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Rebecca Daniel Mbuti, Dr. Leah Wanjama & Dr. Sheila Mutuma

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[1]Rebecca Daniel Mbuti, [2]Dr. Leah Wanjama & [3]Dr. Sheila Mutuma

[1]Postgraduate student, Kenyatta University
[2&3]Lecturers, Department of Sociology, Gender and Development Studies, Kenyatta University

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Abstract

Drug addiction affects every demographic, but individual experiences of treatment vary considerably by gender, making it essential to understand the gender dynamics encountered by patients receiving alcohol and drug addiction treatment services. This study focused on Mathari National Teaching and Referral Hospital, the largest government rehabilitation facility in Kenya, which has a mission to treat, educate, and conduct research on alcohol and drug addiction. The specific objective of the study was to examine the gender-related mechanisms put in place for the treatment of alcohol and drug addiction patients at the hospital, with particular attention to gender bias during admission, enrolment criteria and admission duration, and gender-based separation during enrolment. The Feminist Theory on Equality and Reason, advanced by Mary Wollstonecraft, served as the foundation of the study, providing an analytical lens for examining how institutional mechanisms, though formally gender-neutral, can produce systematically inequitable experiences for male and female patients. A mixed-methods research design was employed to gather both quantitative and qualitative data. The study drew on a sample of 255 respondents, with 232 patients completing the questionnaire, alongside 10 key informant interviews with hospital staff, selected through stratified systematic random sampling. A questionnaire and an interview guide were used for data collection. Quantitative data were analyzed using descriptive and inferential statistics with the aid of SPSS version 23, while qualitative data were analyzed thematically, with verbatim quotes used to enrich the results. The findings revealed that although gender-related mechanisms existed at the hospital, they were unevenly implemented. Women were more than twice as likely to experience gender bias during admission, faced longer admission waiting times, and had reduced access to gender-segregated treatment spaces, and these upstream disparities translated into weaker treatment outcomes including lower comfort with treatment and poorer social reintegration. The study concluded that gender-related mechanisms existed more in principle than in practice and that meaningful equity required deliberate restructuring of admission protocols, resource allocation, and institutional accountability. Recommendations included standardizing admission protocols, expanding female-specific treatment spaces, introducing binding gender-responsive accreditation standards through the Ministry of Health and NACADA, and strengthening post-discharge aftercare to close the social reintegration gap experienced by female patients.

Keywords: *Gender Related Mechanisms, Treatment, Alcohol and Drug Addiction, Patients, Mathari National Teaching and Referral Hospital, Kenya*

1.0 Background to the Study

In contrast to the case of women, research has traditionally focused on how men have fared in substance abuse treatment (Possick & Itzick, 2018). In response, governmental organizations like NACADA support research and treatment while practitioners and researchers concentrate on comprehending and addressing gender differences in treatment access, provision, and outcomes (Richie, 2018). Treatment plans frequently unintentionally obstruct women from receiving care (Mugisha, Arinaitwe-Mugisha, & Hagembe, 2017). These include lack of sensitivity to the needs of addicted women, bureaucracy, and treatment that is primarily geared toward men. According to Mutindi (2016), there is less chance that women will act on their initial urge to seek help as a result of waiting lists for admission, inconvenient times for appointments and treatment, and documentation. Programs without childcare or in locations far from public transportation also put women in need of these services at a disadvantage (Odejide, 2016). These institutional mechanisms therefore constitute critical sites at which gender equity in addiction treatment is either secured or undermined.

According to the National Survey on Drug Use and Health (NSDUH) (2019), there exist distinct gender-specific needs in the context of seeking treatment for drug and alcohol abuse. Consequently, the availability of women-specific programs can be considered a viable and beneficial option for certain individuals. Within a secure and supportive setting, women have the opportunity to engage in dialogue pertaining to various topics, including but not limited to motherhood, workplace dynamics, relationships, and family life. According to Ndegwa, Munene, and Oladipo (2017), gender-specific interventions could potentially offer significant support to women who are in need of addiction treatment subsequent to experiencing a traumatic incident. According to Odejide (2016), it is argued that men possess distinct requirements in the context of addiction treatment, necessitating the resolution of cultural stereotypes and gender-specific roles. Gender-specific interventions have been found to enhance the comfort and acceptance of male individuals seeking treatment, as men often exhibit hesitancy in accessing such services due to concerns about potential judgment or perceptions of vulnerability (Mburu et al., 2018). According to Houghton and Roche (2014), gender-specific treatment is designed to address the physiological, psychological, and emotional needs of men.

According to Grella and Joshi (2019), within the countries comprising the European Union, women exhibit lower prevalence rates of illicit substance use compared to men. However, both licit and illicit drug use rates for benzodiazepines are higher among women in these nations. Women appear to begin using experimental drugs at a younger age than boys, but gender differences in cannabis use among teenagers (15–16 years old) are negligible or nonexistent (Vicente & Wiessing, 2017). According to data on outpatient treatment admissions in the European Union's Denmark, Finland, Germany, Greece, the Netherlands, Spain, and Sweden, 20.8% of all new clients in 2016 were female (EMCDDA, 2018). Almost a third of stimulant users (32.5%) were female, compared to 18.8% for opiates, 15% for cocaine, and 14.2% for cannabis (Brady & Randall, 2019). Women are disproportionately underrepresented in residential care in Germany but overrepresented in some treatment fields, such as opioid substitution therapy (Bocelli, 2016). These admission and enrolment patterns illustrate how institutional mechanisms shape gendered access to addiction treatment.

In the Netherlands, there are mixed-gender programs that offer women effective care (Schuch & De Jonge, 2018). These effective programs can be identified by their attention to women's issues, the personalities of the treatment staff, and their ongoing relationships with patients. The majority of the professional staff in treatment programs that are sensitive to women's issues are frequently women (Van der Meer, Bakker, & Olff, 2017). These gender-specific treatment programs encourage therapeutic conversation about delicate subjects like physical and sexual abuse.

Additionally, these gender-specific therapy programs may encourage therapeutic conversations with women about how they view addiction and recovery differently from men (Pesce, van Veen, & Giltay, 2016). The structure of treatment mechanisms, rather than mixed-gender settings per se, therefore determines the equity of the outcomes delivered to male and female patients.

There exists a notable disparity in the circumstances experienced by women and men in the majority of African countries (Gouse et al., 2016). The individual's encounter with substance use concerns similarly aligns with this observation. Muthuri and Arasa (2017) posit that the recognition of substance use problems among women is comparatively lower than that of men, and is accompanied by a heightened level of social disapproval. As a result of this, there exists a limited understanding regarding the extent, trends, and therapeutic requirements pertaining to substance use among women (Muturi, 2016). Moreover, women who suffer from substance use disorders are believed to encounter substantial barriers when seeking treatment, and it is widely acknowledged that they are underrepresented in treatment facilities (Kabore et al., 2016). Women who use drugs while pregnant or while raising children are particularly stigmatized by society, and pregnant women frequently put off getting help, which has serious consequences for both the mother and the foetus (Mokaya, 2016). However, not many treatment facilities offer child care, and it can be extremely difficult for women in some cultures to leave their homes and take on treatment obligations (Amaro, Raj, Vega, Mangione, & Perez, 2016).

