed and was rushed to the hospital, and they saved me." (Al Minya VCT Centre)

There were some reports of thoughts to overdose intentionally. Many women described their distress.

"I could get into jail again. I could die alone, my dealer may take advantage of me, my family could reach me and kill me." (Al Minya At Friends NGO)

Very few women reported contact with the criminal justice system.

"My friend and I were bored so we tried a couple of times, then we became addicted, and I got in jail for a drug abuse case." Al- Minya at Friends NGO

At Ismailia VCT centre in Suez Canal, several women described their awareness of how WWUD are humiliated in prisons. For some women, however being in prison created an opportunity to cease drug use.

Awareness of risk, risk behaviours and harm reduction

A broad range of health risks were illustrated by the women consulted and underpinned by high-risk drug and sex related activities, and included experiences of unwanted sexual relationships, multiple sex partners, commercial and transactional sex work, exploitation, kidnapping, unwanted pregnancies and unsafe injecting practices. Additional risks included crimes of poverty (for example, stealing, drug dealing).

- » *"My family always forces me to do things I don't want to. That's why I started taking drugs." (Al Shehab Centre)*
- » *"My partner negotiates with me to have sexual relations in return for drugs or money for drugs." (Al Gharbia HIV VCT Centre)*

Low level awareness of harm reduction services was reported across the sample, with most women not knowing anything about harm reduction. Harm reduction principles were observed to be not widely known, due to cultural sensitivities.

"These strategies won't be applicable in our society." Abbasiyah Psychiatric Hospital

However, women attempted to reduce harm and more serious forms of drug use, by tapering and replacing illicit drugs with medications. The displacement between heroin, Tramadol, and hash, injecting, and many women described insufflation.

- » *"I tried quitting drugs using analgesics and it worked." (Al Minya VCT Centre)*
- » *"I tried powder inhalation [sniffing] with my first husband and tried injections with my friend after marital problems, but I got really sick so I went back to inhalations." (Al Minya VCT Centre)*
- » *"Harm reduction as I know it is gradually reducing my intake dose. I am reducing harm by using hash instead of Tramadol." Abbasiyah Psychiatric Hospital*
- » *"To reduce the harm of using, I can change the way I use heroin, to be sniffing instead of injection. Or may be using hashish is also less harmful." (Suhag Psychiatric Hospital)*

Some were engaging with harm reduction NGOs were afraid to enter treatment and change their behaviours.

"I don't want to go to rehabilitation centre or to be treated, I don't want to face my real life." (Caritas NGO)

Awareness, seeking help and accessing support services

Triggers to initiate help-seeking and enter treatment were described and spanned issues such as pregnancy, mental health conditions including drug related psychosis, fear of contracting blood borne viruses, fear of divorce, fear of losing child custody, sexual and reproductive health issues, gender-based violence and fear of death.

- » *"I am so afraid of death, and I don't want to do anything wrong or bad." (Al Minya VCT Centre)*
- » *"Don't want to continue my life as a bad person anymore." (Abbasiyah Psychiatric Hospital)*
- » *"I want to get clean for my children." (Al Gharbia VCT Centre)*
- » *"I want to get clean. I am always irritated and nervous and tired... also to be a respectful lady and be a good person in front of other people." (Al Minya VCT Centre)*
- » *"I want to be a mother to a healthy child." (Al Minya At friends NGO)*

Many voiced that they were tired of addiction.

"... feeling like I am not a whole human being but just broken pieces." (Al Minya At friends NGO)

All participants described their experiences in seeking help for their drug use, with pathways toward treatment hampered by a lack of awareness about available drug treatment modalities, lack of awareness of harm reduction practices and services, lack of specialized clinics for women and a lack of services for them in some governorates outside of Cairo (for example Asiut, Port Saied). Programmes offered centre on hospital admission for detoxification, specialist Hepatitis C and HIV testing clinics and rehabilitation follow up during aftercare.

- » *"Most of my user friends were not aware of available services for the treatment of addiction for women." (Abbasiyah Psychiatric Hospital)*
- » *"I come to the hospital with my brother who is mentally ill, and I used this opportunity to try treatment for my addiction problem." (Suhag Psychiatric Hospital)*

There was little awareness of the provision of treatment in prison. At Al Mamora Psychiatric Hospital, two women reported denial of treatment in prison. One woman at Al-Minya at Friends NGO said;

"I am afraid to go back to jail I got infected with HIV." (Al-Minya at Friends NGO)

Many remarked on the need for treatment services to adopt a more accepting approach for those seeking help. Several women from the Cairo Freedom Rehabilitation Centre said.

