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The Impact of Stigma on Access to Addiction Treatment Services in Iringa Municipality: A Case Study of Iringa Sober House

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ABSTRACT: Stigma is widely recognized as a barrier to accessing addiction treatment, yet how internal and external forms of stigma jointly constrain treatment access within community-based rehabilitation settings in Tanzania remains underexplored. This study examined the impact of stigma on access to addiction treatment services in Iringa Municipality, using Iringa Sober House as a case study, guided by two objectives: to examine the impact of internal stigma on treatment access, and to examine the impact of external stigma on treatment access. A qualitative case study design was adopted, drawing on semi-structured interviews, documentary review and focus group discussions with thirty purposively selected participants, comprising fifteen residents, five family members, eight healthcare providers and support staff, and two community leaders. Data were analyzed thematically. Findings showed that internal stigma operated through shame, guilt and self-blame that inhibited disclosure, delayed help-seeking and reduced motivation to sustain treatment. External stigma operated through social rejection, fear of public labelling, institutional barriers within the health system, and continued stigmatization that disrupted recovery and reintegration after discharge. The study concludes that stigma functions as a multi-dimensional barrier constraining access to addiction treatment at every stage, from initial recognition of need to sustained recovery, and that interventions addressing only internal or only external stigma are unlikely to be sufficient without coordinated action across family, community, healthcare and policy domains.

INTRODUCTION

Substance use disorders are an escalating global public health concern, with far-reaching effects on health systems, social stability and economic productivity. In 2021, approximately 296 million people worldwide used drugs, of whom about 39.5 million were living with drug use disorders requiring structured treatment, yet fewer than 20% received formal treatment, with even lower access in low- and middle-income countries (UNODC, 2023). This persistent gap indicates that the problem is not solely about the availability of services but also about underlying barriers that influence whether individuals actually engage with care.

Among these barriers, stigma remains one of the most persistent and complex, operating through labelling, stereotyping, discrimination and status loss that frame individuals with substance use disorders as morally weak or socially undesirable (Link & Phelan, 2001). Such perceptions extend beyond individual attitudes to shape institutional responses, policy priorities and the design of treatment systems themselves, yet the practical influence of stigma on how individuals navigate access to structured rehabilitation within specific local contexts remains insufficiently examined. This study distinguishes between internal stigma, the internalization of negative societal beliefs by the affected individual, and external stigma, the discriminatory attitudes and behaviors directed at

that individual by others, a distinction widely used in the stigma literature to separate psychological mechanisms of self-devaluation from social and structural mechanisms of exclusion (Link & Phelan, 2001).

Substance use disorders across Tanzania are increasingly recognized as a public health issue, particularly among adolescents and young adults, with national reports from the Drug Control and Enforcement Authority (DCEA, 2019) indicating rising engagement with treatment services; yet these figures likely capture only a fraction of those in need, pointing to hidden barriers such as fear of social labelling, family rejection and potential legal consequences. Within Iringa Region, socioeconomic vulnerability and youth unemployment create conditions that may facilitate substance use, and community-based rehabilitation centers such as Iringa Sober House emerged to address this need. However, enrolment in such facilities does not necessarily reflect the true level of need in the community, suggesting that factors beyond service provision, particularly social perceptions and stigma, shape access in ways that are not yet well understood.

Existing research on stigma and treatment access originates predominantly from high-income settings and, within Tanzania, has examined stigma broadly across rural and urban contexts without linking it to specific rehabilitation facilities or community-based settings. This study therefore examined the impact of stigma on access to addiction treatment services in Iringa Municipality, using Iringa Sober House as a case study, guided by two specific objectives: to examine the impact of internal stigma on access to addiction treatment services, and to examine the impact of external stigma on access to addiction treatment services.

THEORETICAL FRAMEWORK

The study was guided by three complementary theoretical perspectives. Goffman's (1963) Social Stigma Theory explains stigma as a socially constructed process through which individuals are discredited based on attributes perceived to deviate from accepted norms, producing a 'spoiled identity' that distances the stigmatized person from the moral community; this concept is directly relevant to internal stigma, since it is the individual's own absorption of a spoiled identity that produces shame and self-blame. Becker's (1963) Labeling Theory explains how individuals become deviant through social reaction rather than through behaviour alone, with imposed labels evolving into master statuses that overshadow other aspects of identity, offering insight into how external labelling by family, community and institutions becomes internalized over time. Link and Phelan's (2001) Conceptualization of Stigma extends these accounts by framing stigma as a dynamic process involving labelling, stereotyping, separation, status loss and discrimination occurring within contexts of unequal power, capturing how internal and external stigma interact and reinforce one another. Link and Phelan's framework served as the primary theoretical lens for this study because it integrates the identity- and interaction-level insights of Goffman and Becker while explicitly accounting for how internal experience and external discrimination sustain each other, making it the most comprehensive framework for examining how internal and external stigma jointly constrain access to addiction treatment

MATERIALS AND METHODS

Research Approach

This study adopted a qualitative research approach to explore participants' lived experiences and perceptions of stigma related to treatment-seeking and service utilization. The approach was appropriate because it enabled an in-depth understanding of participants' meanings, attitudes and contextual factors influencing behaviour, and supported the collection of rich descriptive data on how stigma affects access to care, interpersonal interactions and decision-making within the sober house environment (Creswell & Poth, 2018).

