Pompidou Group
Groupe Pompidou

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs

Ministry of Health and Population

General Secretariat of Mental Health and Addiction Treatment

وزارة الصحة والسكان

الأمانة العامة للصحة النفسية وعلاج الإدمان

P-PG/Med (2016) 24

Gender Responsive Services for Women with Substance Abuse Disorders in Egypt

Final Report

Prepared by

Prof. Noha Sabry

January 2017

Introduction

The status of women in the Arab world has long been problematic. In 2002 the first Arab Human Development Report cited the lack of women's rights as one of three factors, along with lack of political freedom and poor education, that most hampered the region's progress. In Egypt, women constitute about half of the 90 million population. Traditional gender roles in Egypt are prevalent and clearly defined. These roles are largely associated with traditional family structures, where women's roles are closely tied to the domestic sphere and men's to the public sphere. Gender roles are based on misinterpretation of biological differences between the sexes and can lead to dramatically different life experiences, opportunities and outcomes for individuals. In relation to a number of indicators, women often find themselves disadvantaged as compared with men.
Women work outside their homes, go to school and university, vote and are eligible to stand in all elections. In terms of education and competition in the labour market, however, women still lag behind. Women are four times more likely to be unemployed than men. The majority of women with children work at home, taking care of children and elderly family members.

Substance abuse and other dependence behaviours are much more common in Egyptian men. However, it is not surprising that the gap in drug use between males and females is narrowing in Cairo to approximately 3:1, and that the prevalence of drug abuse in the general population has increased from 2% to 6.4% in two successive research samples (n=14930 and 23678) (Hamdi et al, 2011).

In 2015, the national addiction survey covered 10 governorates including Cairo. Substance abuse and other dependence behaviours are common in Egyptian men. The prevalence of substance use in Egyptian women accounts for 9.5% of total morbidity. The overall male: female ratio for substance abuse is 7:1, and 10:1 for dependency. The composite figure for female alcohol and substance dependence is 0.5%.

The number of female patients who received treatment for drug addiction in Egypt over this 7-year period was 2836/110650 i.e. 2.6%.
The number of female admissions to governmental hospitals was 271/5156, i.e. 5% of all admissions in the period 2014/2015.

In 2013, the UNDP's Gender Inequality Index (GII) ranked Egypt 110th out of 159 countries, with an overall value of 0.59, where 1.0 is a perfect score. These indicators suggest strong gender-based disparities in the areas of reproductive health, economic participation and overall empowerment.

In the area of drug addiction, the General Secretariat for Mental Health and Addiction Treatment undertakes continuous efforts to remove the stigma surrounding addiction and increase public awareness of addiction as a mental disorder. Egyptian society is still far from accepting female addiction and judges such women harshly. This is reflected in the lack of willingness among these women to declare their problem and access treatment, and in the under-development of services for them. In-depth studies of addiction problems affecting women in Egypt have yet to be conducted.

There is near consensus in international literature that rates of addiction to illicit substances and alcohol are rising, and furthermore that women may succumb to severe forms of the disorder more rapidly than men, that they suffer more complications and that they seek out and receive treatment less often than men. There are specific gender-related issues underlying treatment-seeking behaviour and responses in women.

Project objectives

- To explore the need for a gender-responsive service for substance-dependent women in Egypt.
- To build capacity for staff to provide gender-responsive care to women suffering from addiction.
- To develop policies and guidelines to establish gender-responsive addiction services nationwide.
- To start up and assess a public-domain addiction service for women which serves their treatment needs to high standards.

Partnership

This project is the outcome of a partnership between the General Secretariat of Mental Health and Addiction Treatment and the Pompidou Group of the Council of Europe. The Pompidou Group funds the educational and training components of the project, and supplies experts from Europe who participate in those components. In addition, the Pompidou Group provides administrative supervision of its financial aspects.
The General Secretariat of Mental Health and Addiction Treatment provides the human resources and premises, meets the cost of healthcare, and ensures staff training and project implementation.

Project phases

Phase I: Desk review: Gender-oriented substance abuse services worldwide.
• Existing literature specific to female addicts in Egypt.

Phase II: Formative assessment: in-depth interviews (IDI) and focus group discussions (FGD) with a random sample of persons from addiction management facilities

Phase III: Quantitative survey: based on Phase II

Phase IV: Cairo workshop

Phase V: Pilot of female responsive service and evaluation

Phase VI: Data analysis and report writing

Phase VII: End of project conference. Dissemination of final report

This interim report gives a summary of the activities in the second, third, fourth and fifth phases of the project, and outlines in detail the activities coming under Phases V and VI. The first interim report described the activities undertaken in Phase I. The second interim report outlined the activities of Phases II, III, and IV.

Phase I

(A) International literature review of female-responsive services

This review is discussed in the first interim report. The review focused on experiments and centres in Pakistan, Sweden, the United States, Canada and Panama. It covered different systems, including outpatient and residential care, and comprehensive management approaches. The review highlighted the fact that, in the case of women, special attention needs to be given to pregnancy issues and child care, community-based rehabilitation, income generation and networking problems with support systems.

(B) Local situation analysis of services and needs for women with drug-dependence problems in Egypt

Local studies were reviewed to extract information on female substance abuse in Egypt, especially the survey run by the National Addiction Research Programme. The National Addiction Survey showed a 1.6% increase in the lifetime prevalence of substance use in females in Cairo and a 1.8% increase in the current prevalence of substance use between 2009 and 2010.

In 2010 there was a three-fold increase in illicit drug abuse and dependence among women in Cairo, from 2% in 2009 to 6.4% in 2010.

Chart I: Prevalence of substance use among women in Cairo

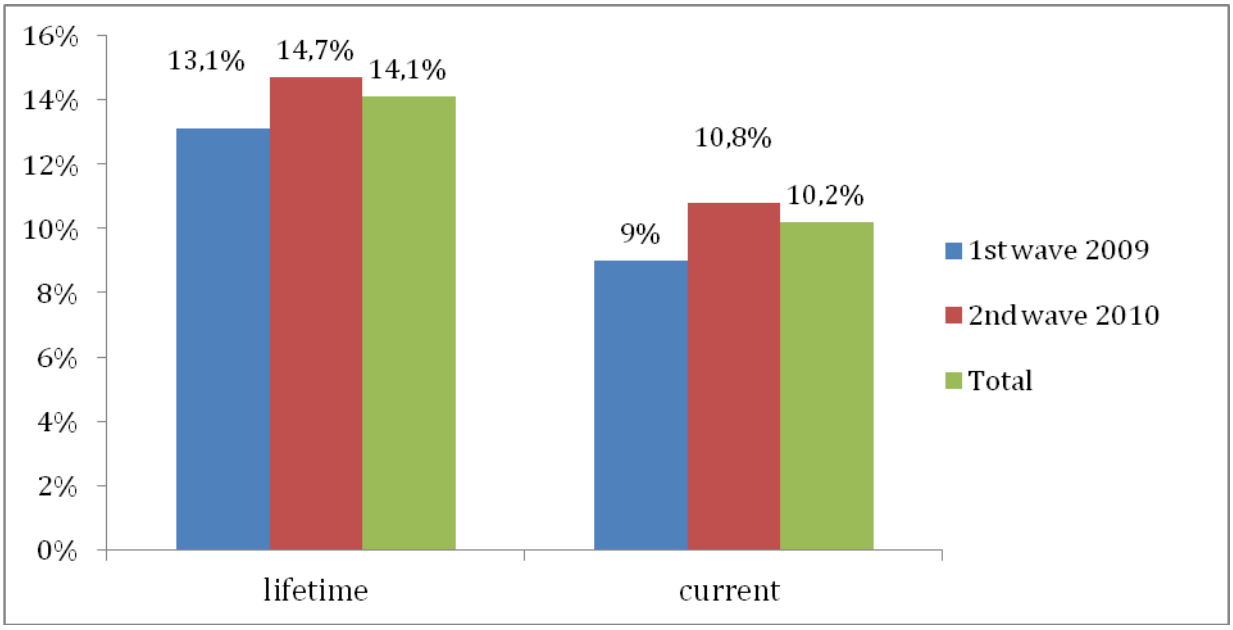


Table 1: Severity of substance use among women in Cairo

Abuse / Dependent	Regular use	Experimental / Recreational	
91 / 4490 (2.0%)	231 / 449 (5.1%)	267 / 4490 (5.9%)	1st wave 2009
526 / 8218 (6.4%)	373 / 8218 (4.5%)	307 / 8218 (3.7%)	2nd wave 2010
617 / 12708 (4.8%)	604 / 12708 (4.8%)	574 / 12708 (4.5%)	Total

In 2015 the most recent national addiction survey revealed that the level of substance abuse and dependence among females in 10 Egyptian governorates including Cairo had reached 3.2%. It should be mentioned that this national addiction survey was based on random household samples taken from the national population survey.