- » *"Be more flexible in accepting people." (Cairo Freedom Rehabilitation Centre)*
- » *"I got rejected from treatment facility since my ID was expired from 1 month only." (Cairo Freedom Rehabilitation Centre)*

They voiced concerns about privacy and confidentiality of treatment and highlighted their wishes to undergo treatment and individual counselling in a gender sensitive manner.

- » *"I am afraid of my husband's reaction if he finds out about my addiction problem." (Suhag Psychiatric Hospital)*
- » *"I am afraid of the idea of group therapy. As our society is small, and it may happen that a neighbour of my husband's family is attending the group session for example or a relative of one of my husband's colleagues at work." (Suhag Psychiatric Hospital)*
- » *"I find it difficult to talk about what concerns me in a group, I prefer individual sessions" (Suhag Psychiatric Hospital)*

Most women were concerned around the attitudes of healthcare providers toward them as women suffering from drug dependence. At the Freedom Rehabilitation Centre two women illustrated discriminatory experiences by medical professionals.

- » *"My doctor didn't want to operate on me and even though I couldn't stop using alcohol." (Freedom Rehabilitation Centre)*
- » *"Doctor refused to deliver me while I was using drugs at the same time." (Freedom Rehabilitation Centre)*

A woman in treatment at Abbasiyah Psychiatric Hospital was observed.

"I used to think so, and that prevented me from seeking treatment for a long time, for fear of bad attitude from staff during treatment in the hospital. However, this changed after I came here." (Abbasiyah Psychiatric Hospital)

All women with caregiving responsibilities voiced the importance of care of children.

"We need home care of young children and day care for children of women in the treatment programme. If you could provide a day care for our children during the sessions (Suhag Psychiatric Hospital)

Gender sensitive service needs

When asked about how current service provision for women in Egypt could improve, the women consulted provided the following key areas for government and civil society attention.

- Raise community level awareness of available drug treatment and harm reduction services and practices
- Provide services for free and locate services in general hospitals, women's health units, and primary care to reduce stigma.
- Devote more attention to the governorates of Upper Egypt to support the existing concentration of services in the Cairo and Delta governorates
- Provide women-only services with qualified and trained female staff in community outreach and government treatment facilities (particularly on intake).
- Ensure confidentiality and that staff are trained in human rights (dignity and respect), and women's unique health needs during drug treatment, including sexual trauma.
- Promote a trusting and empathic therapeutic relationship for the woman.
- Provide individual therapy as opposed to group sessions.
- Provide counselling on HIV, sexual health and STIs, marital and couple therapy, and family counselling.
- Provide parenting skills training and support sessions, and day care provisions for children of women attending treatment
- Provide legal advice and support around child custody aspects,
- Create a model of care and support for women on treatment completion by incorporating elements of sustainable livelihoods into rehabilitation and aftercare programming.

Discussion

This RSA builds on the earlier research efforts by MENAHRA in 2013 which revealed the hidden nature of WWID in Egypt and the substantial traumas, stigma and challenges experienced by them in Egyptian society. This report underscored the need at the time to prioritise women in HIV and drug related stigma reducing activities, awareness raising around harm reduction activities, especially NSP, overdose and safe injecting practices, and the need to incorporate aspects of sexual and reproductive health education and care into harm reduction programmingⁱ. The RSA illustrates the progress achieved to date since then by the Egyptian government and the network of NGOs serving the community. It acknowledges efforts supported by the MeDNET activities since 2017ⁱⁱ and provides a further platform upon which to build a gender responsive service response to WWUD/WWID.

The profile of WWUD/WWID observed in this RSA is in line with the current evidence baseⁱⁱⁱ, and the 2021^{iv}. and to quarter three 2022 NDO-GSMHAT reporting^v, which indicated that most women in treatment are aged between 21 and 40 years. Notably, many women consulted in this RSA had completed university-level education.

