

The Disease of Addiction is also Feminine

A Feminist Analysis of the Gender Dimensions of Addiction and What it Means to Addicted and Recovered Women



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Introduction

The issue of drug addiction in Egypt is one that is difficult to address for many reasons. It is an issue that some people hesitate to talk about or deal with without addressing the negative and judgmental societal attitudes towards it, and its association with harsh assessments of those suffering from this type of addiction. The societal view of this important issue is followed by effects that increases its spread; it becomes a subject that is difficult to talk about without the sense of shame and stigma automatically attached to it. The perception of drug addiction in our Egyptian society may have changed somewhat as a result of many factors, including, but not limited to, the efforts of specialized doctors and psychologists, their defense of patients of drug addiction, and increased awareness about this issue. Other factors include the existence of a relatively large number of—both licensed and unlicensed—treatment sites as well as the existence of some national, regional and international measures aimed at its reduction, along with the existence of self-recovery communities that addiction patients who wish to recover can resort to. However, the societal stigma associated with drug addiction remains present in diverse societies within Egypt, especially in areas inhabited by people without privileged access to progressive community, media and medical approaches to treat drug addiction.

Community stigmatization of drug addiction is violently projected towards women who are drug addicts¹; they are primarily women in a patriarchal society with patriarchal values and practices that expose them to ongoing discrimination and violence, carves out specific molds and roles that prioritize caring for those around them, and place upon them the burden of maintaining the honor of their families and communities. Since the behavior of drug addiction is considered “male” behavior², women’s drug addiction is often matched with extreme rejection and cynicism, making it socially unacceptable whatsoever. Thus, drug addiction patients who are women suffer from a double burden; they bear the burden of their own suffering from drug addiction itself, the societal views of them that translate to their rejection from society and even their families, as well as their systematic disintegration into any mechanisms or measures taken by state institutions, whether medical, community, informational or rehabilitative. Moreover, as a result of all of the considerations referred to above, drug-addicted women patients suffer from various forms and patterns of psychological, physical, and sexual violence during the journey of active addiction that is addressed in this paper. The gender dimension of women’s drug addiction in both its active use and recovery phases will also be analyzed because of the necessity of understanding the ongoing violence experienced by women during active addiction, drug access, recovery through self-recovery communities, and the relationship of this violence to the fact that they are women addiction patients. This stems from Nazra for Feminist Studies’ keen interest in the issue of violence against women in both private and public spheres, as well as the various types of violence experienced by women in contexts and frameworks that are often overlooked. Violence against women does not occur in a vacuum; it is a widespread and systematic practice in all areas and contexts of life, whether during drug addiction or any other space.

The importance and methodology of the paper

The importance of the paper stems from the status of women drug addicts in their private and public societies, bearing in mind that this situation is strongly related to their being women, which is most evident through documentation and analysis of the psychological, physical, and sexual violence experienced in different contexts of drug addiction presented in this paper. The importance of exposing

1 The terms “drug addicts” and “addicts” are used interchangeably in this paper.

2 An interview with Dr. Nasser Loza, Director of the Behman Mental Health Hospital and former Secretary of the Mental Health Association of the Ministry of Health.

crimes of violence to which they are subjected, whether through active addiction or recovery, allows for the opportunity and space to identify their needs and ways to provide state or societal measures to maintain their right to physical integrity and ensure accountability for the crimes they are subjected to. There is also a need to provide gender-responsive rehabilitative mechanisms that accommodate the fact that they are women. The narration of examples and patterns of violence against them will open the door to a broader discussion of appropriate response methods and create a space that may encourage them to talk about these experiences and even demand that they be addressed. The feminist analysis of these experiences will create an opportunity for greater solidarity, and perhaps even understanding, within the Egyptian society, especially since violence against women—although pervasive within private and public spheres—stems from structural foundations that are based on dysfunctional power relations between women and men. Violence against women is rooted in these different structures, whether private, public, or supervised by state institutions. Since no literature, reports, or papers document the experiences of drug-addicted women patients in general, be it exploitation and violence, ways of moving on with their lives during recovery and dealing with the negative societal attitudes towards them, it is necessary that there be this kind of documentation. This necessity does not only arise from the importance of their existence per se, but also such that there is material available to concerned communities and state institutions from which to develop existing strategic plans or design new ones in order to address this issue and ways of combating it, especially because the burden of the disease drug addiction and its resultant troubles are higher among women than men. Between 2005 and 2015, the proportion of women bearing this burden [increased by 25%](#) compared with 19% for men³.

The paper was based on a qualitative approach whereby desk research on reports and papers dealing with the issue at hand, whether local, regional or international, was conducted. Interviews with four physicians, psychiatrists, and psychologists were also conducted to identify the specificity of drug addiction among women, along with the available measures and their efficiency. An interview with the Project Manager at the United Nations Office on Drugs and Crime (UNODC) in the Middle East and North Africa was also held. Despite the use of quantitative information available in some annual reports by different organizations, including the Fund for Combating and Treatment of Addiction and Abuse Hotline Report, the paper does not aim to obtain statistics on the proportions of male to female patients or to analyze the transactions of the drug market in Egypt. Rather, the paper aims to find out if there is a relationship between the quantitative count of women addicts in Egypt and the state response measures to them. Five recovered women patients were interviewed to identify some of the violence they experienced during their active addiction and in self-recovery communities, and two recovered male addicts were interviewed for insight into how they perceived and dealt with recovered women patients. The paper deliberately uses the phrases used by drug-addicted women patients in the interviews to describe examples of the violence they experience during their active addiction and participation in self-recovery communities to preserve the original nature of the testimonies. Furthermore, this use is important to demonstrate the nature of this violence and its relationship to the social stigmatization of women patients, especially in incidents of sexual violence, which emphasize the special nature of violence against women addicts just because they are women.

Difficulties encountered in the research process

The research for this paper faced several difficulties. The first is the lack of some, if any, existent literature that qualitatively documents or analyzes the situation of women drug addicts in Egypt, the crimes committed against them, or the mechanisms by which they are integrated into measures taken by the

3 https://www.unodc.org/wdr2017/field/WDR17_Fact_sheet.pdf

state. Such measures include a workshop held by the Fund for Combatting and Treatment of Addiction and Abuse (FCTAA) [in 2017](#) and attended by the Minister of Social Solidarity, Dr. Ghada Wali, in which she met 25 addicted women. Such literature also includes the information provided by the Program Officer at the Middle East and North Africa Office under the United Nations Office on Drugs and Crime (UNODC) about holding a workshop in cooperation with the Ministries of Health and Interior and the FCTAA. The workshop aims to support drug addicted women patients, especially pregnant women, as will be discussed in further detail in the paper. Another difficulty encountered was the existence of quantitative data from representative samples of the number of women addicts in Egypt and the Middle East and North Africa region, devoid of any analysis concerning them as women, through reports issued by the World Health Organization and the UNODC. There was another difficulty related to the absence of any information on the disease of addiction, especially women's drug addiction, on the Central Agency for Public Mobilization and Statistics (CAPMAS) website and the conflicting statistics on the number of drug-addicted women patients in Egypt in the reports of concerned organizations or news stories. Furthermore, the researcher was not able to access the head of the FCTAA. Accordingly, the methodology described above has been followed in order to obtain as much information as necessary that can be relied upon and analyzed for the purposes of this research paper.