Services available for treating women with substance abuse problems in Egypt are quite limited. They are mostly residential facilities, and the majority of beds are in the private sector. Inpatient wards have been developed only very recently in public hospitals. The following inpatient wards specifically for women with addiction issues existed before this project:

1. Heliopolis Psychiatric Hospital, (MOH, Cairo)
2. Kasr el Maadi Psychiatric Hospital (Private, Cairo)
3. Kasr El Aini Psychiatry and Addiction Hospital (University Hospitals, Cairo)
4. Dar El Mokattam Psychiatric Hospital (Private, Cairo)
5. Serenity Girls Addiction Center (Private, Cairo)

Recently, two more inpatient wards for women with substance abuse problems have been created in public hospitals; Abassiya Mental Hospital (MOH, Cairo) and El Maamoura Hospital (MOH, Alexandria). Except for the El Maamoura hospital facility, all these units are located in the capital Cairo. The great majority of community-based services are mixed gender and attended almost exclusively by men. They are nearly all run by private sector establishments. Public mental hospitals run clinics open to women but are not geared specifically to their treatment needs.

The number of patient-treatment episodes (inpatient and outpatient) in 2015 in the public mental hospitals (tables 2 and 3) reveals that female addicts accounted for a limited fraction of all admissions. This ranged from 8% in the Heliopolis Psychiatric Hospital to 11% in the Abassiya Mental Hospital. The most substantial number of cases was to be found in the Abassiya hospital, which is one of the biggest specialised state-run hospitals for the treatment of addiction in Cairo (Egypt). The highest frequency of new cases was referred to the Heliopolis hospital.

Table 2: Total inpatient episode statistics for Egyptian public mental health hospitals (2015)

Hospital	MALE	FEMALE	TOTAL	% FEMALES
ABASSIYA HOSPITAL	919	113	1023	11%
HELIOPOLIS HOSPITAL	573	51	624	8%
MAAMOURA	607	58	665	8.7%

Table 3: Total outpatient episode statistics for Egyptian public mental health hospitals (2015)

Hospital	Type of cases	MALE	FEMALE	TOTAL	% FEMALES
ABASSIYA HOSPITAL	**Follow-up**	**9020**	**288**	**9308**	3.1%
	New cases	**15950**	**403**	**16353**	2.4%
	Total	**24970**	**691**	**25661**	2.6%
HELIOPOLIS HOSPITAL	**Follow-up**	22567	470	23037	2%
	New cases	4618	249	4867	5%
	Total	27185	719	27904	2.5%
MAAMOURA	**Follow-up**	14951	663	15614	4.2%
	New cases	4476	227	4703	4.8%
	Total	19427	890	20317	4.4%

Phase II

In-depth interviews (IDI) and focus group discussions (FGD) for female patients with substance abuse problems (qualitative study of needs and difficulties)

After obtaining approval from the supervising medical officers, confidential interviews were carried out at the Serenity Girls Addiction Centre and Heliopolis Hospital. Interviews included both free association and direct questions addressing aspects of female addiction, specific needs of substance-dependent women, potential provision of services, different responses compared to male addicts, sexual and reproductive health issues, provider knowledge, attitudes and practices, and so on.

The same team conducted focus group discussions at Heliopolis Psychiatric Hospital, Mokattam Hospital, and Serenity Centre for Girls. Focus groups included service providers. Each comprised 4-10 female addicts from the same centre. The discussions were very well received and appreciated by patients. The focus was on exploring the needs of substance dependent women, their awareness of services designed to be gender-responsive and their needs for, and barriers to, accessing the facilities.

In total, 23 patients and 44 service providers were assessed through in-depth interviews and focus group discussions.

Ethical Considerations

The following ethical principles were adopted:

- Approval from hospital director
- Verbal consent from patient
- Note-taking, no audiotaping
- Private room
- Participants informed about their rights in clear language (Egyptian dialect)

Potential topics

- Awareness of existing addiction management facilities
- Accessing existing facilities
- Gender-specific services or programmes
- Barriers to treatment
- Positive and negative treatment experiences
- Differences between male and female addiction patterns
- Laws, policies, and child custody
- Society, stigmas, provider attitudes
- Suggestions for creating an ideal service
- Hopes, future plans and dreams

Content analysis

Female experience of addiction

Many women responded spontaneously to this question, stating that there was no difference between males and females in terms of addiction. One patient commented "*women go deeper and are more in danger, they take greater risks and are exposed to more problems; for example when they leave home they may disappear for years*."
The main motive for treatment appeared to be total emotional and personal exhaustion.

Stigma and society
Female addicts in treatment were quite open about their experience of social stigma.
Some statements conveyed this experience very plainly: *"It is hard for society to forgive mistakes committed by a woman"; "others consider the female addict to be a criminal, they do not regard her in the same way as a male addict, people think she needs to be disciplined".*

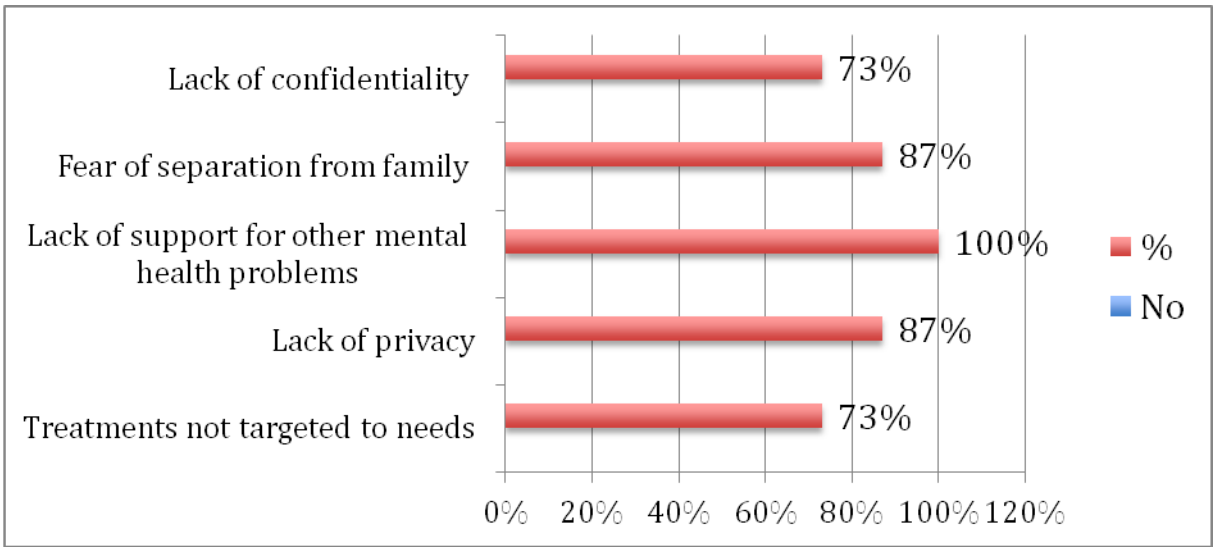
Care provider discrimination
A feeling of being misjudged and marginalised was ascribed to mental health professionals too; whether this was a correct assumption or the patients' own interpretation could be a question for researchers. However, it reflected issues of trust and rejection experienced and felt by female patients. *"The doctor left a note for them at the front desk to charge me an extra L.E. 100 for each visit just because I was a woman. He started blackmailing me and his assistant, may God forgive him, discussed sexual matters with me".*

Provider/patient gender issues
"I do not want men around, we will not be treated well because men think a girl with addiction is not a decent girl"; "It does not matter if it is a male or female provider but with the woman I will feel more at ease when talking about sensitive matters"; "Girls' families care that men and women should be separated"; "The problem with mixing men and women is that it leads to harassment and romantic affairs or sexual relations".

Suggestions for a better service
"We need to distract ourselves with something useful; sports, knitting, cooking, anything"; "One of the reasons why I came here was that they offered a nursery for my baby and my husband was not willing to take care of her".

Reasons given for treatment discontinuation
These are listed in chart 2.

Chart 2: Reasons given for discontinuation of treatment by females with substance abuse problems



Responses by 20 women to the structured questionnaire were analysed, and their reactions to the questions relating to actual experience with treatment facilities seemed to be the most representative and factual. The findings are shown in chart 2.

These responses showed that 100% of women cited a lack of support for other mental health problems as their main reason for discontinuing treatment. This should be understood as a failure to offer more explicit counselling approaches to treatment.

Loss of privacy (87%) and loss of confidentiality (73%) were both seen as significant issues in a treatment context. Women in particular complained about family members acquiring knowledge of their intimate affairs without their consent and also becoming aware that they were in treatment.

Fear of separation from their family, especially their children, was another significant concern for women with substance abuse problems undergoing treatment. Lastly, patients agreed that treatments not immediately targeted to their needs led to discontinuation and relapse.

Phase III

Quantitative study of the bio-psycho-social needs and care expectations of women with substance abuse problems in Egypt

This study was designed and carried out for the second report. The study was conducted in a private halfway house for women, a public addiction hospital, and an anonymous narcotics group for women.
The questionnaire used in the study drew upon the above questions, and omitted questions of an impressionistic or general nature. The fields covered by the questionnaire were determined by content analysis of the in-depth interviews (IDI) and focus group discussions (FGD).