The association of adverse and traumatic experiences including sexual exploitation and coercion to take drugs by partners and husbands, exposure to violence, mental health issues and poverty as observed in other Egyptian studies^{vi vii viii ix x xi} was evident in the narratives of stakeholders and WWUD/WWID consulted. The disproportionate effect of drug related health issues (including psychiatric co-morbidities and blood borne virus acquisition) and negative familial, social and health impacts of drug use (stigma, psycho-trauma) is evident. Notwithstanding some few reports of IDU, risk behaviours centred largely on personal and peer level overdoses and engagement in unprotected, coerced, and high risk (sometimes transactional) sexual activity resulting in substantial trauma and mental health issues.

i MENAHRA (2013). Women injecting drug users in the MENA. MENAHRA: Beirut. Retrieved from www.menahra.org/images/pdf/MENAHRA_OR_Women_Injecting_Drug_Users_2013.pdf

ii Sabry, N (2016). Gender Responsive Services for Women with Substance Abuse Disorders in Egypt Final Report Pompidou Group, MedNET.

iii MENAHRA (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2021. MENAHRA: Beirut. Retrieved from 2021 Assessment of Situation (menahra.org)

iv National Drug Observatory Annual Report (2021). National Drug Observatory Egypt.

v National Drug Observatory Annual Report (2021). National Drug Observatory Egypt.

vi Yousef et al. (2022). Prevalence and clinical implication of adverse childhood experiences and their association with substance use disorder among patients with schizophrenia. *Egypt Journal of Neurology Psychiatry Neurosurgery*. 58:4.

vii El-Sawy, H et al. (2010). Gender differences in risks and pattern of drug abuse in Egypt. *Egyptian Journal of Neurology, Psychiatry and Neurosurgery*, 47(3), 413-418.

viii Oraby, D (2013). Harm reduction approach in Egypt: the insight of injecting drug users. *Harm Reduction Journal* 10:17.

ix Khattab, H. et al. (2007). All Alone: The Stories of Egyptian Women Living with HIV, Stigma, and Isolation. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

x Khattab, H. et al. (2010). The agony of AIDS: A qualitative study of the experience of AIDS in Egypt. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

xi Khattab, H. El-Geneidy, M. (2014). Living with AIDS: Suffering and Courage. Cairo: Egyptian Society for Population Studies and Reproductive Health (ESPSRH).

Drugs of choice are heroin, tramadol, hashish and synthetic cannabinoids, similar to that reported in the NDO-GSMHAT treatment surveillance and extant empirical studies in Egypt^{xii xiii xiv xv}...A minority reported experience of IDU which is also aligned to the NDO-GSMHAT estimate of 9.9% reporting IDU. Narratives, however revealed needle sharing and the reusing of needles, and very low awareness around harm reduction, with reports of self-tapering or switching to other perceived less harmful forms of drug use in efforts to reduce harm. Pharmacies do not provide sufficient clean needles to the WWUD/WWID. This occurs even though PWID are identified as a target group for HIV in Egypt

National HIV Strategic Plan 2021 – 2025 and NSP have been scaled up^{xvi}. Whilst NGOs are providing condom promotion, HIV testing and counselling and NSP for PWID in large cities^{xvii xviii} geographic coverage of both NGO and government services is not sufficient, particularly in governorates of Upper Egypt. Whilst most recent UNAIDS data on Egypt estimates the use of sterile injecting equipment at last injection at 31.5%^{xix} it is recommended to achieve more current surveillance on this public health issue, particularly in hidden groups of WWUD/WWID. It is encouraging that the NAP will conduct the Population Size Estimate (PSE) and Integrated Bio-Behavioural Surveillance Surveys (IBSS) in September 2022.

The RSA yields similar findings to extant research on WWUD/WWID in Egypt, centring on the substantial barriers to help-seeking due to self and cultural stigma^{xx xxi xxii}. The triple stigmas of being a woman, using drugs and engaging in sex work was observed, compounding their health and wellbeing risks, and deterring help-seeking. Findings further illustrate structural barriers to uptake including lack of awareness around harm reduction in the community, cost, and admissions procedures. Coercion, abuse, and domestic, sexual and exposure to gender-based violence are safety concerns for women attempting to access services. "Trust" is a key component within low-threshold

xii National Drug Observatory Annual Report (2021). National Drug Observatory Egypt.

xiii Hussien, R et al. (2021). Acute Toxic Effects of the New Psychoactive Substance "Voodoo" among patients presented to the Poison Control Center of Ain Shams University Hospitals (PCC-ASUH), Egypt, during 2017. Substance Abuse Treatment, Prevention, and Policy, 16:71.