Although more men than women are drug dependent or have drug problems, alcohol and drug abuse affects people of all ages, races, and nationalities, according to the National Authority for the Campaign against Alcohol and Drug Abuse's (NACADA) strategic plan (NACADA, 2017). A women-oriented treatment program, according to NACADA (2017), should be compatible with women's interpersonal preferences and orientations; for instance, it should take into account women's need for and receptivity to social relationships. It takes into account women's status in society, gender roles, and socialization—that is, how women are raised to fill traditionally female roles in the home and society. It does not abuse women; for instance, it forbids sexual harassment of female patients and opposes passive, submissive roles for females. Moreover, it is observed that women exhibit a higher tendency to seek healthcare services in primary care or mental health facilities rather than specialized treatment programs, potentially leading to adverse effects on the effectiveness of their treatment. Treatment and rehabilitation facilities are few, operate in a policy vacuum, and are expensive for the majority of Kenyans in Nairobi City County, the study area (Nairobi City County Government Report, 2018).

Although rehabilitation programs are not a recent development and are focused on both men and women in the nation, their unique needs have not received the attention they deserve. While this may be due to the lower prevalence of alcohol and drug abuse among women, it is more likely that cultural norms in many communities have contributed to a decreased willingness to take action when women are affected, especially given the high cost of rehabilitation (Mugisha, Arinaitwe-Mugisha, & Hagembe, 2017). According to Article 43 of the 2010 constitution of Kenya, every citizen of Kenya possesses the entitlement to the utmost achievable level of health, which encompasses access to healthcare services. People with disorders brought on by drug and alcohol abuse also have the right to attractive, affordable, and appropriate health care that is suited to their unique needs as men, women, boys, and girls (NACADA, 2017). It is against this background that this study focused on Mathari National Teaching and Referral Hospital, the largest government-owned rehabilitation facility in Kenya, in order to examine the gender-related mechanisms put in place for the treatment of alcohol and drug addiction patients, with specific attention to admission processes, enrolment criteria, and treatment placement arrangements.

1.1 Statement of the Problem

Every demographic is affected by the problem of drug addiction, but each person's experience of the problem vary greatly. The decision to seek substance abuse treatment may be influenced at several pivotal points by a person's gender. Once someone admits they have a problem with substance abuse and decides to get help, they may face gender-related barriers to finding and obtaining that help, which affects how patients behave when seeking health care and receiving it. Thus, the purpose of this study was to examine gender related mechanisms put in place for the treatment of alcohol and drug addiction patients in Mathari National Teaching and Referral Hospital. The case study used the Mathari National Teaching and Referral Hospital, the largest facility in Kenya with a mission to treat, educate, and conduct research on alcohol and drug addiction.

1.2 Objective of the Study

To examine gender related mechanisms put in place for the treatment of alcohol and drug addiction patients in Mathari National Teaching and Referral Hospital.

1.3 Research Question

What is the gender-related mechanisms put in place for the treatment of alcohol and drug addiction patients in Mathari National Teaching and Referral Hospital?

2.0 Literature Review

This chapter provides a comprehensive review of the existing literature pertaining to the treatment of alcohol and drug addiction in both male and female populations.

2.1 Empirical Literature Review

Ndegwa, Munene and Oladipo's (2017) research sought to identify the variables influencing alcohol use and abuse among Kenyan university students. Students enrolled at Daystar University in Nairobi and Athi River made up the study's target demographic. The findings showed that a considerable percentage of individuals had a moderate risk of developing alcohol use problems. Additionally, it was shown that patterns of drug use were impacted by the availability of drugs as well as variables including gender, age, academic level, geographic region, peer and parental influence, and media consumption. Similarly, a relationship was discovered between the individuals' drug use and their levels of academic success, anxiety, despair, and post-traumatic stress disorder (PTSD). The goal of the current research is to look at the countrywide treatment of drug and alcohol addiction in people of both genders. This research looked at the factors associated with alcohol use and consumption among Kenyan university students.

According to a study by Tuchman (2011), drug misuse is mostly linked to men, and a sizable amount of research on the subject concentrates on male participants. Gender differences in substance abuse epidemiology, social factors and characteristics, biological responses, dependence progression, medical consequences, co-occurring psychiatric disorders, and barriers to treatment initiation, engagement, and completion have all been found in recent research on substance abuse. Compared to drug use in males, the epidemiology of drug use in women raises different issues. According to the research that is currently available, women who suffer from drug use disorders are more likely than men to run across different obstacles that prevent them from receiving and finishing treatment. According to Tuchman (2011), women are more susceptible than males to contracting the HIV virus. Sex-related risk behaviors and gender-specific drug use patterns interact to produce a mix of gender-specific medical variables that contribute to this vulnerability. Gender, personal traits, and the particular

treatment methods used may all have an impact on the results. The goal of this research is to provide a thorough examination of the gender-specific variables that affect drug and alcohol addiction therapy on a nationwide scale. The treatment of drug and alcohol addiction in people of both sexes was the focus of this research.

According to Chesang (2013), there are significant differences between men and women in a number of areas pertaining to drug use disorders. These include the biological reactions to substance use, patterns of use, progression to dependence, health effects, co-occurring psychiatric disorders, the epidemiology of such disorders, social factors and characteristics associated with them, and factors influencing treatment entry, retention, and completion. According to LaFave and Echols (2016), women who participate in mixed-gender group therapy may face negative outcomes due to the historical dominance of males in society and the prevalence of gender differences in interpersonal approaches. However, Jansson, Spencer, McConnell, Velez, Tuten, Harrow, and Huestis (2016) have argued that drug abuse treatment needs to be customized to effectively address the complex psychosocial challenges faced by women, especially those who are pregnant or have dependent children. Therefore, in order to successfully address the drug addiction difficulties that women confront, as well as to meet their unique requirements and overcome the obstacles they face throughout treatment, treatment programs particularly intended for women must be implemented. The treatment of drug and alcohol addiction in people of both sexes was the focus of the present investigation.

According to Mutindi (2016), a person's gender may have an impact on a number of crucial points throughout the drug addiction treatment process. The first step in receiving therapy is identifying a problem, which may be done by the person seeking treatment or by a variety of stakeholders, including family members, medical experts, employers, or governmental organizations. In certain situations, there seem to be gender-based differences in the identification of a person's drug misuse issue. Women are less likely than men to actively seek treatment for drug dependence, but they also face more barriers to such programs. This statement is true for women of all ages, including younger and older populations. Additionally, it has been shown that women are more likely than males to seek assistance and care in primary care settings or healthcare institutions rather than specialized treatment programs. This preference for primary care settings might result in fewer successful treatment results.