The disease of drug addiction and stigma that always follows women drug addicts

The literature on the proportion of drug-addicted women compared to men varies. [FCTAA Director](#) Mr. Amr Osman stated that the drug addiction rate reached 2.4% of the population in 2016, while its use reached up to 10.4%. Whereas the FCTAA Hotline Report for the period 2011 to 2013 reported the percentage of drug-addicted women patients as 3%, a 2010 report by the University of Tanta entitled "Sexual differences in the ways and risks of drug addiction in Egypt" was based on a research sample of 457 addicts, 319 of whom were men compared to 138 women who were referred to the outpatient psychiatric clinic at Tanta University Hospital [between 2006 and 2009](#). This may indicate that the proportion of drug-addicted women patients may be more than 3%. Although the National Council on Fighting and Treating Addiction (NCFTA) acknowledged that the percentage of drug addicts in 2008 was 8.5%—that is, 6 million people—and that the ratio of drug-addicted men to women is 5:1, Dr. Ehab El-Kharrat, psychiatrist and executive director of the Freedom Establishment for Addiction Treatment, believes that [this ratio is actually 3:1](#). If the disparity of these ratios indicates something, it shows that there is no clear mechanism invested in the status of drug-addicted women. At the same time, the scarcity of information about women with drug addiction shows that they are not seeking treatment—whether by their choice or their families'. This happens out of fear of the stigma associated with women's drug addiction, which results in the lack of in-depth mechanisms that are responsive to women's needs, and enhances the societal stigma attached to them while increasing the chances of exercising violence against them. Furthermore, the information available about the real percentages are neither updated nor available on the official websites of state institutions, such as CAPMAS and FCTAA, although there are updated data in some media sources covering the conferences in which these state entities participate, as will be clarified later in the paper.

Dr. Mona Amer, head of the psychology department at the American University in Cairo, confirmed this crisis. According to her, societal culture conveys the stigma associated with women's drug addiction and its connection to sexual relations, while family honor lies on the shoulders of women. Moreover, there are no comprehensive programs that target women; most awareness-raising campaigns target men; prevention programs are designed with the assumption that drug addiction patients are men.

In fact, male examples are used in these campaigns⁴. For example, awareness campaigns launched by FCTAA display male public figures including actor Mohamed Ramadan, football player Mohamed Salah and artist Mahmoud Abdel Moghny. [In the movie “4X6,”](#) Abdel Moghny assumes the role of a drug addict, while Sawsan Badr and Mima El Shami play the mother and wife. It is interesting that when women feature in the campaigns, they do not assume the role of female addicts; as in the case of Badr and Gamal, they reflect the socially expected roles of women: their forgiveness of the drug-addicted son or husband, and their tolerance of the resultant physical violence they experience. This indirectly exacerbates the cover-up over the fact that there are women who suffer from drug addiction, thereby increasing their social exclusion. The fact that a drug-addicted patient is a woman and the resultant stigma attached to her are related to the societal views of women in general, the socially-expected roles of women are in complete contradiction with the reality of women’s drug addiction disease. According to Clinical Psychologist Dr. Olfat Allam, the main problem facing drug-addicted women patients is that they are “girls” and there are multiple taboos around them; we just have to imagine the views of them when they use drugs. This leads to the denial of their families; the percentage of denial is greater in the families of addicted women patients than male addicts. Quite often, families of addicted women patients make an implicit decision that their daughters had died and that their lives have ended⁵. Those who are “slightly more fortunate” face other destinies, including house imprisonment and physical violence, or marrying them off, thus exposing many of them to violence. There is also another stigma on understanding the nature of drug addiction by the large base of Egyptian society, especially in middle classes and towards women, wherein it is [considered a failure of upbringing](#) and not a disease. [Narcotics Anonymous](#) defines it as follows: “Quite simply, the addict is a man or a woman whom drugs control his/her life ... We are people in the grip of an ongoing and aggravated disease whose ending is always the same: prisons, asylums, and death ... Addiction is a disease that involves more than just drug use ... Some of us believe that our disease existed long before we used drugs for the first time⁶.”

It is worth mentioning that the most dangerous thing is the inculcation of these ideas and beliefs among women who are drug addicts, such that they themselves believe they do not deserve treatment. When a young man and woman in the same household suffer from drug addiction, he is usually treated more than twice, whereas she does not receive any treatment at all. Therefore, according to Dr. Allam, the opportunity to receive treatment for a girl is “the opportunity of a lifetime to save her life.” It is most probably not repeatable as women make it difficult on themselves to be treated because it is out of question: they are not allowed to make mistakes while men are⁷.

The problems of availability of treatment sites for drug-addicted women patients and the shortages of national mechanisms

The societal stigma associated with women in general and their drug addiction in particular extends to the availability of specialized therapeutic places for addicted women patients, particularly the extent to which there is a clear adoption of a gender perspective in treatment programs. Although there are many specialized hospitals, centers, and clinics, there are three basic problems: 1) the number of

4 Interview with Dr. Mona Amer, Head of Psychology Department, American University in Cairo

5 Interview with Dr. Olfat Alem, a clinical psychologist.

6 The Blue Book of the narcotics anonymous.

7 Interview with Dr. Olfat Alem, a clinical psychologist.

beds allocated to women is much less than those available for men; 2) the cost of treatment in hospitals and private centers is high and therefore women from middle, lower-middle, and lower classes cannot benefit from it (the same applies to men as well, but the burden is doubled for women); and 3) the absence of inclusive, gender-sensitive programs in hospitals and public centers.

[According to Dr. El-Kharrat](#), there are about 1,000 drug addiction treatment centers, only a fifth of which are available to people from lower-middle and lower classes. At least 20,000 beds are needed, of which 15,000 are available to people from lower classes. Even when places are available, the societal stigma around drug-addicted women patients is much stronger towards working women from conservative and humble areas, and so they do not seek treatment. Class also determines the type of drug that women are addicted to, and therefore their chances of receiving treatment are very low. In addition, and as previously mentioned, there is a double burden on addicted women, since about 80% of them become sex workers to obtain drugs. Since this is one of the biggest prohibitions in Egyptian society, they do not receive support from their families. Also, this affects their health through the increased chances of suffering from HIV and other sexually transmitted diseases⁸.