Five clinical psychiatrists working in research and clinical practice involving substance abuse and drug addiction participated in formulating and revising the final questionnaire. The final form came in two versions:

- Client form
- Service provider form

The questionnaire covered the following aspects of the patient treatment cycle:

1. Issues and considerations related to seeking help, accepting referral, and initiating a treatment. Issues that may be clarified through group discussion comprise, for example, how to recognise and declare the problem to a close friend, accept family support and select the service and its location.
2. Features of the service in terms of location, structure, residential characteristics, outreach, staff composition and gender.
3. Features of the treatment programme that are responsive to women's needs including employment of female counsellors and therapists, female-only opportunities for group and individual activities, counselling for sexual health and sexually transmitted diseases.
4. Attention to the medical, gynaecological and obstetric needs of patients in treatment. Advice on medication use to alleviate physical and mental health problems.
5. Facilities for home care of young children and day care for children of women in the treatment programme.
6. Support with other problems of everyday life, employment and career choices, and relationship issues.

Client sample (n=23)

The study sample was taken from a number of treatment facilities:

- Heliopolis Psychiatric Hospital
- Private mental health hospitals
- Halfway house (specifically for female addicts)
- Anonymous female narcotic meetings

Service provider sample (n=44)

Service providers included psychiatrists, social workers, and ex-addicts currently serving as therapists for female patients with addiction problems within the same centres from which the patient samples were taken. Their years of experience ranged between 2 and 27 years with a mean of 9.27 years. The number of women under their care was highly variable, ranging between 1 and 45.

Results

Sample Characteristics

Two findings emerged concerning patterns of abuse. Most women abuse heroin, which is a different pattern of abuse from that admitted by men in treatment. Tramadol, a synthetic opioid available in oral tablet form, came second among women; it is the most common substance used by men. Cannabis was joint second. Most women in treatment abused more than one drug.

Table 4: Common types of substances abused by women

Substance	N	%
Heroin	16	(69.5%)
Tramadol	15	(65.2%)
Hashish	15	(65.2%)
Alcohol	11	(47.8%)
Sedatives	4	(17.4%)
Stimulants	3	(13%)
Cough syrup	2	(8.7%)
Volatile substance	1	(4.3%)

In addition to substance abuse a significant number of women in Egypt sought treatment for what was regarded by them and/or their families as behavioural forms of addiction (table 5). These included overeating and binge eating but also promiscuous sexual behaviour: its high proportion in this study (almost 83%) is surprising and probably an overrepresentation, since any sexual experience outside marriage may be regarded as a form of promiscuity in Egypt, even by the female patient herself.

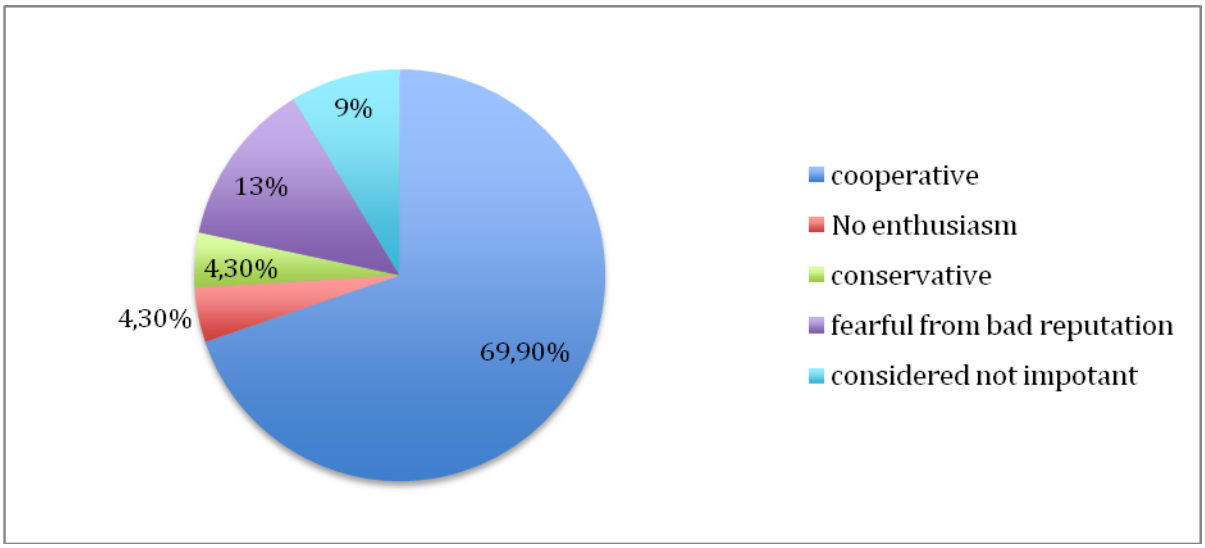
Table 5: Other types of female addictive behaviour

Client experience			Health provider experience		
Binge eating	2	(8.75%)	Binge eating	12	(30.8%)
Continuous snacking	1	(4.3%)	Continuous snacking	12	(30.8%)
Promiscuity	19	(82.6%)	Promiscuity	28	(63.6%)
Gambling	0		Gambling	1	(2.6%)
Internet	5	(21.7%)	Internet	8	(20.8%)

Respondents were asked if they thought society treated women with addiction problems differently from men. The majority were affirmative (17, 73.9%), and respondents were evenly split as to whether society's different attitude helped or hindered women.

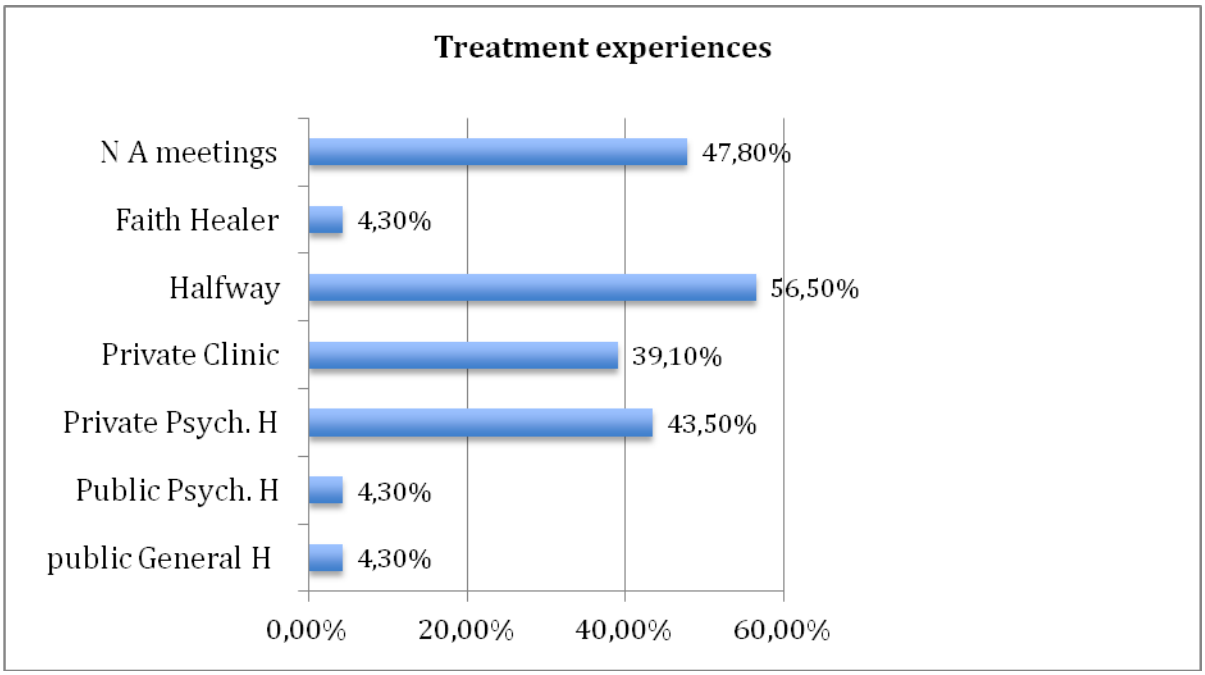
Respondents were then asked about the attitude/behaviour of their spouse/guardian towards their addiction problems (chart 3). Almost 70% reported a positive and helpful attitude. The remainder mentioned a passive response, conservative or defensive attitude and straightforward antagonism or fear about the impact on the family's reputation (chart 3).

Chart 3: Husband/guardian attitude towards patient's addiction



The majority of patients had had previous treatment experiences (chart 4), usually not in a residential setting.