xiv El-Masry, M., Abdelkader, S.I. (2021). Clinical profile of designer drug "Strox" intoxicated cases presented to Poison control center Ain Shams University, Egypt from first of January 2017 to end of January 2018. Ain Shams Journal of Forensic Medicine and Clinical Toxicology 36: 98-105.

xv Balha et al. (2021). Assessment of Psychological Symptoms and Cravings among Patients with Substance Related Disorders Egyptian Journal of Health Care, 2 (3):751 to 763.

xvi MENAHRA (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2020. Retrieved from 2021 Assessment of Situation (menahra.org)

xvii Ministry of Health and Population (MOHP) (Egypt), El-Zanaty and Associates (Egypt), and ICF International. (2015). Egypt Demographic and Health Survey 2014. Cairo and Rockville, MD: Ministry of Health and Population and ICF International.

xviii MENAHRA (2021). Assessment of Situation and Response of Drug Use and its Harms in the Middle East and North Africa 2020. MENAHRA: Beirut. Retrieved from 2021 Assessment of Situation (menahra.org)

xix UNAIDS. (2019). UNAIDS Data 2019. Geneva: Joint United Nations Programme on HIV/AIDS; 2019. Available from: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

xx Balha et al. (2021). Assessment of Psychological Symptoms and Cravings among Patients with Substance Related Disorders Egyptian Journal of Health Care, 2 (3):751 to 763.

xxi Fathy et al. (2021). Effect of Educational Program for Reducing Self Stigma and Shame among Substance Abuser Women. Ilkogretim Online . 2021, 20 (5):2278-2288. 11p.

xxii Egypt Today (2017). 28% of Egyptian drug abusers are female: Minister. Retrieved from www.egypttoday.com/Article/1/4729/28-of-Egyptian-drug-abusers-are-female-Minister

substance use. Wrap around community support could leverage the experiences of former WWUD/WWID to support others.

Matrix of evidence with recommended responses

Evidence Drivers and Contexts

Drivers of women's drug use are often underpinned by trauma in the form of gender and intimate partner violence and bereavement.

Marital discord fears around divorce and loss of custody of their children causes substantial stress and isolation.

Women's engagement with drugs is often initiated and facilitated by men (siblings, partners, sex work clients)

Social networks in the form of friendships, familial relationships, sexual relationships, and commercial sex trans-actioning encourage drug use.

WWUD and WWID engage in various poverty and drug related crimes to support their drug habit (stealing, sex work etc.).

Risk behaviours and harms

IDU occurs mostly within small groups, in a private setting often with injecting facilitated by the male partner.

Whilst most women are aware of the risks associated with unsafe injecting, WWID will share needles or reuse needles if pharmacies do not provide needles to them.

Sexual violations, unwanted pregnancy and unsafe abortions are faced by WWUD/WWID, and contribute to depression, anxiety, insomnia, risk of acquiring STIs, and HIV and other bloodborne virus transmissions.

Sexual risk behaviours (coerced sex, multiple partners, unprotected sex) fuel acquisition of blood-borne viruses and STIs, particularly among WWID and those engaging in sex work. The inability to negotiate condom use is a characteristic of the power differentials in

Response

Outreach for harm reduction and drug treatment and rehabilitation providers should be trained in and adopt a trauma informed gender sensitive approach.

Mediation, couples, and family therapy should form the basis of support and reintegration tactics at all stages of the woman's journey through harm reduction, drug treatment and rehabilitation.

Community organisations should consider using women to connect with WWUD and support them.

Social networks at each level should be leveraged to reach, connect with and support WWUD and WWID via harm reduction and treatment sensitisation. Sustainable livelihoods programming could form a vital component of rehabilitation and aftercare.

All harm reduction strategies and responses should prioritise and target WWUD not limited to WWID.

Targeted awareness raising around risks of unsafe injecting and blood borne virus transmission is warranted at community and hospital levels. Advocacy and sensitisation are warranted at community pharmacy levels to raise awareness around the importance of needle and syringe provision to WWID.

Community organisations providing harm reduction should prioritise women particularly in NSP.

Harm reduction and drug treatment services should include sexual and reproductive health services, underpinned by a gender and trauma informed approach. Harm reduction and treatment services can be integrated into women's health clinics. Psychiatric and psychological support, and HIV VCT (and Hepatitis B vaccination) should form part of overall service provision.

All community and government services should include awareness raising and

sex relationships.