On another note, in [the workshop](#) that was held by FCTAA in 2017 and attended by the Minister of Social Solidarity Dr. Ghada Wali, the presence of only 25 girls out of 200 addiction patients in the Al Mamoura Hospital in Alexandria was announced. It should be taken into account that the Fund collaborates with 21 specialized hospitals in 12 governorates. During the workshop Dr. Wali said, “The hotline provided medical treatment and rehabilitation services at the Al Mamoura hospital for about 12 thousand patients throughout nine months this year, and there are about 11 thousand patients in outpatient clinics. Eighty beds were allocated (male) along with 12 others (female), and service was provided for about a thousand patients in internal holding, including 660 female patients, 80 of whom are internally held.”⁹ This confirms the lack of a suitable proportion for women who are drug-addicted patients. In the 2014 technical report by the Fund, the partner hospitals received 55,593 drug-addicted patients, including 15,058 new patients, and [40,535 old patients](#) sought treatment between January and December 2014. It is striking that the report did not identify the number of women who have been treated out of the total number of patients, indicating the lack of a comprehensive gender perspective. In fact, the issue of drug-addicted women patients is addressed separately from public discourse.

To complement the situation in public hospitals, Dr. Loza and Dr. Amer said in their individual interviews that addicted women patients are admitted to psychiatric departments, while addicted men are admitted to specialized sections for the treatment of addiction¹⁰. According to Dr. Amer, the conceptual framework of the treatment process adopted in these hospitals is very traditional and does not take into account the dynamics of discrimination, injustice, and privileges. Awareness of these dynamics is of utmost necessary in the design of treatment programs for addicted women patients from different classes, and treatment methods are very similar between women and men¹¹.

In the [FCTAA 2016 technical report](#), achievements of the national plan to combat drug abuse were reviewed. Approved in May 2015, the national plan was held in cooperation with 11 ministries, namely

8 <https://www.middleeasteye.net/in-depth/features/hidden-hell-growing-crisis-female-drug-addiction-egypt-904719017>

9 http://drugcontrol.org.eg/media/NewsList/Item_477

10 An interview with Dr. Nasser Loza, Director of the Behman Mental Health Hospital and former Secretary of the Mental Health Association of the Ministry of Health.

11 Interview with Dr. Mona Amer.

the Ministries of Interior, Education, Technical Education, Health, Higher Education, Culture, Manpower, Youth and Sports, Endowments, Cultural Development, and Population, in addition to the Egyptian Radio and Television Union. Dr. Wali also announced [the formation of a technical committee](#) to follow up on the implementation of the national plan to combat drug abuse, with the participation of representatives from the abovementioned ministries. It should be noted that this technical report referred to the mere intention of “expanding the provision of therapeutic places for the treatment of females, allocating treatment programs specifically for them, and attempting to solve problems that prevent their treatment,” without addressing these problems in detail. Referring to addicted women patients in the same report, “the development of a section for the treatment of male and female adolescents in Abbasiya Hospital” was announced. Also announced was that “the gender of patients who contacted the hotline ([contained the fact that](#)) the largest proportion of callers were male (97.7%) compared to (2.3%) for females.” However, the same report has the objective of conducting “a survey of the current reality of Egyptian society, which is currently being carried out by the FCTAA in collaboration with the National Center for Social and Criminological Research and the National Council for Drug Control and Treatment, to identify the rates of drug use based on gender and the different substances, in addition to other variables that will be identified through [the national survey of the phenomenon](#).” Such survey is a necessary factor to start identifying the specificity of gender in women’s drug addiction disease¹².

The incorporation of a gender perspective in the treatment of addicted women patients means to adopt a comprehensive vision of the societal factors that surround women in general, and addicted women in particular, as well as the violence they are subjected to and the ways to combat it, in addition to the provision of essential services to addicted women patients. This is essential given the fact that many of them care for their children single-handedly after their husbands abandon them, or because the husbands in some cases are addicted to drugs. The provision of safe homes for them and their preparation for jobs through which they can become financially independent is necessary, as well as the treatment of any diseases, whether transmitted through use or sex, in addition to the presence of women doctors and physicians in therapeutic sites, the provision of services to those of them who are pregnant, and other services that may occur because of the special nature of their being women. There is also a need to allow women who are patients of drug-addiction to be responsible for treatment decisions and offer them more than [one treatment protocol](#) so that they can choose what suits them, their circumstances and the environment around them.

In this context, Mr. Faisal Hijazi, program officer for the UNODC, stated that a workshop was held in December 2017 in coordination with the Egyptian government and the FCTAA on the application of quality standards for the treatment of addiction among females and pregnant women. In the workshop, Dr. Wali stated that “the data obtained from the national surveys in which the Fund participated revealed that the proportion of females among total drug users is 27.5%. This is similar to global rates, whereby one third of drug users are female. However, the statistics of the Fund’s hotline 16023 indicate that only a small percentage of the callers are female, amounting to only 4.5% of the total number of beneficiaries receiving treatment in partner treatment sites ... The (treatment) service (was provided) to 150 thousand patients [during 2015 and 2016](#).” These measures are of course important for integrating the gender perspective in the treatment of addicted women, but as previously mentioned, they are taken away from the general and comprehensive response to the treatment of drug addiction. There is no detailed information on the number of women who have received treatment from these numbers, and the limited number of workshops is not at all commensurate with the rate of exacerbation of the disease among women. Hijazi stated that other workshops were held before the ones mentioned

12 Ibid.

above, and dealt with addiction-treatment policies, women, human rights, and international standards for the prevention and quality of treatment centers. The role of the UNODC Middle East and North Africa Office remains an advisory one; it does not measure the social impact of the implementation of activities to combat addiction. The office is primarily concerned with developing, modifying, and supporting policies with regard to international standards for addressing drug addiction, with its effects on women, children and people living with HIV¹³.

The law of abuse and police practices against addicted women

In an attempt to understand the general context of drug-addicted women patients and the various forms of violence they are subjected to, it is important to understand the legislative philosophy behind the law of abuse, and whether and how it is applied. An analysis of the practices of some police officers towards addicted women patients is also important, because not only are they subjected to violence by non-state actors in their environment, but they are also victims of violence committed by state actors who belong to the same society that practices patriarchal values against women, promoting further violence and discrimination against them.