Chart 4: Previous treatment experiences



When patients were asked to select potential strong points or positive aspects of previous therapeutic experiences, they cited the following:

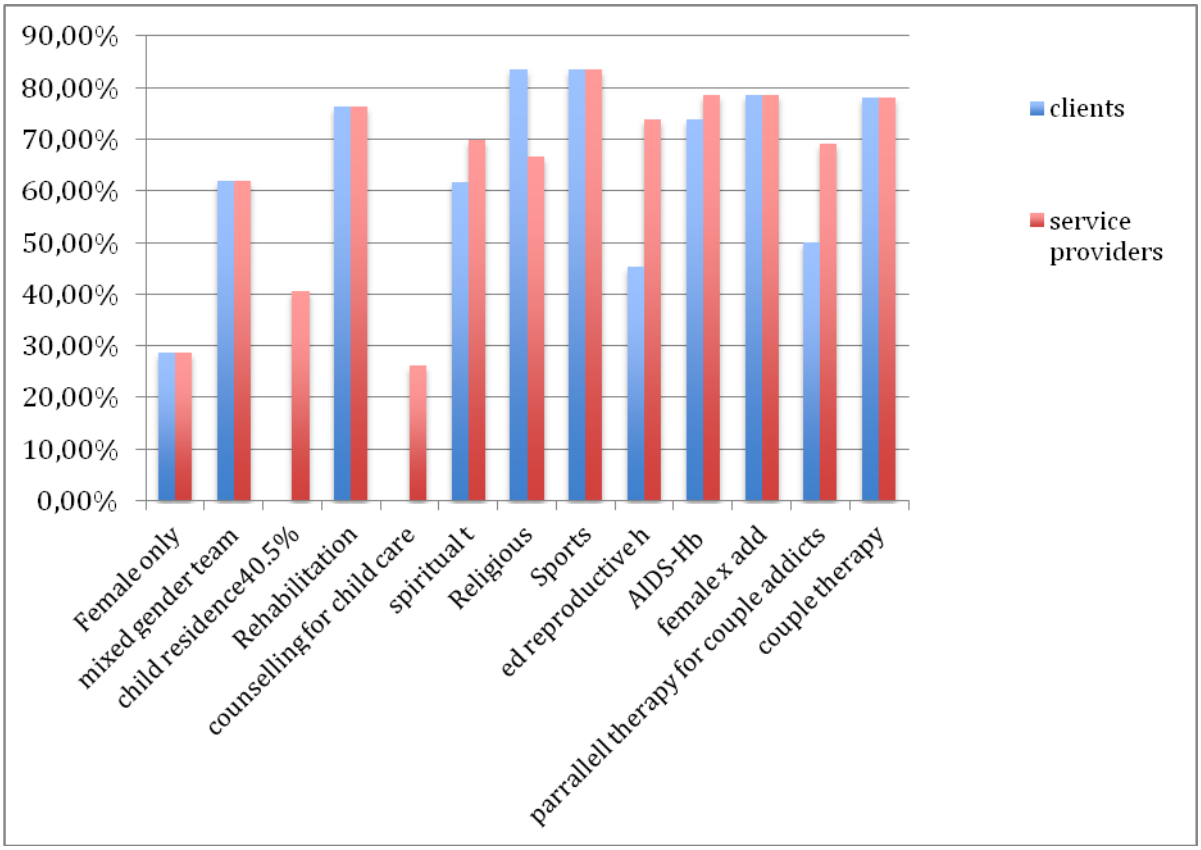
Confidentiality	14	(63.6%)
Trusted and efficient treatment providers	12	(52.2%)
Presence of recreational activities	11	(47.8%)
Established discipline and rules	9	(39.1%)
Therapeutic programme	8	(39.1%)
Women-responsive service	7	(30.4%)

Provision of counselling service concerning		
relations with other people	14	(60.9%)
Marital relations	9	(39.1%)
Sexuality and intimate relations	7	(30.5%)

The final section of the questionnaire asked patients and service providers to state their preferences regarding aspects of the treatment centre and operational characteristics.
The great majority favoured a separate building for female addiction issues (19; 86.6%). Approximately 27% were in favour of treatment in a separate building or ward in a psychiatric hospital and a minority (9%) thought treatment could take place in a general hospital. Again, most patients felt that the treatment team leader should be the psychiatrist (85%). Approximately 60% of patients agreed that medications ought to have a place in treatment after withdrawal from illicit drugs.

When patients were canvassed about aspects of treatment they thought were important, female patients unsurprisingly mentioned a parallel treatment for their addicted spouse or couple therapy in 50-70% of cases. Many women (43%) requested child care facilities. More than half requested sexual health consultations. Only 35% desired exclusively female service providers, and a quarter asked for special women-only departments. The great majority wanted special therapeutic activities dedicated to women (chart 5). The views of patients and service providers were generally similar with regard to those aspects of the service deemed important for recovery.

Chart 5: Preferred aspects of an addiction service for women



Phase IV
One-day workshop in Cairo (15 May 2013)

The workshop aimed to disseminate results, raise awareness about gender issues in addiction services and enable exchanges with internationally renowned experts in the relevant field from the Pompidou Group. The workshop took place concurrently with a roundtable discussion involving international and national experts that tackled the topic of developing a National Drug Addiction strategy (13-14 May 2013). Both the roundtable discussion and workshop were held at the National Training Centre of the Egyptian Ministry of Health.

MedNET/Pompidou Group representatives attended and participated in the presentations and discussion. The workshop was well attended by senior officials from the MOH, Ministry of Interior, Ministry of Social Welfare and Ministry of Justice along with senior decision-makers from the General Secretariat of Mental Health and Addiction Treatment and Addiction Units of various Egyptian medical schools. Also present were former project officers and international addiction experts from the WHO. Daily newspapers announced and publicised the event.

Mr Patrick Penninckx introduced the workshop and described the steps taken to establish the framework for this joint collaborative project with Egypt.

Dr Noura El Nawawi presented the findings from the Phase II qualitative study analysing the views and experiences of women with addiction problems in Egypt. This is the study described above: it was undertaken through in-depth interviews and focus group discussions in 3 selected centres in Cairo treating women with addiction problems. The main difficulties and experiences relating to drug use, treatment access and abstinence were identified by content analysis of these interviews and focus groups.

Prof. Noha Sabry presented the findings from the Phase III quantitative study of the service needs of women with addiction problems in Egypt. The study questionnaire was based upon the findings of the qualitative study. The study included 23 females under treatment for addiction and 44 service providers.

Mrs Elisabetta Simeoni and Prof. Meni Mallori initiated a group discussion around stigmas attached to women with addiction problems and ways of overcoming them. Dr. Anna Vella described a successful integrated model of care from Malta that takes account of specific issues related to treating women.
Dr Rania Mamdouh presented success stories from an exclusively female halfway house in Cairo.

Finally, Dr Tamer El Amrosy presented the expectations for continuing collaboration in operating the first public service responsive to the specific needs of women with addiction issues.

Workshop conclusions and recommendations

- The need to fight the specific forms of stigma attached to female addiction.
- The main barriers to taking up treatment are related to confidentiality, social stigma and lack of sufficient social and treatment support.
- Responding to the needs of women necessitates a dedicated service in separate premises that are both accessible and private.
- Principles of care for women with addiction problems should be extended to existing services. Equitable levels of service should be created across all regions of Egypt.

- A serious care issue relates to organising training and formal licensing of counsellors involved in addiction treatment.
- Treatment programmes should be detailed and structured. Health providers do not necessarily have to be of the same sex, but women should be able to avail themselves of same-sex health providers.
- Clients and health providers have differing views about barriers to seeking treatment. Child care and child custody issues are important barriers to seeking treatment.
- Female addiction is often associated with partner addiction. Facilities for parallel management of addicted couples should therefore be made available.

Phase V
Pilot of female responsive service and evaluation

(A) Establish the programme

- **Identify a successful programme and adapt**

  At present no single complete model of a gender responsive service has been identified. The present model incorporates features from models identified in phase I (Sweden and Pakistan) with experiences derived from training in Malta. The most important aspect is, however, that the care programme will rely on findings from both the qualitative and quantitative surveys completed in the previous phases.

- **Identify centre location**

  Considerable discussions took place at the General Secretariat of Mental Health and Addiction Treatment and MOH. Ideally such centres should be located in Cairo where community research has identified the highest rates of female addiction morbidity. Furthermore, because of the project timeframe an existing building has to be used rather than a new one.

  It was therefore decided to locate this service in an independent **building within the current premises of Heliopolis (El Matareya) Addiction Hospital**. This is a renovated, purpose-built facility and is the largest and most successful centre for treating patients with addiction problems in Egypt.

  The Gender Responsive Service for Females with Addiction Problems was assigned premises in an independent building with a small attached garden and separate inpatient and outpatient facilities.

  The Centre will undergo structural changes so as to be completely protected by fencing but with access on one side to the main hospital, and on the other to the outside. The building can provide residential care for 20 patients and outpatient services in dedicated rooms.

- **Develop a culturally and religiously sensitive training curriculum (to be approved by the General Secretariat of Mental Health and Addiction Treatment)**

  This activity has yet to be completed through the drafting of a training manual. Considerable training and knowledge enhancement was necessary. This was achieved by allowing staff to acquire field experience in a similar centre: this was the main reason why training was undertaken in Malta.

- **Selection and training of trainers**

  The training session was held between 3 and 14 June 2013 under the supervision of Dr. Anna Vella in a female-only addiction treatment facility in Malta. MedNET funded the entire training programme.

  The team undergoing training had four members: a nurse and a social worker from Heliopolis Hospital (El Matareya), a psychiatrist from El Maamoura hospital and a psychiatrist from the General Secretariat of Mental Health and Addiction Treatment.