2.2 Theoretical Framework

The study was anchored on the Feminist Theory on Equality and Reason, originally advanced by Mary Wollstonecraft in 1794, which argues that women possess the same capacity for rational thought and moral reasoning as men, and that observed inequalities between men and women are not the product of natural difference but of institutional structures, social norms, and resource distribution patterns that systematically disadvantage women (Lugones, Spelman, Kolmar, & Bartkowski, 2005). The theory holds that genuine equality cannot be achieved through formally neutral policies alone, because ostensibly gender-neutral institutions often embed historical patterns that privilege men, and therefore achieving equity requires deliberate restructuring of institutional arrangements and equitable allocation of resources based on documented need rather than on inherited administrative routines. Liberal feminist extensions of this framework further contend that while women have the same capacity for reasoned participation in public institutions as men, patriarchal structures, particularly the gendered division of labour and gendered assumptions about vulnerability, have historically denied women equal access to the means through which these capacities can be exercised (Price & Shildrick, 2017; Finke, 2018).

The theory was directly relevant to this study's examination of gender-related mechanisms put

in place for the treatment of alcohol and drug addiction patients at Mathari National Teaching and Referral Hospital because it moves analysis beyond the surface question of whether gender-sensitive mechanisms exist to the deeper question of whether these mechanisms produce equitable outcomes in practice. The framework illuminated why the hospital's admission procedures, gender-based separation arrangements, and staff training protocols appeared gender-responsive on paper yet produced systematically different experiences for male and female patients, explaining why formal non-discrimination policies and constitutional guarantees failed to prevent female patients from experiencing higher rates of admission bias, longer waiting times, and reduced access to gender-segregated treatment spaces. By emphasizing reasoned, evidence-based policy design and equitable resource allocation based on need rather than on historical admission patterns, the theory provided both an explanatory lens for interpreting the observed disparities as manifestations of deeper structural inequality and a normative basis for recommending institutional reforms aimed at restructuring admission protocols, resource allocation, and accountability systems to achieve substantive rather than merely formal gender equity in addiction treatment.

2.3 Conceptual Framework

The connection between the two types of variables is laid out in a conceptual framework. It's a diagram that may help students learn more about the factors that are being studied as shown in Figure 1

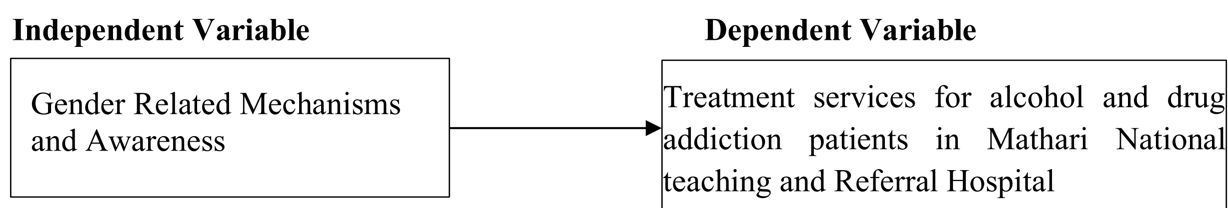

Figure 1: Conceptual Framework

3.0 Research Methodology

This study adopted a mixed-methods case study design integrating both quantitative and qualitative approaches to comprehensively examine alcohol and drug addiction treatment at Mathari National Teaching and Referral Hospital, Nairobi City County, Kenya. The hospital was purposively selected as the largest government-owned rehabilitation facility in Kenya, offering diverse patient representation, national-level policy relevance, and sufficient male and female patient volumes for gender-comparative analysis. The target population comprised approximately 550 patients undergoing alcohol and drug addiction treatment, along with the staff attending to them. Using Fisher et al.'s (1998) formula at 95% confidence and 5% precision, a sample size of 232 was calculated and adjusted upward by 10% to account for non-response, yielding 255 respondents. Stratified systematic random sampling was applied, with the patient list first stratified by gender and a Kth value of 2 used independently on each gender list to select approximately 128 patients per group, ensuring balanced gender representation. An additional 10 staff members were randomly selected for key informant interviews. Data were collected using a questionnaire (for patients) containing both open- and closed-ended items, and an interview guide (for staff) to capture deeper qualitative insights.

The validity of the research instruments was established through the Kaiser-Meyer-Olkin (KMO) test, with all items scoring above 0.5, alongside assessments of face, content, construct, and concurrent validity. Reliability was confirmed using Cronbach's Alpha, with all items scoring 0.7 or higher, indicating strong internal consistency. A pilot study involving 20 participants (15 patients and 5 staff) at a smaller rehabilitation unit within the hospital was

conducted to refine the instruments, with minor adjustments made to improve clarity before the main data collection. Quantitative data were analyzed using SPSS version 23 through descriptive and inferential statistics, with results presented in tables, graphs, and charts, while qualitative data were analyzed thematically, with respondents' verbatim quotes used to enrich the findings. Ethical considerations were strictly observed: ethical clearance was obtained from Kenyatta University Graduate School, institutional permission was secured from Mathari Hospital management, informed consent was sought from all respondents, and confidentiality was maintained through the use of pseudonyms and code names throughout the study.

4.0 Data Presentation, Analysis and Discussions

This chapter presents data presentation, analysis and discussions. Each of the section is discussed in depth.

4.1 Response Rate

The study administered 255 questionnaires to respondents undergoing alcohol and drug addiction treatment at Mathari National Teaching and Referral Hospital. Additionally, 10 interviews were conducted with key hospital staff involved in treatment and rehabilitation programs. The response rates for both data collection methods were recorded and are summarized in Table 1.

Table 1: Response Rate Summary

Category	Total Targeted	Completed Responses	Response Rate (%)
Questionnaire Respondents	255	232	90.98%
Interviewees	10	10	100.00%

Out of the 255 targeted respondents, 232 successfully completed the questionnaire, yielding a 90.98% response rate, while all 10 interviewees participated, achieving a 100% response rate. A response rate above 70% is considered sufficient for reliable data analysis (Baruch & Holtom, 2018). The high response rate in this study indicates strong engagement from the respondents, ensuring that the findings accurately reflect the gender-related mechanisms, challenges, and treatment strategies at Mathari National Teaching and Referral Hospital.

4.2 Demographics Profile of Patients

This section presents the demographic characteristics of the respondents undergoing alcohol and drug addiction treatment at Mathari National Teaching and Referral Hospital. The demographic profile includes age distribution, gender, duration of stay at the hospital, education level, marital status, and employment status. Table 2 below summarizes the demographic distribution of the respondents.