Law No. 122 of 1989 concerned with the use of drugs provides an exception from the penalty, which amounts to imprisonment and a fine, for people who only carry drugs for use (not trafficking) in the following case: if the court considers the abuser an addict (meaning patient). In this situation, the court orders that the defendant be placed in a suitable hospital to receive medical, psychological, and social treatment for a period of 6 months to 3 years (whichever is shorter), usually equal to the prison term; or if the addict or a relative of his applies for treatment in an appropriate hospital, the treatment period is determined by a specialized committee¹⁴. Although many male and female treatment specialists believe in the necessity of the desire to recover, and that “the use of drugs alone is not a sufficient reason for forced placement in hospitals for treatment,” as Dr. Loza said, the law is not activated [for unknown reasons](#). According to Dr. Loza, the law alleges the existence of addiction treatment centers in all governorates while this is not true, so many of those arrested end up overcrowding at the Al Khanka hospital¹⁵. There is also a strong correlation between the societal stigma around the disease of drug addiction and the seriousness of law application on behalf of many specialized doctors, psychiatrists, policemen, and social workers. A study of the circulation and use of illegal substances in Egypt shows that 42.4% of respondents consider drug-addicted patients to be criminal patients; accordingly, they are seen to receive a rehabilitative treatment along with a punishment¹⁶. This reflects the gravity of not addressing the social stigma associated with drug addiction in general and especially that of drug-addicted women patients.

In the interview with Dr. Mohamed Helal, specialist psychiatrist and neurologist, facts were narrated that show the violence against addicted women patients by state actors. This led to a need to make a decision regarding the paper’s use of the same words and phrases that were mentioned during personal interviews in which such violence was narrated. This has more than one reason: the paper at-

13 Interview with Mr. Faisal Hijazi, Middle East and North Africa office for the UN Office on drugs and crime.

14 United Nations Office on Drugs and Crime Report on the Illicit Use of Drugs in Egypt, conducted jointly with the Behman Hospital Team.

15 An interview with Dr. Loza.

16 United Nations Office on Drugs and Crime Report on the Illicit Use of Drugs in Egypt, conducted jointly with the Behman Hospital Team.

tempts to retell the experiences of addiction patients as they happened without any reductions of their severity. Also, the phrases used are indicative of the special nature of all forms of violence against women that are directly related to their being women. After all, addicted male patients are often not exposed to these patterns of violence.

Dr. Helal narrates an event that clearly shows the views of state actors towards addicted women patients, whether those in the stage of active addiction or rehabilitated patients. While accompanying a number of recovering women who receive treatment in one of the rehabilitation centers on a trip to the city of Dahab in South Sinai, their identification cards were looked at at a security checkpoint. When the officer asked Dr. Helal what they would do there and he explained, the officer replied, “addicts? You mean sharam [sluts]!” Dr. Helal continued affirming the violence against addicted women patients in police stations, where officers consider a drug-addicted girl an “insect.” In his experience, “if the officer is well off, he will insult and hit her and call her father and humiliate them before letting them go. And that is if she is well off. Although they deal with the drugs, only the legal action is taken. There is no awareness on part of the state that this is a disease . . . Efforts must be made to make them understand that it is a disease, not a moral deficiency. Officers, hospital emergency departments, and doctors must be made aware because they treat the patients with the utmost violence, contempt and disgust.”¹⁷

It is worth mentioning that the attacks are not limited to verbal insult or the views of inferiority towards addicted women patients, but oftentimes reach rape and gang rape. According to Akmal¹⁸, a recovering drug addict, “A woman was arrested in an ambush on the road in a province and all the clerks and soldiers slept with her and then threw her on the road without any money.” In this respect, Dr. Allam speaks of the philosophy behind attitudes towards addicted women patients by some Anti-Drug Administration (ADA) officers: “When the ADA [officers] arrest an addicted woman, their concern is how to sleep with her, because she came for free, is available, and will not complain; she is an easy hunt.”¹⁹

These events are just examples of the sexual exploitation and abuse of addicted women patients because of the stigma associated with drug addiction in general and with women patients in particular. It is also apparent to the women patients themselves that if they attempt to disclose what they were subjected to or file complaints, they will most probably not receive any support. They therefore prefer to remain silent about these crimes, which is consistent with the reluctance of female survivors of sexual violence to report crimes against them because of the lack of respect of their privacy and the lack of response to them most of the time.

17 Interview with Dr. Mohammed Helal, expert in psychiatric and neurological diseases and treatment of addiction.

18 The name has been changed in order to preserve his identity and privacy.

19 Interview with Dr. Olfat Allam.

Examples of violence against addicted women patients during active use

The examples of violence against women patients by state actors mentioned above give an indication of the extent to which the abuse of these women is normalized. If all of this violence is committed by those who supposedly work to protect them and provide all available means to help them, we can only imagine the extent of violence committed by non-state actors, including their families and the surrounding communities. Interviews with a number of recovering women patients were full of accounts of incidents of physical and sexual violence; all of them were subjected to various types of violence during their active addiction phase. It should be clarified here that the names of recovered women who were interviewed have been changed in protection of themselves and their privacy. Thuraya²⁰ speaks about the automatic exploitation of women by men patients, just because they are women. Her self blame is obvious, as derived from the culture of survivor guilt:

We are in a society in which knowing that you are a girl means expecting favors. Knowing that you are also an addict means automatically ending the relationship, even among friends. There are exceptions, but to the vast majority if you want to use, whether or not you have money, is that first, I have to sleep with you so that we do drugs and in return there are many options. [He] either shows me off in front of people or takes something sexual, or uses you to get drugs and make some drama in front of the dealer ... It was even worse with me because I was attractive. There are acts of violence: some of them because of you, others because of reasons that are out of my hands. For example, if I go to the desert with a stranger to smoke hash and he does that. A arabāwi [bedouin] slept with me twice on the same day without my consent because he thought I wanted to trick him and after they left us and made sure we meant no such thing they took our money and phones, and the dealer who was there slept with me without my consent ... I always remember this.

Marwa²¹ also remembers how she was subjected to violence and exploitation to obtain drugs or access her source: “There was harassment, meaning they would grab me, but nothing more because I was a (virgin).” Although she was fortunate not to have been raped, she was sexually exploited and her body was violated.

Ghalia²² speaks of her rape: “there was severe exploitation. As a girl, men think that okay I can give you drugs on the condition that I sleep with you. It happened by dealers and people whom I saw for the first time. It also happened by my male friends. I was once forcibly taken into a house and raped“.

20 The name has been changed in order to preserve her identity and privacy.

21 The name has been changed in order to preserve her identity and privacy.

22 The name has been changed in order to preserve her identity and privacy.

Although Radwa²³ acknowledged that there are things she cannot remember because of the use, she nevertheless speaks of her exposure to physical and sexual violence in minute detail.