WWUD/WWID are aware of risks of overdose and symptoms (sedation etc) and aware of peer overdoses and fatalities in their networks.

Drug displacement patterns are observed from oral and insufflation to injecting, and in reverse in attempts to reduce harm (switching from heroin to Tramadol or hash, from injecting to insufflation).

Stigma and Help-seeking

Women experience multiple levels of stigma relating to their behaviours, in terms of their gender, engagement in IDU and sex work. WWUD/WWID are uncomfortable in group sessions due to fears of confidentiality and privacy. Discriminatory experiences by medical staff and lack of flexibility regarding admission procedures form substantial barriers. Positive service providers are important.

WWUD/WWID are frequently in contact with the criminal justice system and prison. Denial of treatment and humiliating experiences of women in prison are reported.

Harm reduction is perceived to be culturally and religiously unacceptable as perceived by studied women and some health care providers.

OAT is welcomed

Connecting with women in recovery is important to WWUD/WWID.

Concerns around childcare hamper efforts to attend drug detoxification and rehabilitation.

Financial constraints

sensitisation around unsafe sexual behaviours cognisant of cultural and local dimensions.

Women's empowerment programmes should include aspects of safe sex and condom negotiation.

Targeted overdose training regarding signs, symptoms and peer responses should be initiated by community organisations, ideally inclusive of naloxone provision if available in Egypt. Provide local confidential service points for WWUD/WWID to contact in the event of a suspected overdose. Ensure that hospital policies include a gender dimension, and that emergency department staff are trained to respond to drug overdose in women in a confidential manner.

Community and hospital level harm reduction awareness raising initiations should be scaled up to promote evidence-based harm reduction (NSP, OAT).

The GSMHAT and community actors must continue to work towards reduction of stigma surrounding addiction and increase public awareness of addiction as a mental disorder. Provide outreach workers with skills to encourage women's self-esteem and empowerment and support healthy coping skills. All efforts should assure the confidentiality of women when accessing services and where possible, provide individual level counselling and therapy.

All staff at government and community levels providing drug treatment and harm reduction to WWUD/WWID regardless of their stage of drug dependence and recovery must complete anti-stigma (empathy) and human rights training (dignity, respect). All services regardless of level should include self-esteem promotion and empowerment initiatives for women. All services should be provided for free to all requiring treatment or harm reduction.

Law enforcement training in public health approaches to tackling drug dependence and human rights of WWUD/WWID are warranted. Harm reduction and hospital settings should include legal clinics to support women. Advocacy against

arbitrary arrests and human rights violations of women in detention are advised.

Advocacy to sensitise religious leaders, community elders, and government policymakers/health professionals on the evidence that supports a harm reduction approach is advised.

OAT should be implemented and scaled up for all genders.

Peer outreach approaches using women as trusted connectors and role models of successful recovery must be encouraged.

Childcare programming and activities should be incorporated on site to facilitate intake and retention in treatment.

Consider mobile health units in the community, including providing take-home OAT when available and transporting women to treatment settings.

Conclusive Remarks

The evidence and recommendations generated in this RSA are intended to support further development of a culturally sensitive scaled up and sustainable gender responsive approach in Egypt. The routine consideration of the unique needs of WWUD and WWID in all aspects of design and delivery of future services and programmes are warranted (accessibility and availability, staffing and training of staff, programme development, and in addressing socio-economic empowerment, legal aid, trauma, and concurrent mental health disorders). A trauma-informed and trauma responsive is imperative given the vulnerabilities and prior exposure to many forms of violence of WWUD/WWID in Egypt.

Core principles of ethical, evidence-based, and sustainable approaches to gender sensitive harm reduction, treatment, and rehabilitation applicable to future development in Egypt are:

- » Gender mainstreaming must be acknowledged as a priority approach to designing drug policies, services and community and prison-based responses.
- » WWUD are a heterogeneous group with various vulnerabilities, needs and expectations relating to their gender, age, marital status, social class, and care giving responsibilities and require targeted approaches.
- » Future actions and services must be evidence based and act per human rights and medical ethics.
- » Efforts to provide tailored services for women, whether in stand-alone facilities or integrated into existing women's health programming should be underpinned by gender-sensitive training for medical, community and criminal justice practitioners and sufficient continuity of care.
- » All future actions based on this RSA are advised to be supported by gender budgets, adequate coverage, regular training and a training cascade, female specialist staff at hospital and community levels and the incorporation of a gender and human rights dimension in routine health surveillance.
- » Capacity building within organisations and working groups is crucial to support gender mainstreaming within drug policy and there are practical steps that can be enacted as per the WHO guidelinesⁱⁱ
- » Access of women to evidence-based drug disorder treatment in the community is further important as part of non-custodial sentencingⁱⁱⁱ. Detention facilities are advised to acknowledge the gender sensitive needs of women and uphold the rights of WWUD/WWID to access non-discriminatory