(B) Training content drawn from visits to the treatment facilities:

1. A therapeutic community centre managed by NGOs and funded by the church. The patient is assessed and a multidisciplinary therapeutic plan devised: the patient can either be referred to an appropriate facility for plan implementation or follow a day-care activity within the centre in the form of group, family and/or individual psychotherapy. If the patient drops out of the proposed therapy, she reattends the centre where reasons for drop-out are analysed and the plan is modified appropriately.

2. Care provided by the state and NGOs for children of addicted female patients when the parents are unable to look after them. This is based on reports from supervising social workers. The system requires all members of the team to reach consensus on transferring the children to a selected foster family. The adopted children are followed up in their new homes by regular and unannounced visits. At the same time, the addicted mother or parents are followed in their own therapeutic programme, which includes training in parenting skills. This situation is reviewed monthly by a team in which a psychiatrist usually speaks on behalf of the mother and the visiting social worker on behalf of the child, followed by discussion and evaluation of overall progress of both parties; the final decision is always made in favour of the child.

3. Presentation of a rehabilitation model for females with substance-abuse problems administered by an NGO under church supervision. The therapeutic programme is very similar to that for men but is supplemented by a network of services based on client needs. Such services include parental education and employment training. Rehabilitation programmes supervised by the church are based on the confrontation method typical of the therapeutic community. The client is totally separated from the outside environment for at least a month. At the end of the programme each client should be able to rejoin the workforce, or at least undergo training to enhance their job skills.

4. Presentation of the system of providing methadone maintenance via the outpatient clinic of a governmental centre along with administration of a harm reduction programme.

5. Another model of providing methadone treatment to women during pregnancy and after delivery and to their newborn infant within a government-run general hospital. Women are referred from the same hospital or elsewhere.

6. Another model of methadone provision for inpatients in a psychiatric hospital among patients with dual diagnoses.

7. Presentation of outreach services supplied by an NGO with church funding. They are made available in centres providing services and meeting places for women, which offer counselling and referral in the event that more help is needed.

8. Presentation of addiction preventive programmes planned and implemented in schools, universities and workplaces by an NGO. The programme is supported financially by the state.

Conclusions of the Malta training

The need to develop training programmes for mental health personnel especially nursing staff, and training to improve their attitude toward female addicts.

The need for proper preparation of patients before their enrolment in the inpatient programmes in order to improve programme compliance. This includes work on object relations, codes of behaviour and motivational aspects.

The need to develop a network of services with other non-governmental sectors working in the field so as to improve referral systems and provide extra assistance after discharge from the rehabilitation and support system.

The need to develop a proper mechanism for after-care, including social and occupational support for treated women.

The need to reconsider the importance of methadone provision, especially for prenatal care and pregnant addicts.

The need to consider priorities in decision-making which favour the offspring in the case of pregnant addicted women.

The need to empower outpatient and community services and not only inpatient programmes as an effective alternative type of care.

Comments

Several aspects of the conclusions of the Malta training were deemed inappropriate or impossible to achieve at this stage of the project:

1. Methadone is not available in Egypt. Suboxone and Sibutramine are occasionally found but are very expensive and not available in government-run institutions. Being able to set up methadone maintenance programmes in government facilities would require legislative change.
2. Although the people of Egypt are traditional and religious by nature, the role of mosques differs from that of the Church. The present socio-political climate in Egypt precludes direct encouragement of mosque practices in this field.
3. Placing children in foster homes in Egypt is not at all standard practice and would be culturally unacceptable. A different approach relying on family support needs to be developed and implemented.

Phase VI
Programme evaluation: Open clinical study (January 2015 – July 2016)

The sixth phase followed actual implementation of the gender-responsive service at Heliopolis (El Matareya) Addiction Hospital. This phase started after the project had been put on hold for six months from June-December 2014 due to various administrative issues.

At this late stage in the project the ultimate targets are to:

1. Establish a gender-sensitive service for substance-dependent women in Egypt.
2. Identify social determinants underlying substance abuse that are specific to women in Egypt.
3. Build up staff capacity to provide gender-sensitive care for women suffering from substance abuse.
4. Develop general policies and guidelines to establish gender-responsive addiction services nationwide.

The project moved into the experimental stage once practical clinical trials had been launched to implement a gender-responsive service.
The aim of this study was to develop the programme and identify how many of the project's end goals had been achieved.

To achieve this we worked on four levels:

1. Developed a therapy team integrating colleagues who had visited Malta with others who had not.

2. Held regular meetings with the team: working clinical teams met with the project coordinator and research advisor on a bi-weekly basis for development and follow-up.

   The meetings included:
   a) Review and modification of the clinical sheet with the addition of gender-sensitive items to the assessment
   b) Discussing the scientific background of many gender-related topics
      1. Physiological differences of substance abuse in women
      2. Impact of relationships on the development of substance abuse and the partner effect
      3. Assessment of co-dependency problems
      4. Risk factors, especially trauma, anxiety, depression, eating disorders and sensation seeking
      5. Impact of substance abuse on menstruation, pregnancy, labour and breastfeeding.
      6. Correlations between substance abuse, sexuality and violence, etc.
      7. Women’s treatment challenges or obstacles to accessing treatment and compliance management
   c) Revising the clinical record sheets to include specific items related to the gender issues. Routine records did not include a single item.
   d) Allocating roles to team members for the required activities
   e) Revising the case management of inpatients, especially those with extreme social difficulties likely to challenge the treatment
   f) Designing electronic patient files in order to record interventions
   g) Motivating women to enrol in the programme after assuring them of confidentiality
   h) Identifying alternative community services following discharge

3. Programme development

    a) Establishing a treatment programme for inpatients including daily group therapies: motivational groups, meditation, parenting skills, marital counselling, psycho-educational assistance, support group, physiological feedback and effects of drugs on female hormonal health, in addition to co-dependency issues. Introducing rehabilitation activities including handicrafts, art activities, cooking, reading, gardening, etc.
    b) Reducing the recommended length of the inpatient stay to 4 weeks instead of 6 weeks: this was based on our observation that long stays were inappropriate for married women and a reason for dropouts.
    c) Trials to make the once weekly daycare programme exclusively for females.
    d) Planning for community-based follow-up of our clients in order to stay in touch with them and maintain the therapy momentum.
    e) Providing outpatient clinics in the morning over 3 days plus 2 afternoon clinics
    f) Developing a computerised documentation programme, spanning the patient's life from birth to the present, in order to have confidential records for all centre clients and be able to monitor their progress.
    g) Developing a system to follow up and motivate patients after their discharge: this includes phone-calls and construction of a website called LHAA ("for her"), including motivational statements and educational topics as well as providing a secure means of exchanging questions and answers while respecting personal privacy.

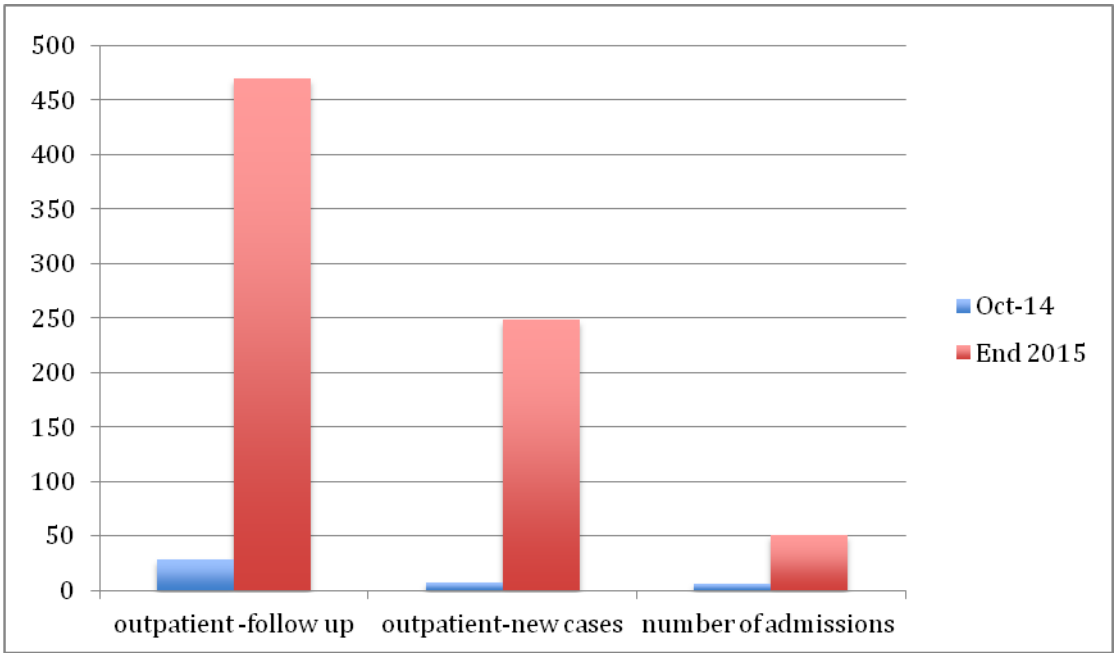
4. Conducted an audit in order to assess and develop actual practices. The audit sought to determine how current practice corresponded to the standards identified in the previous phases.