I was very high and with nowhere to stay so I went to a local qahwa [coffee shop]. At dawn, a guy picked me up; I told him I wanted hash so he said okay, instead of just sitting here go to my friend's house until I finish the qahwa shift. After nagging, I slept with the house owner and then the guy arrived with another one. Both tried to sleep with me and hit me so much that I couldn't fight back. What was painful is that they both inserted it (their penises) in the same place and at the same time in my vagina. When it was 6am, they left and the house owner said I'm going to work so you're on your own. One of them had stolen my money. The waiter used to take vudu, which is hash with a hallucinogen that probably comes from America. There was this other time, on that day I was with my ex and a bit high. When we left the restaurant I said the food is not as good as before, so he got really angry and said "God have mercy on the days when you were fucked for 40 pounds and a McDonalds meal." When we were at the car I said I won't get in, so he kept kicking and slapping me and I kept shouting that he's my husband so nobody hurt him and I ran away. A man in a car was there so I got on and told him to take me to the nearest place. He was smoking hash and gave me a cigarette. He had a bag and said he was going to Sharm El Sheikh for a couple of days, so I went with him. He took me to the hotel and came on the same day to have dinner. He said his wife was traveling abroad and we slept together and he became feverish. I tried to get his fever down until 3pm without use. His brother was in Sharm El Sheikh too, so I called him and said I can't do anything and have to leave, so he wanted to speak to the guy. He suddenly got out of bed then like an angry beast, and he is gigantic, I was slapped and fell down, and he called me a slut and daughter of a bitch I told you not to call anyone. With his fifth slap my eye was about to get poked. What made him stop was my screaming while I had my hand on my eye. He kept swearing and went to look for the hash, then he put on his clothes and took me back to the hotel.

It should be noted that while some are aware that they have been raped, others refer to rape and sexual exploitation as a sexual act through which satisfaction is achieved. This may indicate either their way of coping with the traumatic experiences they have faced, or their misunderstanding that as long as they receive something in return (accessing drugs or meeting people who have that access), it cannot be considered violence. Furthermore, the societal culture's views of addicted women patients automatically cancels out their eligibility and ownership of their bodies and their right to physical integrity.

23 The name has been changed in order to preserve her identity and privacy.

On the other hand, Alaa²⁴ was not sure whether the incidents of violence she experienced could be considered violent. In her own heart, she did not want them to occur and felt they happened against her will, but her acceptance of them and failure to defend herself confuses her. This clearly illustrates the trap that female survivors face, given the masculine societal culture and the constant blame that causes survivors to deny that they have been subjected to violence, because they have not violently acted to stop it. More broadly, this reflects the saturation with the sick notion that it is not possible to attack or rape as long as women do not have severe bodily injuries, completely doing away with the fact that some of them surrender due to the sense of threat, fear, or a state of shock that makes them unable to do anything:

The first time I did heroin was with a work colleague. I can't remember anything from the first time; it is known that the effects of heroin the first time are very strong. The second time I went there to do heroin, I sat on a chair outside his room after I used. I was surprised to find him standing in front of me, he took his pants off and put his penis in my mouth ... It is very strange because I remember what happened very well and feel it took a couple of seconds but also very long ... I didn't try to push him or anything but I was shocked: it was like my body was acting one way and my mind was trying to stop it without use ... I remember clearly that he suddenly took his penis out and ejaculated over my chest; I was wearing a white blouse with an opening in the top ... I will never forget what it looked like and how disgusted I felt when I looked into the small mirror above the sink and saw the disgusting thing on my blouse and chest. At the same time I was scared that he would notice my revulsion, so I kept cleaning the revolting thing off my blouse and body with a smile on my face because I was afraid I'd bother him ... I remember the look of victory in his eyes and couldn't understand why he did this, although he always told me that I'm like his sister and he worries about me.

Although she realized many years later that what she was subjected to was oral rape, Alaa continues to argue with herself that she cannot consider it as such, because she didn't stop it or express her dissent of it afterwards. She continued to deal with it for quite a period of time. This reinforces the idea that drug-addicted women patients accept, to a certain extent, the violence they experience during active addiction because they are socially convinced that it is a necessary consequence. Alaa also reports a sexual assault incident as follows:

I was trying to quit and an officer "friend" who was trying to quit too convinced me that Tramadol will make the withdrawal symptoms pass unnoticed. I went to his house because he told me it would be safer to take it there. He used to nag me all the time about getting married; thank God I didn't do that. When I took the Tramadol he told me to rest on the bed because of the withdrawal symptoms and then he got on top of me with his clothes on and started "sleeping" with me in our clothes. I was shocked

24 The name has been changed in order to preserve her identity and privacy.

and froze and he started to sweat and moan and told me to moan. I was scared and at the same time felt I was out of my body watching what was happening. I pretended to do what he asked and when he finished he went to get something to drink. I quickly got up, disgusted of myself. Everytime I remember this I feel the same disgust. I told him that I'm late and must get home and haven't seen him since. I saw him once afterwards at self-recovery fellowship meeting; he was trying to reach me to talk and I told the people I was with so they prevented him from reaching me. I haven't seen him since ... Everytime I see a car like his in the street I am horrified that he might be in it, watching me.

From this incident, it is apparent that the violence committed by male addicts is twofold: not only do they exploit the fact that they are men, but they also take advantage of their privileges, in this case as a police officer, to terrorize women and make them feel the great imbalance in power relations between men and women, even though they are both drug addicts.

Examples of the extension of violence against recovering women drug addicts in recovery societies

Many people assume that the drug-addiction recovery phase is free of exploitation and violence against women. What must be remembered, however, is that recovery societies are mirrors of the very society in which all forms of sexual violence against women are practiced, alongside their defamation, psychological terrorization, and physical assault. Among recovering male addicts are examples of perpetrators who exploit their privileges as men; many escape impunity and are supported by a society that is characterized by violence and persistent discrimination against women. In particular, women are made to endure the burden of the violence they experience in the absence of a comprehensive and effective implementation of mechanisms to combat violence. Such mechanisms do, in fact, exist: they include the national strategy to combat violence against women, issued by the National Council for Women in May 2015, at the same time around which Dr. Wali announced the national plan to combat addiction. Thuraya says:

I am one of the girls who entered a recovery place for girls at the time of the Amr Khaled campaign. I went to find more than 20 girls and was shocked because I had imagined I was the only girl that was using drugs. The place was doing its best, but I couldn't endure the lock up and left 6 days later. It put me on the first steps of the road and I went to (a self-recovery society). This (society) is welcoming because it has many girls; as individuals, however, there were many exploitative people because we are similar in the disease but not the environment. This society has different environments and when people quit, they get back to their origins. Class makes a difference in thought, especially in attitudes towards girls. I didn't personally experience a transgression because I set limits. But many girls relapsed and died because of relationships inside that com-

munity. I don't blame them but we're not angels; we have faults and must be extra careful. Recovering girls must make more effort than men in this society. I mean, you could be raped but you must set limits. I had a recovered boyfriend who had quit for the same time and he supposedly loved and wanted to marry me. I was afraid of the marriage thing and he didn't like that I refused it, so it turned into beatings and curse words and I left him as soon as he started doing that because I didn't want it. You already know you're not going to marry him early on, so why go through the relationship? So I see that I was wrong. The first problem between myself and my (recovered) husband was because he called me an addict although he himself is a recovering addict: "I had forgotten where you came from; I rescued you." I know that several girls died because of the lack of support; boys took advantage of that fact so they abused and slept with them, and they relapsed and died. I know about three girls, may they rest in peace. The exploitation of girls in this society is increasing because there is no awareness. Places of recovery are supposed to create awareness that this is not okay and that girls are a red line. I had once quit for two months and attended a meeting where the speaker is like a gecko. Five girls were at the meeting and he kept speaking about the girls (in this community), showing off having sex with them

Thuraya's testimony has many implications; the behavior of some recovering male drug addicts and their perception of women is no different than that during their active addiction phase. This behavior is not associated with active addiction, but the social imbalance that many men are raised on in their relationships with women. The incident of her husband's shaming shows how men's addiction is accepted while women's is not, despite their participation in the same self-recovery community. Whether women patients are addicted or recovered, the inferior views towards them and their abuse are persistent.