Table 2: Demographics Profile

Category	Response	Frequency	Percentage (%)
Age Group	Below 10 Years	5	2
	10 - 20	60	26
	21-30	70	30
	31-40	50	22
	41-50	20	9
	51-60	15	6
	Above 60	12	5
Gender	Male	150	65
	Female	82	35
Duration at Hospital	Less than 1 year	186	80
	1 year	20	9
	2 years	10	4
	3 years	8	7
Education Level	Primary Level	30	13
	Secondary Level	90	39
	Diploma	65	28
	Graduate	35	15
	Post Graduate	12	5
Marital Status	Married	70	30
	Single	110	47
	Widowed	15	6
	Divorced	37	16
Employment Status	Employed	60	26
	Unemployed	120	52
	Self-employed	52	22

The majority of respondents were between 21-30 years (30%), followed by those aged 10-20 years (26%) and 31-40 years (22%). The lowest representation was among those above 60 years (5%) and below 10 years (2%). These findings suggest that young adults are the most affected by alcohol and drug addiction, likely due to peer pressure, unemployment, and societal exposure (WHO, 2023). The presence of patients below 10 years, though minimal, indicates the early onset of substance use, highlighting the need for early intervention programs. Research by Degenhardt et al. (2021) emphasizes that early initiation of substance use is associated with increased risk of developing substance use disorders later in life, making early detection and intervention critical for preventing long-term addiction trajectories.

The study found that 65% of respondents were male, while 35% were female. The dominance of male respondents aligns with global trends indicating higher substance abuse rates among men (NACADA, 2022). However, the notable presence of female patients emphasizes the increasing vulnerability of women to substance abuse, often due to socio-economic challenges, trauma, and domestic influences. A significant 80% of patients had been at Mathari National Teaching and Referral Hospital for less than one year, while only 9% had stayed for one year, and 11% had been at the facility for two or more years. The high percentage of short-term patients suggests that many individuals seek treatment but may not stay for long-term rehabilitation, potentially due to financial constraints, stigma, or challenges in treatment adherence. This observation was corroborated by a hospital staff member (R3) who stated: "Some patients raise concerns, but others fear backlash or feel that speaking out will not change

much." Additionally, another respondent (R10) explained: "The main challenge is stigma, many patients, especially women, fear judgment from their families and society." These insights suggest that barriers beyond clinical factors influence treatment duration and completion rates.

The study revealed that the highest proportion of patients had secondary education (39%), followed by diploma holders (28%) and graduates (15%). Only 5% had postgraduate education, while 13% had primary-level education. These findings suggest that addiction affects individuals across different educational backgrounds, though it is more prevalent among those with lower education levels, possibly due to limited awareness and employment opportunities. A substantial number of respondents were single (47%), followed by married individuals (30%), while 16% were divorced, and 6% were widowed. The high percentage of single individuals could be attributed to the social and psychological effects of addiction, which often strain personal relationships. The notable proportion of divorced individuals further underscores the impact of substance abuse on family stability.

The majority of respondents were unemployed (52%), while 26% were employed, and 22% were self-employed. The high unemployment rate among patients highlights a critical issue, as financial instability and lack of opportunities may drive individuals toward substance abuse. These findings reinforce the need for economic empowerment programs and job placement initiatives for recovering addicts. Overall, the demographic profile of patients at Mathari National Teaching and Referral Hospital suggests that young men, particularly those unemployed and with secondary education, are the most affected by alcohol and drug addiction. The findings emphasize the necessity of targeted prevention programs, long-term rehabilitation strategies, and socio- economic support systems to enhance recovery and reintegration into society. Global evidence confirms that integrated approaches combining treatment with social and economic support improve recovery outcomes (WHO, 2023). Studies show that unemployment and poverty increase relapse risk, making socio-economic interventions essential (Degenhardt et al., 2016). In Kenya, NACADA (2022) recommends vocational training and community-based support to reduce stigma and sustain rehabilitation.

4.3 Gender-Related Mechanisms Put in Place for the Treatment of Alcohol and Drug Addiction Patients in Mathari National Teaching and Referral Hospital

This section presents findings on the gender-related mechanisms implemented at Mathari National Teaching and Referral Hospital to support the treatment of alcohol and drug addiction patients. The objective was to determine whether gender-based considerations were integrated into the admission process, treatment procedures, and overall patient experience. The key aspects analyzed include gender bias during admission, duration of admission for different groups, and gender-based separation during enrolment. The results provide insights into how gender dynamics influence access to and experience of addiction treatment as shown in Table 3.

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Table 3: Gender-Related Mechanisms in Treatment

Category	Response	Male Patients (n = 150)		Female Patients (n = 82)		Total (n = 232)	
		Freq.	%	Freq.	%	Freq.	%
Gender Bias During Admission	Yes	20	13.33%	25	30.49%	45	19.40%
	No	130	86.67%	57	69.51%	187	80.60%
Admission Duration	Less than 2 hours	65	43.33%	25	30.49%	90	38.79%
	2 – 8 hours	55	36.67%	30	36.59%	85	36.64%
	8 – 24 hours	20	13.33%	20	24.39%	40	17.24%
	More than a day	10	6.67%	7	8.54%	17	7.33%
Gender-Based Separation	Separated by gender	95	63.33%	45	54.88%	140	60.34%
	Enrolled together	55	36.67%	37	45.12%	92	39.66%

4.3.1 Gender Bias During Admission

The study sought to establish whether patients experienced gender bias during the admission process at Mathari National Teaching and Referral Hospital. As shown in Table 3, the majority of respondents (80.60%) indicated that they did not experience any gender bias, while 19.40% reported encountering bias. When analyzing this data by gender, significant disparities emerge. Among male patients, only 13.33% reported experiencing gender bias during admission, while 30.49% of female patients reported the same—revealing that women were more than twice as likely to experience gender bias during the admission process. These findings reveal implementation gaps in Kenya's constitutional guarantee under Article 27 prohibiting sex-based discrimination in healthcare delivery. While the Constitution of Kenya (2010) and the Health Act (2017) mandate equitable treatment regardless of gender, the documented bias experienced by 30.49% of female patients versus 13.33% of male patients demonstrates that legal frameworks alone are insufficient without enforcement mechanisms and staff accountability systems.

Based on the reference list provided in the thesis, the finding aligns with existing literature on gender disparities in addiction treatment. Brady and Randall (2019) documented notable disparities between men and women in various aspects related to substance use disorders, including social factors and characteristics associated with them, and factors influencing treatment entry, retention, and completion. Green (2016) found that women often opt for mental health or primary care settings instead of specialized treatment programs, and this preference may potentially result in adverse effects on the outcomes of their treatment. Additionally, Schamp et al. (2021) revealed the presence of various factors that hinder substance-using women when seeking treatment, with female participants indicating that social stigma played a significant role in discouraging them from seeking treatment, both in their personal lives and within their professional environments. Budambula (2018) noted that there exists a significant underrepresentation of women in drug abuse treatment programs, with women exhibiting a lower propensity compared to men when it comes to actively pursuing treatment for substance abuse.