i Council of Europe (2022). Implementing a gender approach in drug policies: prevention, treatment and criminal justice A handbook for practitioners and decision makers. Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs. Council of Europe:Strasbourg. Retrieved from 1680a66835 (coe.int)

ii WHO (2011). Gender mainstreaming for health managers: a practical approach. Facilitators' guide. World Health Organization, Geneva. Retrieved from www.who.int/publications/i/item/9789241501057

iii UNODC and WHO (2020). International standards for the treatment of drug use disorders. Revised edition incorporating results of field testing. World Health Organization and the United Nations Office on Drugs and Crime. Retrieved from International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing (who.int)

- equivalence of care^{iv} v.
- » Gender-oriented programmes or services require sufficient monitoring and evaluation. It is recommended to routinely use the UNODC checklist to assess the implementation of gender mainstreaming within programming to assess and plan progress and to review existing strategy or policy documents^{vi}.
 - » Continued research to support practice and that informs evidence-based interventions to respond in a culturally sensitive and effective manner to the impact of gender-based violence, trauma, drug use disorders, drug-related criminal offences and co-morbidities on the health and human rights of vulnerable WWUD/WWID is warranted^{vii}.

iv UN General Assembly (2016). United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela Rules). Resolution adopted by the General Assembly on 17 December 2015⁶³, No. A/RES/70/175, United Nations, New York

v UN General Assembly (2010). The Bangkok Rules. United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders, adopted by the General Assembly on 21 December 2010 in A/RES/65/229⁶⁴.

vi UNODC (2021). Gender mainstreaming in the work of UNODC. Guidance note for UNODC staff⁶⁵, United Nations Office on Drugs and Crime, Vienna. Retrieved from www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf

vii UNODC (2017). Guidelines on drug prevention and treatment for girls and women. United Nations Office on Drugs and Crime, Vienna. Retrieved from www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf

Annex One National Drug Observatory Snapshot Profile

Patient registration form for the National Drug Observatory

Sheet number:.....

Date of interview:...../...../.....

ID:.....

Hospital:.....

Department: Inpatient () outpatient ()

Gender: Male () female ()

Date Of birth:...../...../.....

Social status

*Single ()

*Married ()

* Divorced ()

*widow ()

* Separated ()

*If he has children ()

Living in (Only the area):.....

Current Housing Governorate:.....

Surrounding environment:

* independent ()

* With the father and the mother ()

*With the wife () *Withthewifeandthekids () *Inaninstitution ()

*In a punitive institution () *Withfriends () * He doesn't have housing ()

Educational level:

*Uneducated ()

* Read and write ()

* elementary school ()

* Preparatory ()

* secondary ()

* Technical education()

* Intermediate Institute ()

* university ()

*PostGraduate ()

Current Occupation:

*full time()

*part time()

* doesn't work()

* student ()

The main source of income: (Choose everything that applies)

*Fixed salary()

* Unsteady pay ()

* Fixed income from property

* Assistance from parents ()

* Assistance from NGOs ()

* other ()

Previous treatment attempts:

Yes ()

No ()

Number of trials for treatment ()

Previous treatment places

* Government Outpatient Clinic () * private outpatient clinic ()

* Specialist doctor's clinic ()

* Licensed Recovery Home ()

* Unlicensed half way house ()

* Day care ()

* At home without specialist help () *Other and mention.....

History of previous Admission

Yes ()

No ()

Number of hospital admissions ()

Year of admission for the first time:.....

Year of admission last time:.....

Longest period of abstinence: day.....month.....year.....

Source of referral

* The patient himself. () * Relatives and friends () * General Practitioner ()

* A specialized institution in treatment ()

* Another hospital()

* Educational aspect)

* Toxicology center ()

*Justice system()

*A patient was treated in the same

place. ()

* Support group (NA, AA)

*Other:.....