As for Marwa, her testimony contains details of sexual exploitation, which led to the loss of her virginity in one of the aforementioned communities:

I was trying to quit from the street and went to a meeting and became (a non-virgin) by someone who had quit for 10 years. He told me he'll (hold) a meeting at his place. I met him the day before in a cafe and we agreed to meet the next day. We went to a meeting (that didn't have space) and he made some phone calls (to organize) an unofficial (meeting) at his place. I had some mild withdrawal symptoms: I went to the bathroom and found some blood and felt it was normal. There was exploitation and he laughed at me. When I would go to a meeting that he's going to, I turn around and walk away. He sent me a message after I had quit for two years saying I feel that I have hurt you but don't know how ... The incidents are becoming much more frequent, because for example I (help) 13 girls, most of

whom (are newcomers in the society) and most of the newcomers who want to quit are young (men and girls). Rape incidents happen if a girl needs money or anything else. Most men are people who've been there for long. For example, if a girl is kicked out and has no money. Or for instance, someone pays the rent in exchange for sleeping with her, on the inside they don't want to but they are forced to. Sometimes it happens that girls don't even have 10 pounds so the boys ask them out for dinner and sleep with them in exchange. They will always see that an addicted girl is dirt.

Marwa's testimony shows that some recovering male addicts who commit violence against recovering women taking advantage of their poor conditions at the onset of their recovery journey. Those who come from modest backgrounds and lack support systems—whether from their families or friends—are exploited and manipulated on the pretext of providing their basic needs. This reflects the need for mechanisms to help women who wish to recover financially and provide for their basic needs.

It seems that the methods used by some recovering addicts are not different, as Ghalia narrates:

Exploitation happens by people who have quit for 10 years at a time. We were out to eat once and I needed to use the bathroom and we were close to his house so we went up. He attacked me and I ran down immediately. I didn't speak to anyone about it except my sister, because words have a life of their own and it would end up badly. In these situations, the girl is to blame, as if I gave him the chance to do so ... As this society expands, this increases, especially with the new girls. They come on to them even by speaking about (how to recover) and that they don't understand yet and so on. By the way, many girls want to quit but their parents cannot accept it; they see it as a stigma and don't know it has treatment. Of course, these practices do not help at all and only add to the sense of despair. The number of doctors who have (this dimension) are scant; there must be safe houses since recovered women addicts are the most people who have faced this so they have experience, whereas doctors and recovered male addicts are not aware of this dimension whatsoever.

Ghalia's testimony raises a highly important point, which is the need for women doctors and psychologists who are aware of the gender dimension. Male doctors and psychologists should receive such training, as it is essential to deal with addicted women patients who wish to recover.

Radwa also speaks about the violence she experienced in that community, saying, "I was in a mixed (activity by the community), and someone put his hand on my back. I thought it was by mistake (the plastic chair has holes) but it happened again so I shouted at him and (the person in charge of the activity) took me outside and the psychologist tried to calm me down with the other girls. His wife was there with him and I was told I had imagined it. I felt that because I am an addict no one would believe me. No action was taken." As is clear here, recovering women patients bear a double burden related

to their being women; their testimonies are doubted because they are women and addicts, whereas an automatic assumption around the truthfulness of a male addict is related to the privileges associated with him being a man. This has to do with the wrongful prevailing societal stereotypicalization of women: they may not speak the truth all the time, exaggerate or overreact, or imagine things that do not happen.

As regarding defamation, Alaa speaks of a friend of hers in the same “community” doing so, gravely shocking her:

One of the biggest shocks I’ve ever had in my whole life within friendships has been in this society. I realized the extent to which people deal with double standards. I was involved with this “friend” in voluntary activities in the same community, and he was in a relationship with a woman outside the community and they got married. Because of my naivety, I assumed he understood that he was like a brother to me; I always made that clear to him and his wife before their divorce. I won’t speak about why they got a divorce because it doesn’t concern me. The real shock was that he spoke about me behind my back, defaming me and saying that I was the reason for his divorce. I had absolutely no feelings about him; it didn’t even cross my mind and I was very clear about the nature of the relationship. Until now, I don’t understand why he did this and I will never forgive him. I went through multiplied efforts because I know how sensitive this society is and had set limits and felt that this coward came along and destroyed all that I’ve built in a second. I had dealt with him in good faith and brotherhood and he always said he understood this and that I am a sister of his. The crisis is that he did this at a time when I was going through the worst and cruelest circumstances in my life. I never want to see him again, not even by chance. To me, he is a traitor and betrayed my respect for him.

Alaa’s defamation highlights the double standards of some of the recovering male addicts in the society in question. Some of those who claim to be open-minded and progressive are in fact not so; they follow the patriarchal and masculine values practiced by many in the Egyptian society. These values do not recognize relations of friendship between women and men, since women always try to seduce men—an ideology belonging to the dysfunctional stereotyping of women, and an extension of the practice of constant blame for actions by some women who are not responsible for them at all.

And Dr. Helal confirms the burden of recovering women patients in self-recovery societies, as:

A girl is required to undergo many tests over a very long period until (her colleagues) understand that she is good. But at the same time, if the girl went to the manager (of the place that supervises a certain activity) and complained, he is expelled and a (vote) is taken to decide whether

he should continue, and the girl is apologized to. But not all girls fight for their rights. When she arrives, fear is huge, and she is silent. But the community does not want to forget and instead shames her. Violence is the tool of exploitation. It is possible to deal with the recovered man as a miracle worker, but not the girl, who is then connected to the tripartite of sex and drugs, and the parents also do the same, and I cannot blame the parents because it is the societal outlook.