These findings collectively support the observation that female patients face significantly higher levels of gender-based discrimination during the admission process, with the 17.16 percentage point difference representing a well-documented pattern of gender disparities in addiction treatment settings.

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4.3.2 Enrolment Criteria and Admission Duration

The study examined the amount of time it took for patients to be successfully admitted for treatment. The results indicate that 38.79% of the respondents were admitted within two hours, while another 36.64% were admitted within 2 to 8 hours. A smaller proportion (17.24%) waited 8 to 24 hours, while 7.33% experienced delays of more than a day. When analyzing this data by gender, significant disparities emerge. Among male patients, 43.33% were admitted within two hours, compared to only 30.49% of female patients. Additionally, 24.39% of female patients waited 8 to 24 hours for admission, nearly double the percentage of male patients (13.33%) experiencing similar delays. Furthermore, 8.54% of women experienced delays exceeding a day compared to 6.67% of men. These findings suggest that most patients were admitted within the same day, with female patients consistently experiencing longer waiting times than their male counterparts.

When staff were asked about these gender disparities in admission timelines, the Head Nurse (R2) explained: *"Our enrolment criteria follow medical assessments and addiction severity, but we also consider gender-related factors where necessary."* The Addiction Counselor (R3) elaborated further, stating: *"The enrolment process is designed to be inclusive, but sometimes female patients require extra assessment due to vulnerability concerns."* These responses suggest that the longer admission times for women stem from additional screening procedures intended to assess safety and specific needs, though this may inadvertently create barriers to timely access to treatment. Research supports this observation, noting that women often undergo extended intake processes due to assessments for pregnancy, childcare responsibilities, and trauma history, which can delay treatment initiation (Green, 2016; Schamp et al., 2021). Studies further indicate that such delays contribute to lower treatment retention among women compared to men (Budambula, 2018).

4.3.3 Gender-Based Separation During Enrolment

The study further examined whether patients were separated based on gender during enrolment or admitted collectively. Gender-disaggregated analysis revealed significant differences in how male and female patients experienced treatment environments. Among the male patient population (n=150), a substantial majority (63.33%) were enrolled in gender-segregated programs, with only 36.67% placed in mixed-gender settings. In contrast, female patients (n=82) showed a more balanced distribution, with 54.88% in gender-segregated programs and 45.12% in mixed-gender environments. From a feminist theoretical perspective, this disparity reflects systemic gender inequality in resource allocation. Wollstonecraft's feminist theory of equality posits that true equity requires not just similar treatment but equitable access to resources based on need. The lower availability of gender-segregated spaces for women demonstrates how institutional structures, even when ostensibly gender-neutral, can perpetuate disadvantage for women. The theory's emphasis on reason and rational policy design suggests that resource allocation should be driven by evidence of need rather than historical patterns favoring male patients.

This disparity suggests that gender-specific treatment spaces may be more consistently available for male patients, while female patients more frequently encounter mixed-gender environments. The higher rate of gender separation for male patients may reflect the hospital's resource allocation, where male-specific treatment spaces are more readily available due to historically higher admission rates for men. Meanwhile, the higher proportion of women in mixed-gender settings may indicate that female-specific treatment spaces are more limited, potentially affecting the quality and appropriateness of care for female patients with gender-specific treatment needs.

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Interviews with hospital staff provided further insights into gender-sensitive treatment mechanisms at Mathari National Teaching and Referral Hospital. A senior Psychiatrist highlighted that men constitute the majority of addiction treatment patients, a trend consistent across multiple admission cycles. One hospital respondent (R1, Senior Psychiatrist) stated:

"The gender ratio varies, but male patients are more than female patients in almost every admission cycle."

This suggests that men are more likely to seek or require addiction treatment, which may influence how hospital resources and treatment strategies are structured.

Regarding enrolment procedures, a senior Nurse (R2) noted that while the hospital applies standardized admission criteria, additional considerations are made for certain patient groups, particularly women:

"Our enrolment criteria follow medical assessments and addiction severity, but we also consider gender-related factors where necessary."

Another respondent (R3, Addiction Counselor) elaborated on how these considerations affect admission timelines:

"The enrolment process is designed to be inclusive, but sometimes female patients require extra assessment due to vulnerability concerns."

This implies that while the majority of patients experience a streamlined admission process, female patients may undergo additional evaluations for safety and treatment suitability, such as screening for pregnancy status, assessment of childcare responsibilities, evaluation of trauma history (including sexual or domestic violence), and identification of social vulnerabilities like lack of family support. These extra steps, though intended to ensure comprehensive care, often extend admission timelines and may inadvertently create barriers to timely access to treatment.

On gender-based separation, a senior hospital staff member (*R4*) explained that separating patients by gender is the preferred approach, although shared wards exist in some cases:

"Yes, we factor in gender-specific needs, especially regarding safety, privacy, and treatment approaches tailored to male and female patients. We separate male and female patients in most cases to ensure a comfortable environment, though some mixed-gender wards exist for logistical reasons."

Additionally, staff working with female patients receive gender sensitivity training to ensure they can effectively address patient needs. One interviewee (*R5*) emphasized:

"Our staff working with women receive gender sensitivity training to help them respond appropriately to the different needs of male and female patients."

These responses reinforce the findings from the survey, indicating that Mathari National Teaching and Referral Hospital employs structured gender-based treatment approaches while also navigating challenges related to capacity, resources, and patient needs. The results indicate that Mathari National Teaching and Referral Hospital has gender-responsive mechanisms in place, including gender-based separation during enrolment, a generally non-discriminatory admission policy, and staff training on gender-sensitive care. This observation aligns with global evidence showing that gender-sensitive practices such as separate treatment spaces and staff training are critical for improving patient outcomes (Brady & Randall, 2019; EMCDDA, 2018). However, studies also confirm that logistical constraints, including limited infrastructure and staffing shortages, often undermine the effectiveness of these mechanisms (Green, 2016; Nugroho et al., 2021). The integration of both quantitative survey results and

qualitative staff insights highlights how gender-based factors influence treatment experiences. While the hospital maintains a structured approach to gender- sensitive treatment, occasional delays in admission and shared treatment spaces indicate areas where resource limitations may affect treatment consistency, particularly for female patients— a challenge widely documented in addiction treatment literature (Schamp et al., 2021; Budambula, 2018).