Service progress in numbers

The number of female patients who attended the hospital service from October 2014 until the end of 2015 was as follows:

- New outpatient cases increased from 5 to 249 cases
- Follow-up outpatient cases increased from 28 to 470 cases.
- Female inpatients with substance abuse problems increased from 7 to 51 cases. (Table)

Chart 6: Services received by female substance abusers at Heliopolis hospital (inpatients-outpatients) from October 2014 until end 2015.



The average lengths of stay for inpatient groups on study termination in May 2016 were as follows:

Number of days	Number of patients
16-30 days	25 patients
31-45 days	11 patients
46-60 days	8 patients
61-75 days	4 patients
76-90 days	3 patients

Therapeutic activities in the inpatient ward (June 2015 – June 2016)

The treatment programme in the inpatient ward became more established with a fixed daily schedule in May 2015. The programme ran on a regular basis except for two months (August and September 2015) when the ward was reconstructed. Each patient was able to receive individual psychotherapy and to attend group activities.

The day usually started with meditation and the programme integrated the Narcotics Anonymous (NA) book "*Just for Today*". Patients were able to complete 250 messages. The aim of this daily practice was to boost motivation, overcome obstacles to recovery and promote the treatment decision.

The group therapy programme consisted of various approaches including motivation groups, psychological coaching, cognitive behaviour therapy and emphasis on the here-and-now.

Table 6: Average number of group sessions conducted between June 2015-June 2016:

Number of sessions	Type of groups
45	Motivational groups
40	Psycho-education
40	Here and now (Emotional expression)
45	Cognitive behaviour therapy

Couple and family counselling
- Counselling and treatment of couples was provided in individual cases
- Family psychoeducation was performed according to need but not on a routine basis
- Parenting skills and childcare skills were provided according to need.

Rehabilitation activities included
- Creative art activities including painting, handicrafts and writing were offered once weekly, for a total of 45 sessions.
- Clients could participate in 3 workshops in the district cultural centre.
- The ward library was improved in order to enhance the reading activity of clients.
- Cooking activities: clients were encouraged to cook their own food the way they liked once weekly. This was a "special" day and clients shared their food with the therapy team.

Social integration with families
- The social workers developed a telephone service in order to communicate with the patients' families.
- Breakfast parties were held for all patients including recovered ones in order to instil hope and provide role-models for those still under therapy.
- Patients' families were invited to attend a collective Ramadan breakfast with

the patients.

Phone service for patients and their families

This service was set up as a minimal method of staying in touch and following up clients after they leave the service.

The total number of activities were:

- 200 telephone calls with patients' families during their inpatient period in order to ensure that clients completed their therapy.
- 150 follow-up calls to encourage clients to attend the outpatient clinic.
- 120 telephone calls to follow up cases after their discharge and ensure that they continued to abstain.
- 70 telephone calls to remind regular day-care attenders.
- Tele-counselling of clients and their families in the event of crises.

Location and complete structural changes

Structural changes were undertaken to enhance privacy and facilitate access to the service. All gender-responsive requirements were integrated in order to guarantee client engagement with treatment.

Structural improvements to the gender-responsive service had been approved but could not be completed. They included:

1. Modification of the building to accommodate a private service exclusively for women, which would include all requisite medical and psychological services.
2. Construction of a perimeter fence and direct street access for female patients.
3. Improvements to inpatient activity services including occupational and recreational activities.
4. Provision of a nursery reserved for female patients on community visits.

Evaluation of programme development and team building

This evaluation was designed and performed following two visits to Malta and after work had been done on building clinical skills and considering gender topics in daily practice for about 6 months. It also aimed to assess the application of standards relating to gender issues in the service.

These standards included:

1. Recognising the role and significance of personal relationships in women's lives
2. Addressing the unique health concerns of women
3. Recognising the importance and role of socioeconomic issues
4. Assembling an integrated and multidisciplinary team
5. Paying attention to the relevance and existence of various caregiver roles assumed by women throughout their lives
6. Supporting the development of gender competency specific to women's issues
7. Adopting a trauma perspective

The questionnaire

This consisted of 24 questions covering routine practice skills and how gender-related issues had been integrated in practice. Gender-related issues had been a focus of discussions in previous phases.

Examples of gender issues included monitoring the correlation between drug abuse and the menstrual cycle, assessing the frequency and type of substance abuse during pregnancy

and the effect of substance misuse on maternal and infant safety during labour. Sexuality and its relation to substance misuse was another important issue.
Gender-related issues related to therapy were also considered in the assessment questionnaire. These included running family sessions, exploring sexual health and possible inclusion of the spouse during treatment.

We also evaluated the therapists' self-reflection about the treatment process, and ethical issues raised during the patient's therapeutic journey.
The study questionnaire enquired about requirements for a gender-responsive service from the standpoint of the health provider.
The questionnaire was designed by the project coordinator and revised separately by 4 consultants in the addiction field.

Subjects and Procedure

Evaluation was performed twice (April and November 2015)

The first evaluation was carried out in April 2015 after the second Malta visit and was used by the team to establish:

1. The treatment programme,
2. Regular case conferences,
3. Developing the case management plan for individual cases,
4. Building up team spirit,
5. Dividing responsibilities among team members.

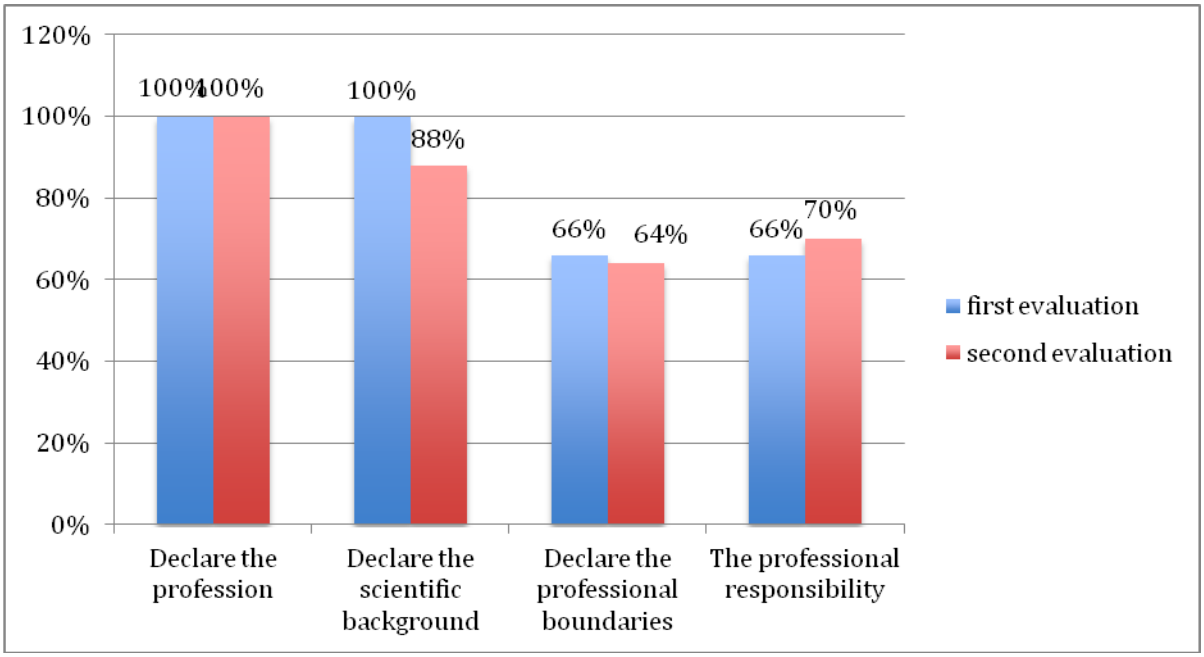
There were 6 team members on the first round of the questionnaire, who attended the meeting on that day and represented the main service providers for female clients. They consisted of two psychiatrists, two nurses, one social worker and one recovered addict volunteer in the counselling programme. The head psychologist was not available on that day (female: male ratio 5:1).

Second questionnaire round

The second evaluation was done on November 2015, when the programme had become established. However, because of changes in higher management several changes had taken place within the working team. The established programme was maintained. Participants were three psychiatrists, two psychologists, one social worker, one recovered addict and ten nurses.
Five of the 17 service providers repeated the questionnaire. In this phase we evaluated all nurses who contributed to client care in all shifts (female: male ratio4:1).