From another angle, Akmal²⁵ explains that although there are multiple incidents of sexual exploitation and violence against recovering women addicts in self-recovery societies, there are also examples of recovering male patients who do not follow these practices. In fact, they try to organize activities that will educate recovering women and men patients in these communities: “There have been many workshops on the subject of sexual baiting, twice or three times, in Cairo and Alexandria during the last three years.” He also clarifies that the relevant material has been acquired from self-recovery communities in other countries.

Akmal continues, “the problem is that a rotten tomato ruins the rest, but in (self-recovery societies in my estimation), from 30 to 40 thousand and the proportion of girls in it exceeded 25%. There are so and so, and a few respects themselves,” he said. In Akmal’s words, he explains that the self respect of recovering male addicts and the respect they have for recovering female addicts reflect the real values of the self-recovery community. It becomes apparent here that the lack of violence or exploitation of recovering women addicts stems from respect and the necessity of being a respected recovering addict rather than belief in their right to physical and psychological integrity.

Mahmoud²⁶, a recovering addict in this community, explains that recovering women patients are sometimes treated in a “nicer” way. He illustrates that when some recovering male addicts “(glimpse) a woman standing outside and (there is no place) in the meeting, he stands up so that she can enter. When a girl in an Eastern society attends a meeting, she pressures herself when she knows that she’s an addict; a girl’s recovery is like that of 10 men. At the same time, if a meeting has 100 men and one girl, you’ll find 200 eyes pricking her.” It is thus possible to conclude that the exploitation and violent practices on behalf of recovering male addicts towards recovering female addicts cannot be generalized; at the same time, however, they can not be denied or overlooked.

Mahmoud continues, “what I accept for myself I accept for others; what I don’t accept for my sister I won’t accept for anyone else ... After 25 years of addiction, (I realized) that I have 4 sisters and must be concerned with them, and God gave me 4 daughters.” His statement highlights that to him, the rights of recovering women patients to be free from exploitation and violence stems from the societal role of men to protect women in a pretext of “sisters or daughters.” This brings to mind some narratives adopted in recent years by some anti-harassment initiatives and groups in the public sphere. Emanating from a “protectionist” principle by which there is guardianship over women, these narratives build upon something that is contrary to the widespread violence against women and girls in the private sphere, committed by fathers or male relatives or spouses for many years. Such violence is either psychological, physical or sexual violence in various forms, many of which have been addressed through the latest international tweeting campaign #MeToo.

25 The name has been changed in order to preserve his identity and privacy.

26 The name has been changed in order to preserve his identity and privacy.

On the issue of exploitation and sexual baiting by some recovering male addicts in self-recovery communities and the ideas they adopt, Akmal continues:

They are our war captives and what are you going to pretend you're honorable? You're a slut all your life. One of the girls was about to be engaged and her soon-to-be fiance wanted to sleep with her while she didn't want to. A (recovered male colleague) told her to do so only after the wedding ceremony. Meanwhile, a (recovered female colleague)'s response was: "are you going to pretend to be honorable? You've had 3 abortions and used to accept an order for 5 pounds." In my opinion, the root of the problem is the stigma around addicted women patients in a patriarchal society. Everyone thinks this is a men's problem. I know three girls who were virgins and had sex under a pretense that it is some kind of support. Women addicts are not brought up and there aren't any advertisements targeting women. The dominant conception is that if it is a boy at home then he's a corrupt brat and if it's a girl she's a slut because of a 70% chance she must have made concessions. Of course, there is collusion on part of society as a whole and (the self-recovery community). I'm always told you are harming us and you benefit from what you're saying and keep it to yourself.

Thus, while emphasizing the nature of the masculine society in self-recovery communities, which stems from the wider Egyptian society, Akmal also clarifies the adoption of the conservative and patriarchal concepts of women's "honor" and "chastity" that do not allow their sexual intercourse before marriage while this is accepted when engaged in by men. Akmal's statement also indicates the extent to which this conservative concept has become integrated among some of the recovering women patients, who are forced to embody these concepts and principles to be able to protect themselves in this society. Thereby, this was violently met by one of the recovering women patients, without addressing the desire of the recovering patient to exercise ownership of her body and her right to decide what to do sexually. The complicity practiced by some of the recovering male addicts in this society reflects the degree of complicity that exists among the majority of the Egyptian society in general. Denial of these facts and being silent about them is not only enough, but necessary to preserve the opportunities to exploit them for the benefit of many.

In another context, Dr. Allam touches upon another type of violence against addicted women patients who wish to recover: "The violence practiced against girls at the time of recovery is that they are harassed in the recovery sites by doctors, specialists and addicted boys. It remains a joint responsibility because she assesses her value by the extent of her desirability among boys, whom she seeks for protection. Simultaneously, he stigmatizes and despises her but does not want to see how he's taking advantage of her." Thus, the patriarchal beliefs and values that many girls and women are raised to in the wider society contribute to the belief of some recovering women patients in faulty standards about their value among men. Furthermore, they go to lengths to adopt the way—the only way as they believe—to protect themselves because of the power imbalance between women and men and societal privileges of men in general.

Dr. Allam sees the utmost necessity for the state and its various institutions to adopt a different direc-

tion and perspective that are not subject to the patriarchal values prevailing over the Egyptian society. If this happens, it will aid the implementation of certain recommendations that will help addicted women patients to truly recover. She believes that this will not happen without providing the basic needs of addicted women patients who wish to recover. There is also an important role for media, education and health institutions as follows:

The issue has several things that must be kept in mind ... It must be kept in mind that in the early stages of treatment and therapeutic assistance of girls, the parties should remain separated until she experiences psychological growth and self respect, especially in our culture. It reduces relapses because this factor increases in relationships when they discover that the relationship is not real. The ideal scenario is a segregation in meetings for the first 3 to 6 months of recovery. (And in my opinion) the state's efforts in general is not enough because they cannot weigh the problem properly and still deal with the subject in primitive terms (as in) bad friends, money, and pampering. So they are not aware that girls need a different direction related to the violence that they experience. And the media needs to have a completely different role. Recovered girls have not featured in any program. Usually, those who are hosted are either recovered male addicts or their wives. Also, the General Secretariat, the Abbasiya Hospital, and places that receive patients must be trained in the direction of treatment of addicted women patients with a perception of the psychological structure of women addicts.

Dr. Allam also believes in the need to design and activate preventive measures against drug addiction, which, in her opinion, will reduce the spread of the disease among both men and women in the long term:

Prevention is necessary for youth and adolescents in preparatory and secondary schools and universities from 12 to 18 years. As well as (designing) awareness and prevention programs at professional and scientific levels and the disease of addiction should be part of the educational curriculum. Education must include life skills and self-expression methods through the study material, and not be separated from the material they learn, because direct advice and awareness create a sense of ridicule among young people. Volunteering and assistance should be integrated to teach young people to remain useful and productive at the time of school and not to forget university.