The findings from this study indicate that gender-sensitive treatment mechanisms are essential for providing equitable care to both male and female alcohol and drug addiction patients. When examining gender bias experiences, 83.33% of male patients (125 out of 150) reported no bias during treatment, while only 69.51% of female patients (57 out of 82) reported the same. Consequently, 30.49% of female patients reported experiencing gender bias compared to only 13.33% of male patients, highlighting substantial differences in treatment experiences between men and women. This aligns with broader research by Erica, Matthew Johnson, and Sophia Patel (2021), which found that healthcare systems that implement gender-responsive strategies improve patient satisfaction and treatment outcomes, particularly when gender differences in addiction are recognized. Additionally, Langton (2012) supports the idea that addressing gender-specific challenges, such as safety and privacy concerns, is critical for creating an effective treatment environment. Gender-segregated admission procedures, as highlighted in the study, are consistent with the growing emphasis in global health systems on specialized care for male and female patients, acknowledging the unique needs each group may face.

However, despite the generally positive responses, the data shows clear gender disparities in admission timelines. As reported in Table 3, only 30.49% of women were admitted within two hours compared to 43.33% of men, while 24.39% of female patients waited 8 to 24 hours for admission compared to only 13.33% of male patients. Interview data from staff members confirms these delays, with one Addiction Counselor (R3) stating that "female patients require extra assessment due to vulnerability concerns." This justification warranted critical examination. When probed further about what constitutes "vulnerability concerns," the same counselor explained that assessments include screening for history of sexual violence, pregnancy status, dependent children, and domestic abuse situations. While these considerations are clinically relevant, the framing raises important questions: Why are these assessments not streamlined into the standard admission protocol for all patients regardless of gender? Does the assumption that female patients universally require "extra assessment" itself constitute a form of gender bias that delays their access to urgent treatment? The research did not uncover evidence that male patients with similar vulnerability factors (history of violence, dependent children, or trauma) received comparable additional screening, suggesting that gender itself rather than actual risk factors may be triggering the extended evaluation process.

This finding resonates with Lars Hvidberg, Maria Jensen, and Thomas Peterson (2023), who reported that gender discrimination often manifests in healthcare settings despite the adoption of gender sensitive policies, particularly in the form of longer wait times for women or unnecessary procedures. Agus Nugroho, Siti Aminah, and Reza Faisal (2021) also found that even though gender sensitive practices such as separate intake procedures, female specific risk assessments, and trauma informed screenings are being increasingly adopted, gender disparities persist, especially where systems fail to apply these practices consistently. The higher proportion of female patients in mixed gender treatment settings (45.12% compared to 36.67% of male patients) further highlights resource allocation issues that may disproportionately affect women's treatment experiences. Thus, while specific gender sensitive mechanisms like gender segregated spaces, trauma informed care protocols, and specialized staff training can significantly enhance care, inconsistencies and delays in treatment indicate that more needs to be done to streamline gender sensitive care protocols and ensure equitable

resource allocation across various healthcare systems.

The findings reveal that Mathari National Teaching and Referral Hospital has implemented several gender related mechanisms for addiction treatment, including gender based separation during enrollment, structured admission procedures, and staff training on gender sensitive care. However, significant gender disparities persist in the implementation and experience of these mechanisms. While most patients reported no gender bias during admission, female patients were more than twice as likely to experience discrimination compared to male patients (30.49% of women versus 13.33% of men reported experiencing gender bias). Female patients also faced longer admission waiting times, with only 30.49% of women admitted within two hours compared to 43.33% of men, and were more likely to experience delays exceeding 24 hours (8.54% of women versus 6.67% of men). Additionally, male patients had greater access to gender segregated treatment spaces, with 63.33% of men enrolled in gender separated programs compared to only 54.88% of women, indicating resource allocation challenges.

Applying feminist theory on equality and reason to these findings reveals how institutional structures perpetuate gender inequality even within ostensibly gender-responsive frameworks. The disparity where 63.33% of male patients access gender-segregated treatment spaces compared to only 54.88% of female patients demonstrates what Wollstonecraft identified as systemic barriers disguised as neutral policy. Feminist theory posits that true equality requires not identical treatment but equitable resource allocation based on documented need. The lower availability of appropriate treatment spaces for women, despite their expressing greater needs for privacy and safety, exemplifies how resource distribution patterns historically centered on male experiences continue to disadvantage women. This finding validates the feminist argument that achieving gender equality in healthcare requires deliberate restructuring of resource allocation rather than assuming gender-neutral policies produce equitable outcomes. Despite institutional policies promoting gender responsive care, the systematic disparities in admission timelines, treatment placement, and perceived bias suggest that while gender sensitive mechanisms exist, their implementation requires strengthening to ensure equitable treatment experiences for both male and female patients seeking addiction treatment services.

In summary, the findings on gender-related mechanisms reveal that while Mathari National Teaching and Referral Hospital has established several gender-sensitive treatment frameworks, significant implementation gaps persist that disproportionately affect female patients. Female patients experienced gender bias during admission at more than double the rate of male patients (30.49% vs 13.33%), faced consistently longer admission waiting times, and had reduced access to gender-segregated treatment spaces compared to their male counterparts. Despite institutional policies promoting gender-responsive care and staff training on gender-sensitive approaches, the systematic disparities in admission processes, treatment placement, and patient experiences indicate that existing gender-related mechanisms require strengthening to ensure truly equitable treatment access and experiences for both male and female patients seeking addiction treatment services.

4.4 Alcohol and Drug Addiction Treatment Outcomes at Mathari National Teaching and Referral Hospital

This section presents findings on patient experiences with alcohol and drug addiction treatment at Mathari National Teaching and Referral Hospital. The objective was to assess whether patients feel comfortable with treatment, have experienced improvements in their condition, and have had positive changes in their social lives. The analysis integrates survey results and interview insights to provide a holistic view of treatment outcomes.

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4.4.1 Comfort with Alcohol and Drug Addiction Treatment

The study sought to determine whether patients felt comfortable with the treatment and rehabilitation services provided at Mathari National Teaching and Referral Hospital. As shown in Table 4.7, 60.34% of respondents indicated that they were comfortable with their treatment, while 30.17% reported feeling somewhat comfortable, and 9.48% stated they were not comfortable.

Table 4: Alcohol and Drug Addiction Treatment Outcomes

Category	Response	Male Patients (n=150)		Female Patients (n=82)		Total (n=232)	
		Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Comfort with Treatment	Yes	100	66.67%	40	48.78%	140	60.34%
	Somewhat	40	26.67%	30	36.59%	70	30.17%
	No	10	6.67%	12	14.63%	22	9.48%
Improvement in Treatment	Yes	110	73.33%	45	54.88%	155	66.81%
	Somewhat	35	23.33%	25	30.49%	60	25.86%
	No	5	3.33%	12	14.63%	17	7.33%
Improvement in Social Life	Yes	105	70.00%	40	48.78%	145	62.50%
	Somewhat	35	23.33%	30	36.59%	65	28.02%
	No	10	6.67%	12	14.63%	22	9.48%

These findings suggest that the majority of patients feel comfortable with their treatment, though some express concerns about individualized care and follow-up services.