Results and comments

Chart 7: Treatment team openness with patients

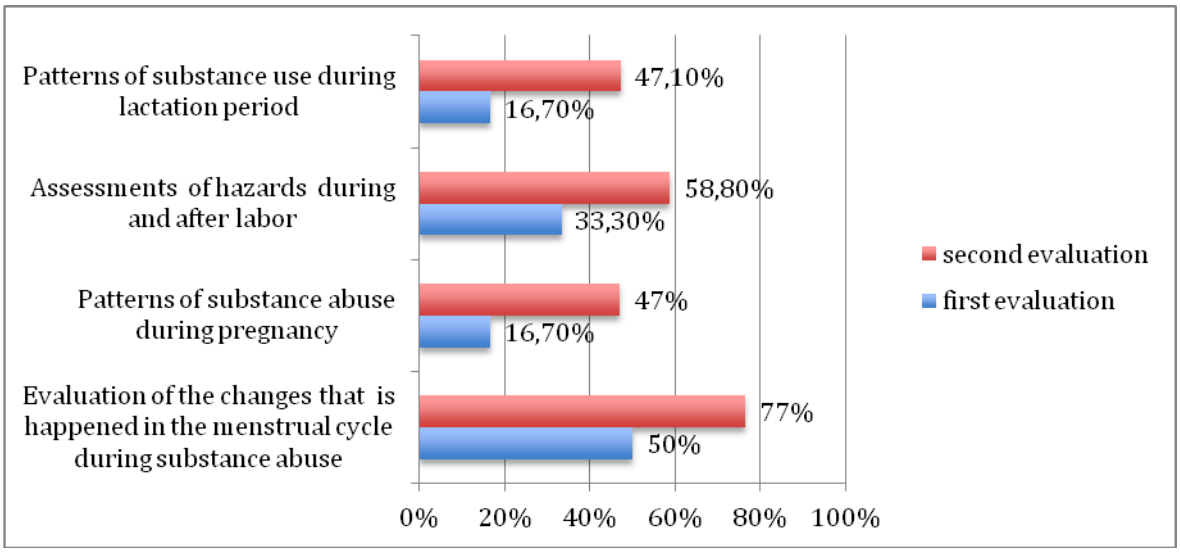


The first part of the evaluation dealt with treatment team openness and how members introduced themselves to female clients. There was 100% agreement about stating their professional and scientific background. This attitude was maintained in the second evaluation for professional qualifications but decreased somewhat for scientific qualifications. Team members were less forthcoming about informing clients of professional boundaries and responsibilities. There was no statistically significant difference between the two evaluations.

Incorporating gender issues within the assessment:

This section covers inclusion of the reproductive health dimension in patient assessment.

Chart 8: Assessing how substance use relates to female physiological life



Comparison of the two evaluations revealed an improvement in how gender-sensitive topics,

especially reproductive health, were assessed in the second evaluation. The latter covered possible changes affecting women during menstruation and pregnancy, hazards to mothers and neonates during labour, as well as changes in the pattern of substance abuse during breastfeeding.
There was an improved degree of inclusion of all these factors in how female reproductive health was assessed. The difference between the two evaluations was statistically significant only for menstrual changes (x^2 =-02, p=1.468 using Mc Nemar's test*).*

Reports from health providers about the environment in which female addicts are introduced to services

Table 7: Environment including site, staff and work programme dedicated to the gender service

Service Description	First evaluation	Second evaluation
Special wards for women	100%	100%
Availability of dedicated team for women	50%	76.6%
Availability of group therapy for women	66%	53%
Availability of child care services	0%	17%
Services related to sexual health	16%	35.6%
Special services related to reproductive health	33%	30%

An environment was defined in terms of site selection, staff selection, programme development, content and material reflecting an understanding of the realities of clients' needs.

On both evaluation dates all health providers were providing treatment in female-only premises. For the second evaluation more team members acknowledged that their work was dedicated to female addicts only (76.6%) versus 50% in the first evaluation. The inclusion of sexual health education for female addicts was also improved in the treatment programmes, especially harm reduction and preventing unwanted pregnancy.
The second evaluation suggested that childcare was being provided albeit on a limited scale for female addicts. This occurred during their visit or on follow-up while receiving services.

There was a considerable drop in group therapy activities, as reported by health providers. This finding may be due to the fact that most of these activities are daytime events whereas the majority of responders for the second evaluation were night-shift nurses who do not participate in group activities.

Routine admission procedures

Table 8: Admission procedures for female addicts

	First evaluation	Second evaluation
Parents or husband's consent before admission	66.7%	35.3%
Mandatory pregnancy test	100%	93%
Mandatory HIV and hepatitis screening	50%	59%
Educational material and reproductive and sexual health awareness-raising	66.7%	87.6%

Evaluation of procedures routinely conducted on admission of female addicts revealed an important change. It was less often necessary to seek consent from parents and/or a husband for admission of female addicts, irrespective of the age group. This reflects a movement to reinforce the female addict's right to receive treatment of her own volition. Health provider emphasis on including reproductive and sexual health promotion has also reduced the need for a mandatory pregnancy test before admission. This finding has been

countered somewhat by an increase in mandatory HIV and hepatitis screening.

Table 9: Treatment sessions introduced by the health providers

	First evaluation	Second evaluation
Evaluation	83%	82%
Individual sessions	66.7%	70.6%
Group sessions	83.3%	64.6%
Family sessions	66.7%	70.75%
Skill training	100%	88.9%
Recreation and therapeutic activities	100%	82.4%
Sexual health education	16.7%	29.4%
Marital counselling	66.7%	52.9%
Harm reduction skills	66.7%	70.9%
Involving the addict's spouse in treatment	50%	52.9%
Others	16.5%	41.2%

Concerning treatment sessions introduced by the health providers, it was observed that the various therapeutic activities continued with different degrees of team involvement. There was greater concern about harm reduction behaviour, sexual health education and, as mentioned elsewhere, managing the sequelae of trauma and interpersonal violence.
On the other hand, both group therapy and marital counselling were less often provided. Specialised psychiatrists, psychologists and trained nurses performed these services but not the entire team.
More staff members were also involved in the individual sessions and greater interest was shown in harm reduction skills.

Acknowledging social and economic obstacles

Table 10: Evaluating social obstacles to treatment for women

	First evaluation	Second Evaluation
Confidentiality	100%	100%
Stigma in relation to treatment	88%	80%
Economic and financial problems	83.3%	70%
Motivation to undergo treatment	83.3%	88%
Fear of legal consequences	33%	41%
Balance between treatment and family obligations	50%	63%
Refusal of the guardian to allow treatment	50%	41%
Self-protection against violence	-	23%

One of the most important dimensions in a gender-responsive service is taking account of social and economic pressures which hinder women from first seeking and then complying with a treatment programme.
Health providers emphasised the overriding importance of confidentiality in both evaluations.
Stigma and reputation and their relation to treatment were mentioned by most of the health providers in the first evaluation; this decreased to some extent in the second evaluation. The same trend was observed with clients' economic and financial problems. Health providers underlined motivation to undergo treatment in both evaluations, with an increase in the second evaluation. Clients experiencing legal and police problems was a topic that started to receive more attention in the second evaluation.
Although providers showed less concern about guardians/husbands agreeing to treatment of their clients, getting the balance right between treatment and family obligations proved to be a very important conflict issue for women, and the percentage rose in the second evaluation. This issue is especially important for women in eastern cultures. In the second evaluation, trauma and how to deal with it was a new topic introduced into the health providers'

programme.

Conclusion

1- Gender-related topics were introduced in the assessment and management plans.
2- Performance standards were maintained in the second evaluation in spite of the fact that most of the team had not joined the Malta visit.
3- Greater attention was given to some topics especially sexuality and trauma in the second evaluation.
4- Reproductive health still needs more attention. Including a gynaecologist in the team will be a priority in future.
5- The child-care service still requires further development, and is one of the obstacles to progress.

Comparative findings from Heliopolis and Abassiya female addiction treatment units

Hypothesis

Standard treatment in the Heliopolis (El Matareya) hospital (a gender-responsive service) should show better response rates and greater client satisfaction.

There is a basic structural difference between the hospitals in Abassiya and Heliopolis. In Heliopolis, the female unit exists independently in a separate building and with separate grounds. In Abassiya, there are separate male and female wards, but the female addicts are treated in the same building as women with mental disorders.

Sample

48 female clients from two locations received services. 21 (42%) were female addicts from Abassiya, which is one of the largest mental health and addiction treatment hospitals, and 29 (58%) were women in Heliopolis hospital, an addiction treatment clinic where gender-responsive services are being introduced.

There was no statistical difference between either sample as regards age, level of education, occupation and marital status (table 11).