A research paper with the title "[Women Survivors of Violence: Where to Go?](http://nazra.org/en/node/502)"²⁷ reflects the dilemmas of safe homes for women survivors of violence, one of which is their scantity, with nine safe houses,

27 <http://nazra.org/en/node/502>

one of which is closed. Women who are accepted in these houses face arbitrary practices, where most house managers prefer to admit married survivors most of the time, in addition to the attempts by some workers to reconcile the survivor with the perpetrator, completely doing away with the necessary measures to protect her. It follows that there is a bigger problem in the extent of availability of these houses to receive addicted women patients who often need a place to go to, even for a temporary period, so that they can protect themselves and complete their journey of recovery at its onset. In this sense, this would be a transitional phase in their recovery process so that they can rely on themselves and take the necessary measures to achieve some stability in their lives. Therefore, Dr. Allam stresses the need to create safe houses for recovering women patients, since their importance lies in creating a safe environment for them to ensure that they pass this critical stage:

The state has to establish reception houses because one of the main problems is treatment followed by the return to homes; this is a fatal problem, especially until they find work or study. In 2004, an addicted girl in her sister's wedding stole her wedding gift and was about to be taken and thrown away in Upper Egypt. I told them to allow her to stay with me and consider it a therapeutic place, and if you don't find a difference after 6 months don't pay the treatment fees retroactively. The place then gave me the jurisdiction to do so. Nine months later, her father visited her and it was a touching encounter. Today, she's been sober for 13 years and is married and has kids. This is why transitional state homes are important, because girls are terrified to return home in fear of what her neighbor would say, and whether or not her brother's wife will be there on Friday, etc. Unlike the boy, of course, who is treated as a Vietnam veteran and is cooked for and celebrated.

Summary and recommendations

During active addiction and recovery, drug-addicted women patients are exposed to multiple types of violence and discrimination, including but not limited to psychological violence, intimidation, threats, imprisonment, physical violence, baiting, and sexual violence of all kinds. The violence against them stems from the fact that they are women who are expected by the patriarchal community to play stereotypical roles concerning the preservation of "honor" and care for others, and that each of them is an obedient mother and wife. While addicted male patients are often accepted, especially recovering ones, the societal inferiority and stigmatization of addicted women patients continues before and after their recovery. Many of them are sexually exploited by narrow and wide segments of the community, ranging from community actors—both private and public spheres—and some of the state actors. The absence of protection mechanisms from violence and their fear of the sense of shame that is socially-constructed around experiencing such violence contribute to their decision to be silent about these crimes. Despite the success of self-recovery communities in helping addicted male patients and changing their lives, many recovering women patients are subject to violence in these communities, which are supposed to be a positive source of their protection and the change of their lives for the better. Unfortunately, however, reality is far away, causing some to relapse and some to die, given the nature of this life-threatening illness which causes death.

Moreover, the absence of documentation and analysis of the crimes of violence committed against addicted women patients in general, and the challenges they face as a result of their being women, lead to the absence of comprehensive and effective mechanisms to safeguard their right to physical and psychological integrity and to lead dignified lives. Despite the launch of a national plan to combat and treat addiction in May 2015, there is no information on measures being taken to protect addicted women patients and hold perpetrators accountable. There is also an absence of gender mainstreaming, along with restructuring the relevant state institutions and revising national laws or strategies on violence against women, including the national strategy to combat violence against women, which has no reference to violence against addicted women patients. Also, the national plan referred to above does not contain measures to protect them from violence. Most of the activities of the national plan to combat and treat addiction are limited to public awareness about the disease of addiction, which also lacks the integration of gender. The situation is worse for addicted women patients who are from economically and socially moderate or low classes. While they are not granted access to treatment, especially from their families, they do not have the financial resources to obtain treatment and rehabilitation from private hospitals and treatment centers. The public facilities are very limited in number and lack the resources that could help place them on the path to recovery, so that they are able to claim responsibility of themselves and their recovery. Therefore, the paper presents some recommendations that could change the status of recovery processes for addicted women patients, by responding to their needs due to the economic and social setting in which they live. This is based on our belief that healthy societies that promote values of democracy need the presence of women figures who are interested in public affairs and do not bear the burden of suffering from the addiction disease or exposure to various forms of violence. **The recommendations are:**

- 1.** The activation of a genuine political will to adopt mechanisms and measures that focus on the thorny situation of drug-addicted women patients and the challenges and violence they face and are exposed to.
- 2.** The revision of all national plans and mechanisms for the control and treatment of addiction to integrate the gender perspective and restructure the themes and activities accordingly, and to consult experts in the field of gender mainstreaming and the treatment and rehabilitation of drug-addicted women patients in the review and planning processes. Furthermore, the revision of the national strategy to combat violence against women and the 2030 women's empowerment strategy is important for them to include clear mechanisms and measures to address violence against women, both addicted and recovering women patients.
- 3.** The allocation of a fund that takes into account the criteria of privacy, neutrality, and professionalism for the treatment and rehabilitation of drug-addicted women patients.
- 4.** Addressing the issue of the drug addiction disease in educational curricula in schools and universities, which not only raises awareness, but also disseminates necessary information such as hotlines and entities that can be contacted to treat the disease of drug addiction.
- 5.** The design and publishing of directories containing institutions, hospitals,

and treatment centers that can be accessed by addicted women patients who wish to recover.

6. The launch of periodic media campaigns that feature examples of drug-addicted women patients from different classes and contexts that challenge societal values which enhance the stigmatization of addicted women patients and methods of their recovery. This should happen through advertisements and short films without the appearance of recovering women addicts themselves, out of respect of their privacy and in protection of their identities.

7. The establishment of safe houses for addicted women patients to temporarily stay there and work on their recovery to overcome the critical stage at the onset of recovery until they achieve independence and are able to take responsibility of themselves and their recovery, and that the internal regulations do not contain arbitrary conditions for the admission of recovering women patients.

8. The launch of awareness programs on the benefits of volunteering and integrating elements that challenge the stigma around women in general, and drug-addicted women patients in particular.

9. The allocation of sections for the treatment of addicted women in hospitals and general treatment centers separate from psychiatric departments and to ensure the integration of gender perspective in the treatment plans that are implemented with the participation of experts in the field of gender mainstreaming and treatment and rehabilitation of drug-addicted women patients.

10. The conduction of an expanded demographic survey in cooperation with national and independent research centers to identify the percentage of drug-addicted women patients in Egypt every one or two years, and extracting information about their different classes in all governorates until the needs are determined according to each geographic region. This will result in a broader and more comprehensive planning of the provision of necessary measures.

11. The establishment of at least one clinic in each governorate where drug addiction is prevalent among women, which they can visit to detect any diseases transmitted sexually or through abuse. Physicians, doctors and employees there shall maintain privacy and refrain from exercising any discriminatory acts that may result from their preconceptions of the patients.

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