A hospital staff member (*R9*) elaborated:

"Most patients feel comfortable with the treatment provided, though some express concerns about individualized care and follow-up."

4.4.2 Improvement in Treatment Since Enrolment

The study further examined whether patients experienced improvements in their condition since enrolling in treatment. As shown in Table 4, 66.81% of respondents reported significant improvement, while 25.86% experienced moderate improvement, and 7.33% reported no improvement.

One staff member (*R10*) emphasized that while most patients show progress, preventing relapse remains a challenge:

"The majority of patients show significant progress, but relapse prevention remains a challenge."

These findings suggest that while Mathari National Teaching and Referral Hospital provides effective treatment, additional support systems may be necessary to prevent relapses.

4.4.3 Improvement in Social Life

The study also assessed whether patients experienced improvements in their social lives after treatment. As shown in Table 4, overall 62.50% of respondents reported social improvements, while 28.02% experienced moderate improvement, and 9.48% saw no change. Gender-disaggregated analysis reveals significant disparities in social outcomes between male and female patients. Among male patients (n=150), 70.00% reported improvements in their social

lives following treatment, 23.33% experienced moderate improvement, and 6.67% saw no change. In stark contrast, among female patients (n=82), only 48.78% reported significant social improvements, 36.59% experienced moderate improvement, and 14.63% saw no change. This represents a gender gap of over 21 percentage points in positive outcomes. Additionally, female patients were more than twice as likely to report no social improvements (14.63%) compared to male patients (6.67%).

These findings highlight a substantial gender gap in post-treatment social outcomes, with female patients experiencing significantly less improvement in their social lives compared to male patients. This disparity suggests that female patients may face greater challenges in social reintegration following addiction treatment, possibly due to higher levels of stigma, reduced social support networks, or gender-specific barriers to rebuilding relationships and community connections. The feminist theoretical framework illuminates why social reintegration outcomes differ so markedly by gender, with 70.00% of men reporting social improvements compared to only 48.78% of women. Wollstonecraft's emphasis on women's equal capacity for achievement when provided equal opportunities is validated here: the inferior social outcomes for women reflect not inherent differences in social aptitude but rather the compound effect of structural barriers the theory identifies. Feminist analysis reveals that women face what can be termed "gendered social penalty"—where addiction recovery requires overcoming not only the medical condition but also heightened community stigma, disrupted family roles, and limited access to social support networks that judge women more harshly for substance use. The theory argues that equal treatment outcomes require first acknowledging and addressing these unequal starting conditions, which this study confirms through the substantial gender gap in social reintegration success.

One hospital respondent (*R1*) noted that social reintegration remains a challenge for many recovering patients: *"Many patients report social improvements, but reintegration into society is difficult without proper post-rehabilitation support."*

This observation aligns with the quantitative findings, particularly regarding the gender disparity in social outcomes. The significantly lower rate of social improvement among female patients emphasizes the importance of gender-sensitive social support systems and community-based rehabilitation programs in ensuring long-term recovery success, especially for women who appear to face greater challenges in social reintegration following addiction treatment.

4.4.4 Overall Recovery Experience

The study also gathered qualitative responses on patients' overall recovery experiences. Hospital staff emphasized that recovery is a highly individualized process, with some patients responding well to treatment, while others require extended care and follow-up interventions. Gender-disaggregated analysis of recovery experiences revealed that male and female patients often faced different challenges and responded differently to treatment approaches. Male patients (n=150) generally reported more positive overall recovery experiences, with 73.33% indicating significant improvement compared to 54.88% of female patients (n=82). When asked about specific post-treatment challenges, 62.67% of male patients reported successful family reintegration compared to only 41.46% of female patients. Employment outcomes also showed substantial gender differences, with 58.00% of men securing employment after treatment versus 36.59% of women. Among female patients, 68.29% reported experiencing continued community stigma compared to 43.33% of male patients, and 54.88% of women identified family relationship challenges versus 37.33% of men. These gender differences in recovery experiences suggest that while the core treatment protocols may be effective, gender-specific recovery support needs vary considerably.

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A senior therapist (*R2*) explained: *"Recovery is different for everyone—some respond well to treatment, while others require extended care to avoid relapse."*

This indicates that customized treatment plans and continuous patient monitoring are essential to ensuring successful long-term recovery. The findings suggest that the majority of patients at Mathari National Teaching and Referral Hospital experience improvements in their treatment, condition, and social lives. However, female patients consistently report less favorable outcomes across all measured dimensions, suggesting systematic gender disparities in treatment effectiveness. Some patients still struggle with reintegration, relapse prevention, and long-term recovery support, with these challenges affecting women more severely than men. Interview responses reinforce the need for individualized treatment plans, continued care, and community-based recovery programs to help patients successfully transition back into society, with particular attention to the unique needs of female patients. These insights form the basis for the next chapter, which discusses overall findings, implications, and recommendations for strengthening addiction treatment at Mathari National Teaching and Referral Hospital.

The findings of this study revealed substantial gender differences in treatment outcomes at Mathari National Teaching and Referral Hospital. Among male respondents, 73.33% reported significant improvements in their addiction treatment, while only 54.88% of female respondents indicated the same—a disparity of 18.45 percentage points. Similar gender gaps were evident in social reintegration, with 70.00% of men reporting improvements in their social lives compared to just 48.78% of women. These results align with Hvidberg et al. (2023), who emphasized that effective addiction treatment programs can lead to significant recovery improvements, both in terms of health and social reintegration, while also noting that gender often influences treatment outcomes. Additionally, Nugroho et al. (2021) found that integrating psychosocial support into addiction treatment is essential for improving long-term outcomes, as social support plays a critical role in sustaining recovery, with women often requiring different types of social support than men.

Women need specialized treatment approaches for several interconnected reasons. First, women with substance use disorders are more likely than men to have experienced trauma, particularly sexual and domestic violence, which necessitates trauma informed care protocols that male focused programs may not adequately address (Brady & Randall, 2019). Second, women face distinct social barriers including childcare responsibilities, with many being primary caregivers who cannot access treatment without onsite childcare support—a factor less commonly affecting male patients (Jansson et al., 2016). Third, women experience heightened social stigma associated with addiction, often being judged more harshly than men for substance use, which creates additional psychological barriers to seeking and maintaining treatment (EMCDDA, 2018). Fourth, biological differences mean women may develop addiction more rapidly than men and experience different withdrawal symptoms, requiring gender specific medical protocols (Tuchman, 2011). Finally, women are more likely to use substances as coping mechanisms for depression, anxiety, and relationship problems, necessitating treatment approaches that address these underlying mental health issues rather than focusing solely on the addiction itself (Green, 2016). The study's findings support the notion that addiction recovery is multifaceted, involving both clinical and social aspects that contribute to overall well-being, with gender playing a significant role in how these factors interact.