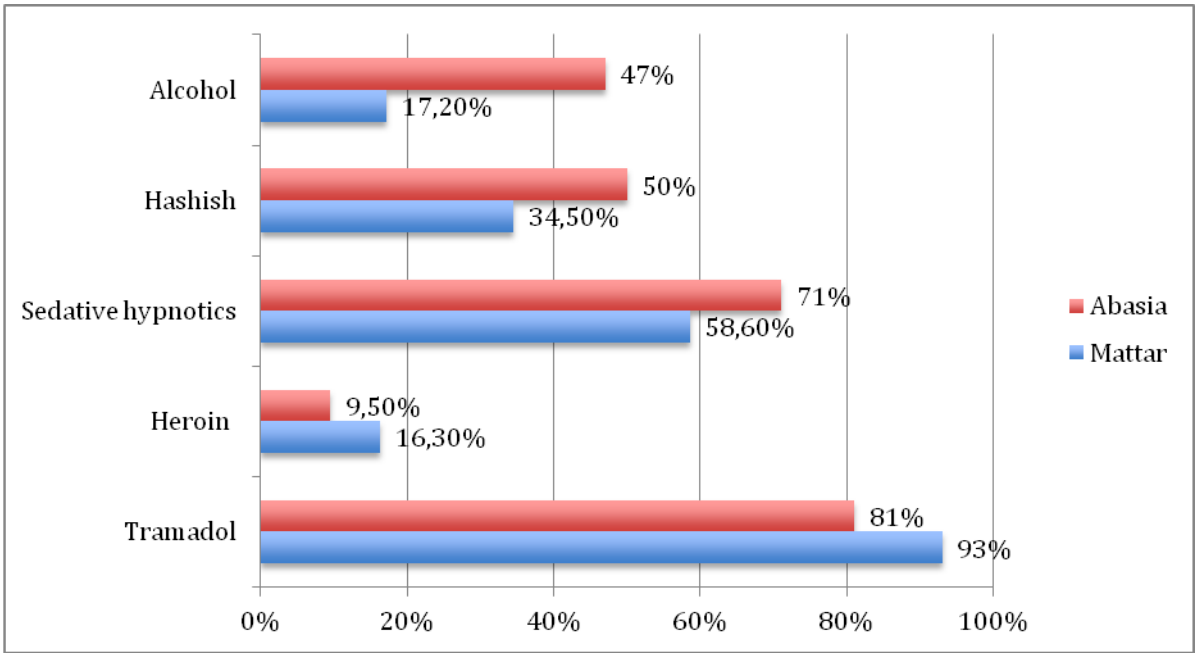
The substance abuse profile for both groups was also fairly similar. Tramadol (a synthetic opiate) was the most frequently used substance, followed by sedative hypnotics, hashish (cannabinoids) and alcohol.

Table 11: Demographic characteristics of female addicts in two hospitals

	Heliopolis Hospital		Abassiya Hospital	
Mean age	28.5+5.23		25.5+7.7	
Education				
Literate	8	27.6%	5	25%
Basic education	5	17.7%	3	15%
High School	12	42.9%	6	30%
University	3	10.7%	6	30%
Occupation				
Housewife	19	65.5%	10	20%
Unskilled worker	6	16.8%	1	5%
Skilled professional	2	6.9%	6	30%
Student	0		2	10%
Retired	0		1	5%
Marital Status				
Single	10	43.5%	8	38.8%
Married	9	31%	5	31%
Divorced	6	20.7%	8	38.1%

	Heliopolis Hospital		Abassiya Hospital	
Separated	2	6.9%	0	0
Widow	2	6.9%	0	0

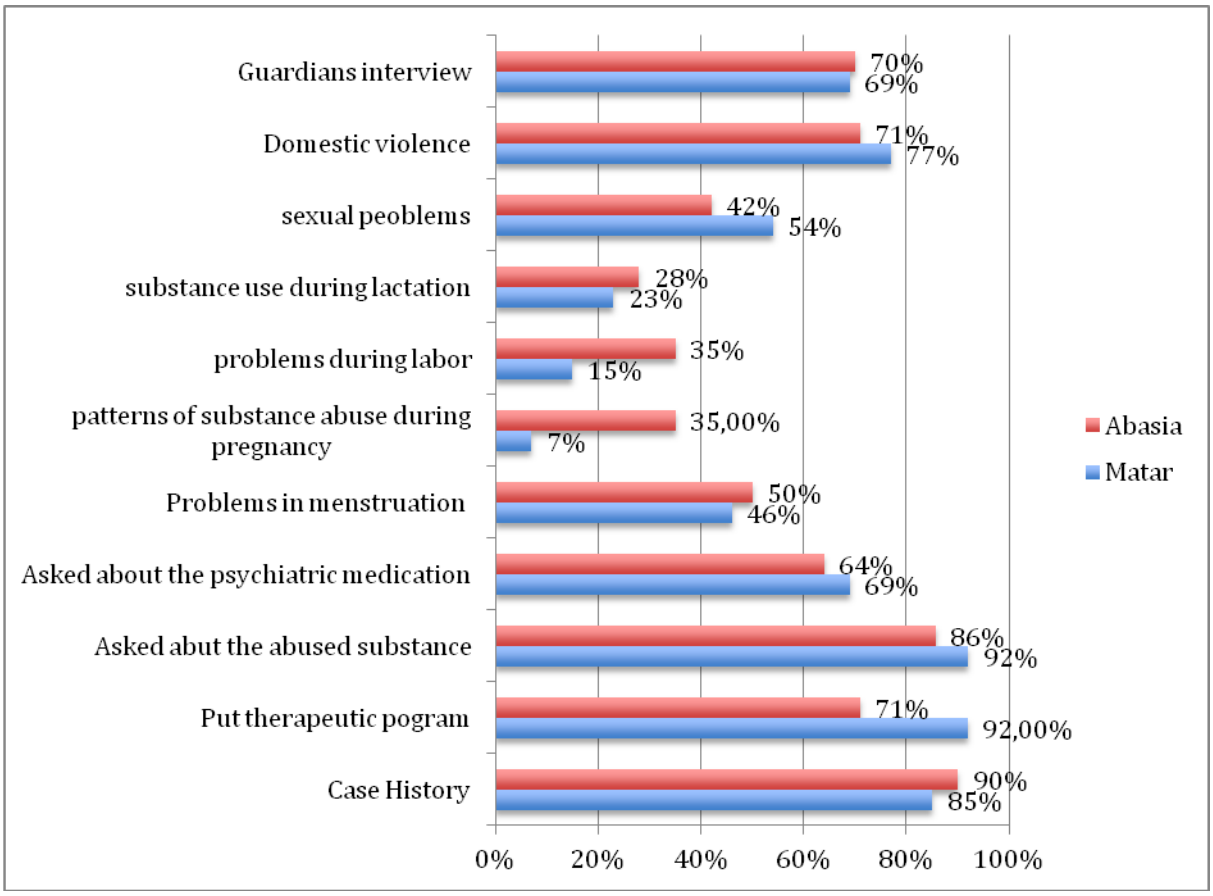
Chart 9: Types of substance use by female clients in two hospitals



Client perception of the evaluation process:

Clients were asked about the evaluation components and whether evaluation included topics such as problems with the menstrual cycle, modified patterns of substance abuse during pregnancy and problems during or after labour as well as during breastfeeding.
Domestic violence was an important aspect of female suffering and was also a topic explored when interviewing guardians/husbands.

Chart 10: Client feedback on the evaluation process



The number of clients in both hospitals who reported that they had been asked about most topics was nearly identical, and there was no statistically significant difference between the two hospitals.
More clients at Heliopolis (El Matareya) hospital reported having received a declaration of the treatment programme, an evaluation of substances used and been asked about domestic violence.
It was observed, however, that the topic of reproductive health received the least attention, especially risks during labour and breastfeeding: this suggests how important it is to work on this dimension when developing specific needs.

Assessing violence

Clients of both hospitals reported that they had been assessed for a history of violence in over 70% of cases.

Table 12: Types of services received in both hospitals

	Heliopolis Hospital	Abassiya Hospital
Special female sections	100%	95%
Outpatient clinics specifically for women	70%	28.6%
Daycare specifically for women	38.5%	47.5%
Female service providers	85.6%	70%
Group therapy specifically for women	69.5%	90%
Specific child-care services	0%	0%
Gender-specific services including sexual problems	11.5%	47.6%
Reproductive health services	30%	28.6%

Table 13: Requirement to perform a pregnancy test before admission

	Heliopolis Hospital	Abassiya Hospital
Compulsory	54.9%	61.5%
Choice based	13.6%	14.3%
No need	31.8%	23.8%

One of the most important gender-responsive practices is to assess whether a patient is pregnant. Deciding to carry out such an assessment is however problematic, since a balance has to be found between the safety of mother and child and gender-based human rights which allow a woman to determine her own physiological condition.
Freedom of choice has to be respected when considering whether such an assessment is necessary.
Given the challenging nature of this practice it would appear that the trend is towards testing on a less compulsory and more voluntary basis. The test is less often required in Heliopolis compared to Abassiya hospital.

Conclusions

1. A gender-sensitive and responsive service for women in Egypt has been created.
2. This gender-sensitive and responsive service is both culturally acceptable and responds to the needs of Egyptian women.
3. In spite of a number of shortcomings this service has had an impact on all public mental health services in Egypt, creating a cascade of similar services.
4. Its main achievement is that many professionals in various specialities now know about the specific needs of women in treatment and are prepared to support them.
5. The future challenge will be to maintain collaborative links and interact with similar services worldwide in order to provide the impetus for further improvements.
6. Statistics provided by the service from its inception indicate that it has an increasing and unique role in providing services for women with substance abuse problems in Egypt.
7. This service needs to be integrated with community services in order for it to be fully beneficial.

Future directions

1. Update structural changes in women's units to include clinics for reproductive health and provide child-care services.
2. Develop the mother-and-child services for female addicts as a complementary step which integrates practice with a gender-responsive treatment.
3. Maintain the project and consider it a model to be replicated in other hospitals.