Diseases/health symptoms

- * **HBV hepatitis virus:** Yes() No () I don't know () According to the date of the analysis.....
- * **HCV hepatitis virus:** Yes() No () I don't know () According to the date of the analysis.....
- * **HIV virus:** Yes() No () I don't know () According to the date of the analysis.....
- * **Seizures:** Yes() No () I don't know ()
- * **A brain drawing has been made:** Yes() No ()
- * **Pregnancy / Lactation (For ladies):** Yes() No () I don't know ()
- * **Other diseases**.....

Substances of abuse

Note: Primary substance is written in the first row, then secondary substance and so on

Substance ↑ Code	Age of onset	Route of intake	Frequency of use during last 30 days	Nature of use	Average usual dose	Largest dose ever reached	last dose		
							D	M	Y

Addictive substances

- | | | | |
|------------------|-----------------------|--------------------------------|---|
| 1- beer | 10- Codaine | 18- Barbiturate derivatives | 25- Hallucinogen |
| 2- Alcoholic | 11- Cough medications | 19- Benzodiazepine derivatives | 26- Voodoo |
| 3- Hashish | 12- Cocaine | 20- Parkinol | 27- Strox |
| 4- Bango | 13- Sweep | 21- Kimmadrin | 28- Volatite substances such as batex or glue |
| 5- Tramadol | 14- Nalophine | 22- Akinton | 29- Pregabalin (Lynorin-Lyrica) |
| 6- Heroin | 15- Cold medicines | 23- Cogintol | 30- Other |
| 7- Opium | 16- Amphetamines | | |
| 8- Morphine | 17- Atropine | | |
| 9- Maxtone-forte | | | |

Route of intake (key):

- 1- Oral ()
- 2- Inhalation by nose ()
- 3- smoking ()
- 4- Injection ()
- 5- Injection + Sharing (injections or tools) ()
- 6- Other diseases and remember.....

Frequency of use (key):

- 1- Every day
- 2- () More than once a week.
- 3- () once a week. ()
- 4- More than once a month ()
- 5- Once or less in last month ()

Nature of use

- 1- Simple use ()
- 2- Misuse ()
- 3- Dependency ()

Using other
prescriptions

No

Yes

Antidepressant\
Anxiolytic

Antipsychotics

Sedative\
hypnotics

Mood stabilizers

Analgesics

Naltrexone (Rivia)

Methadone \ OST

Others:

Annex Two Key Informant Interview Guide

Guide Key Informants! This list of questions is not exhaustive.

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?

QUESTIONS

Tell me about treatment and harm reduction services for people who inject drugs in general in Egypt? **PROBE: treatment, health services, HIV testing, needle distribution**

What do you know about WWUD/WWID in Egypt? **PROBE Why do they use drugs? What drugs do they use? Poly drug use? Where do they inject drugs? With whom do they inject? In what kind of situations needles might be shared? Do you know about any experiences of overdose? Do you know what kind of drug treatment and service experiences WWUD and WWID have in Egypt or in your governate?**

What kind of specific treatment and harm reduction services are there for WWUD and WWID ?

Who is referring WWUD and WWID to treatment or harm reduction services? How do they find their way to the services? **PROBE: health providers, family members, friends, husband** How do people around women influence WWUD and WWID in seeking harm reduction or treatment 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? 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)

Describe the kind of WWUD/WWID who access harm reduction services or treatment in Egypt? **PROBE Age, socioeconomic level, urban, rural, with children, single.**

Are there policies that may hinder their access to treatment or harm reduction services for WWUD and WWID? **PROBE: mandatory testing for HIV, custody laws, pregnancy, motherhood**

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 treatment or 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?

ⁱ Adapted from MENAHRA (2013). Women injecting drug users in the MENA. Retrieved from www.menahra.org/images/pdf/MENAHRA_OR_Women_Injecting_Drug_Users_2013_.pdf

What do you think are the unique service level needs of WWUD/WWID in Egypt? Where are the gaps?

What kind of service aspects 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.

What do you think are the key aspects of a gender sensitive service to support treatment or harm reduction for WWUD/WWID in Egypt? PROBE Do you think all female staff are important? Do staff need specialised training in gender sensitive treatment and harm reduction provision?

Are female-only opportunities for group and individual activities, care and counselling for sexual health and STIs important? Are facilities for home care of young children and day care for children of women in the treatment programme; success and relapse rates, and aftercare supports important?

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

BACKGROUND INFORMATIONⁱⁱ

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 to WWUD and WWID.