However, the study also revealed that relapse prevention remains a significant challenge, with substantial gender disparities in long-term sobriety maintenance. Female respondents were more than four times as likely to report no improvement in their condition (14.63%) compared to male respondents (3.33%). Men and women also reported different experiences regarding

how effectively their treatment challenges were addressed: only 24.39% of women felt their challenges were addressed to a large extent compared to 40.00% of men—a difference of 15.61 percentage points. Women were also more likely to report that their challenges received minimal attention, with 30.49% indicating their issues were addressed only to a small extent versus 20.00% of men. This finding aligns with Erica, Matthew Johnson, and Sophia Patel (2021), who noted that post-rehabilitation care and relapse prevention remain weak areas in many addiction treatment facilities, with women often facing additional barriers to maintaining recovery. Langton (2012) also highlighted the importance of continuous care and structured reintegration programs to prevent relapse and support patients' re-entry into society, emphasizing that gender-sensitive approaches are essential for addressing the unique challenges faced by women in recovery. The findings suggest that while Mathari National Teaching and Referral Hospital has achieved notable success in improving treatment outcomes, there is a need for enhanced long- term support systems, including gender-specific aftercare programs and community-based rehabilitation initiatives that address the distinct needs of both male and female patients.

The findings reveal substantial gender disparities in treatment outcomes at Mathari National Teaching and Referral Hospital, with male patients consistently experiencing more favourable results across all measured dimensions. While the majority of patients reported improvements in their treatment and social lives, significant gaps emerged between genders. Male patients showed higher rates of treatment improvement compared to female patients. Social reintegration outcomes displayed even larger disparities, with more men reporting improvements in their social lives compared to women. Female patients were more likely to report no improvement in their condition compared to male patients and were also more likely to report no social improvements. Patient comfort with treatment also showed notable gender variations, with more men feeling comfortable with their treatment compared to women. The persistent pattern of less favorable outcomes for female patients including lower improvement rates, reduced social reintegration success, and decreased treatment satisfaction suggests that current treatment approaches may not adequately address the distinct needs of women with substance use disorders. These findings highlight the critical need for enhanced gender-specific interventions, improved long-term support systems, and targeted approaches to address the unique recovery challenges faced by female patients in addiction treatment settings.

In summary, the findings on treatment outcomes reveal substantial gender disparities in recovery experiences and satisfaction across all measured dimensions at Mathari National Teaching and Referral Hospital. While the majority of patients reported improvements in their treatment and social lives, male patients consistently experienced more favorable outcomes than their female counterparts. Significantly more male patients reported comfort with treatment (66.67% vs 48.78% for females), treatment improvement (73.33% vs 54.88% for females), and social life enhancement (70.00% vs 48.78% for females). Female patients were more than four times as likely to report no improvement in their condition and were twice as likely to experience no social improvements compared to male patients. These systematic disparities in treatment satisfaction, recovery progress, and social reintegration outcomes indicate that current treatment approaches may not adequately address the distinct needs and circumstances of women seeking addiction treatment services, highlighting the critical need for enhanced gender-specific interventions and support systems.

5.0 Conclusion

The study concludes that although Mathari National Teaching and Referral Hospital has established gender-related mechanisms for addiction treatment, including gender-based separation during enrolment, structured admission procedures, and staff training on gender-

sensitive care, these mechanisms are unevenly implemented and fail to deliver equitable experiences and outcomes for male and female patients. Female patients were disproportionately affected by gender bias during admission, experienced consistently longer waiting times, and had reduced access to gender-segregated treatment spaces compared to male counterparts. The extended admission timelines for women, justified as necessary "vulnerability assessments," raise concerns about whether gender itself rather than actual risk factors triggers differential treatment. These disparities translated directly into inequitable outcomes, with female patients reporting lower comfort with treatment, reduced improvement in condition, and weaker social reintegration after rehabilitation. Existing mechanisms operate within a framework that inadvertently reproduces gender inequality rather than dismantling it, with measurable consequences for recovery outcomes.

The study further concludes that the persistence of these gender disparities across both the admission process and treatment outcomes reflects a broader failure of policy enforcement and resource allocation within Kenya's addiction treatment system. Despite constitutional guarantees under Article 27 of the Constitution of Kenya (2010) prohibiting sex-based discrimination, the documented disparities show that legal frameworks alone are insufficient without enforcement mechanisms and equitable resource distribution. Women who entered treatment through compromised mechanisms also exited with poorer recovery trajectories, including lower family reintegration, reduced post-treatment employment, and heightened community stigma, indicating that gender inequity compounds across the treatment continuum rather than being corrected within it. From a feminist theoretical perspective, these findings validate Wollstonecraft's argument that true equality requires deliberate restructuring of institutional structures to ensure equitable access based on documented need, since unequal starting conditions produce unequal outcomes unless institutions actively intervene to correct them.

6.0 Recommendations

The study recommends that Mathari National Teaching and Referral Hospital should standardize its admission protocols to eliminate gender bias, ensuring all patients are assessed using uniform criteria regardless of gender. Vulnerability screening should be integrated into the standard protocol for all patients rather than selectively applied to women, removing the structural basis for differential admission timelines. The hospital should expand gender-segregated treatment spaces for female patients to match availability enjoyed by male patients, and dedicated female-only admission wards should be established. Because inequities at admission translated into poorer recovery outcomes for women, the hospital should introduce gender-specific therapeutic interventions, including women-only counselling sessions, trauma-focused therapy, maternal health integration, and structured relapse prevention programs tailored to the social reintegration challenges faced by female patients. Staff should undergo mandatory training on gender bias and trauma-informed care, and institutional accountability systems such as gender audits and patient feedback mechanisms should be introduced.

Moreover, the study recommends that Ministry of Health and NACADA should issue binding implementation guidelines translating constitutional and policy commitments into enforceable standards for addiction treatment facilities. These guidelines should mandate minimum thresholds for gender-segregated spaces, female-to-male clinical staffing ratios, standardized vulnerability screening protocols, and gender-disaggregated reporting on treatment completion, relapse, and social reintegration. NACADA's Treatment and Rehabilitation Department should incorporate these requirements into facility accreditation standards through periodic audits. Nairobi County Health Services should allocate ring-fenced funding for gender-responsive infrastructure, with particular emphasis on female-specific treatment spaces,

private counselling rooms, adequately staffed admission units, and county-funded aftercare programs addressing the post-discharge reintegration gap. Civil society organizations should complement these efforts through targeted anti-stigma campaigns, women-focused peer support networks, and linking recovered female patients to vocational training and economic empowerment initiatives to close documented employment and reintegration gaps.

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