Policy making

Strategic planning

Resource mobilization

Program management

Outreach care

Treatment

Service Characterists during Observation

During site visits national consultants will also document features of the service in terms of location, structure, residential characteristics, outreach, staff composition and gender; licensing and qualifications of staff, features of the treatment programme that are responsive to women's needs including employment of female counsellors and therapists,

OK, great. I enjoyed listening to your thoughts and ideas. They will be very helpful for our research and for improving access for WWID/WWUD to services and treatment. We appreciate your participation. Thank you very much.

Annex Three Focus Group Guide with WWUD/WWID

Guide WWUD/WWID in treatment, accessing community harm reduction and in prison¹.

Date _____

Interviewee code _____

Name of focus group facilitators _____

A. Ground rules · As explained in the consent form, this focus group 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?

First, I would like us to talk about WWUD and WWID in Egypt?

Can you tell me a little about the following

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?

Can you tell me a little about the problems faced by WWUD and WWID in their family and in the community?

PROBE: financial, health, stigma, violence

What about for WWUD and WWID in prison?

Do you think healthcare providers or police treat WWUD and WWID differently than other people?

What kind of risks do WWUD and WWID experience?

PROBE: selling sex or stealing to secure funds, stigma, health harms, violence

What kind of legal consequences do WWUD and WWID fear when they start injecting drugs ?

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

What do you know about services provided for WWUD and WWID in Egypt?

PROBE: treatment, detoxification, distribution of needles and syringes, distribution of condoms, health services, HIV testing.

Can you tell me a little about the reasons WWUD/WWID have to seek harm reduction or seek treatment.

PROBE: sexual and reproductive health issues, motherhood, pregnancy, infectious diseases, depression; mental health/comorbidity

What do you think are the unique service level needs of WWUD/WWID in Egypt? Where are the gaps? Are WWUD/WWID in Egypt aware of the services in place?

What kind of service aspects encourage and discourage WWUD/WWID 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,

¹ Adapted from MENAHR (2013). Women injecting drug users in the MENA. Retrieved from www.menahra.org/images/pdf/MENAHRA_OR_Women_Injecting_Drug_Users_2013_.pdf

concerns around privacy and confidentiality.

What do you think are the key aspects of a gender sensitive service to support treatment or harm reduction for WWUD/WWID in Egypt?

PROBE: sexual and reproductive health issues, laws, policies and child custody aspects, social, provider knowledge, attitudes and practices, what an ideal services would look like, training needs of staff

Do you think all female staff are important? Do staff need specialised training in gender sensitive treatment and harm reduction provision?

Are female-only opportunities for group and individual activities, care and counselling for sexual health and STIs important?

Are facilities for home care of young children and day care for children of women in the treatment programme; success and relapse rates, and aftercare supports important?

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

BACKGROUND INFORMATION I would like to ask some background information before we end 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. 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

6. Are you employed

7 If yes, what is your occupation?

8. What are the sources of income

Full time employment

Part time employment

Casual work

Family support

Friend/peer support

Partner/ boyfriend support

Other _____

9. Do you have a permanent house/ home?

Yes No if no ask

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

Annex Four Consent Form

Consent Form:

My name is _____. I am working in a research project that aims to understand the needs of women who use drugs, and their barriers to accessing harm reduction and treatment in Egypt. The project is commissioned by UNODC.

Specific objectives are to:

- i. update the available information on WWUD/WWID in Egypt.
- ii. determine services available for WWUD/WWID in Egypt.
- iii. identify harm reduction services availability for WWUD/WWID in Egypt.
- iv. document services delivery gaps for WWUD/WWID in Egypt.
- v. determine the knowledge, attitude, behaviors, and practices regarding WWUD/WWID in Egypt.

You are kindly asked to volunteer to participate in this study by volunteering for an interview that will collect information about your background characteristics, your experiences in drug use and your opinions about factors that hinder and facilitate your access to services that are provided for women who use drugs in Egypt.

Your input is especially 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 government to know more about drug use and barriers to access services that helps them to develop services to meet the needs of women who use drugs. 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 on any 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?

Rapid Situation Assessment of women who use drugs in Egypt



Drug use among women is a complex and multifaceted issue that has significant implications for the individual, the family, and society as a whole. While drug use can have devastating consequences for both men and women, women are often disproportionately affected due to a range of factors such as gender-based violence, social and economic inequality, and limited access to healthcare.