Research Design

A case study design was employed, focusing on Iringa Sober House, to enable an in-depth, holistic understanding of stigma within a real-life setting. This design was suited to examining complex social processes and generating detailed data from multiple perspectives, including clients, staff and community stakeholders, and facilitated investigation of a bounded system from multiple data sources (Creswell & Poth, 2018).

Area of the Study

The study was conducted in Iringa Municipality, a rapidly growing urban area in Tanzania's Southern Highlands with relatively higher levels of alcohol consumption than national averages and a community characterized by strong stigma surrounding addiction. The municipality has available mental health and rehabilitation services, including Iringa Sober House, a community-based residential facility that provided a suitable, bounded environment for examining how internal and external stigma shape treatment-seeking and treatment utilization among its clients.

POPULATION AND SAMPLE SIZE

The target population comprised residents, family members, healthcare providers, support staff and community leaders associated with Iringa Sober House, selected to capture diverse perspectives on stigma, treatment experiences and service utilization within the bounded system of the facility and its surrounding community. Purposive sampling was used to select participants most relevant to the research objectives.

The study included thirty participants: fifteen residents of Iringa Sober House, five family members, eight healthcare providers and support staff, and two community leaders. This distribution represented 50% residents, 16.7% family members, 26.7% healthcare providers and support staff, and 6.7% community leaders, and was sufficient to reach data saturation while keeping the data manageable for transcription, coding and thematic analysis. The resident sample was entirely male, reflecting the demographic composition of clients enrolled at Iringa Sober House during the study period.

DATA COLLECTION

Both primary and secondary data were used. Primary data were collected through semi-structured interviews, documentary review and focus group discussions with eight participants, conducted at Iringa Sober House and surrounding areas. Documentary review included policy documents, rehabilitation center reports and statistical records. Secondary data were drawn from scholarly literature, institutional reports and policy documents to contextualize the findings. Two brief illustrative accounts were also gathered during community-based fieldwork from non-resident individuals with active, untreated substance use disorders, each of whom gave verbal informed consent before their account was recorded; as these fell outside the formal sampling protocol, they are presented separately as supplementary contextual evidence rather than core data (see Ethical Consideration for full detail on consent procedures for this sub-group).

DATA ANALYSIS

Thematic analysis was used to identify recurring patterns related to stigma, as this approach is well suited to extracting patterns of meaning from qualitative data rather than quantifying the frequency of themes, aligning with the study's case study design. Data were transcribed, coded and categorized into themes and synthesized into a coherent narrative, with triangulation across participant groups and data sources employed to enhance credibility (Creswell & Poth, 2018).

TRUSTWORTHINESS OF THE STUDY

Trustworthiness was established through credibility, dependability, confirmability and transferability. Credibility was enhanced through prolonged engagement with participants during interviews and focus group discussions, member checking of preliminary interpretations with selected participants, and data triangulation across participant groups and data sources to ensure convergence of perspectives. Dependability was supported through a detailed audit trail documenting sampling procedures, data collection methods, interview guides, coding decisions and analytical processes, alongside systematically maintained field notes and a reflexive journal. Confirmability was supported through reflexive journaling to acknowledge and bracket the researcher's assumptions, the use of verbatim quotations to demonstrate clear linkage between data and interpretation, and peer debriefing with supervisors. Transferability was supported through rich, thick description of the research setting, including the socio-cultural context of Iringa Municipality, participant characteristics and the nature of addiction treatment services provided at Iringa Sober House.

ETHICAL CONSIDERATION

This study received formal research clearance from the University of Iringa's Office of the Vice Chancellor (Ref. No. UoI/R.2/1/VOL.III/168, issued 26th March 2026), granted under the government circular empowering university Vice Chancellors to issue research clearance to staff and students on behalf of the Tanzania Commission for Science and Technology (COSTECH) (Ref. No. MPEC/R/10/1, 4th July 1980). This clearance authorized data collection at Iringa Sober House between April and August 2026. The Foundation for Alleviation of Drugs Addiction and Sufferings (FADAS), under which Iringa Sober House operates, formally reviewed and accepted this clearance and granted institutional permission for the study (Ref. No. FADAS/ISH/R.1/VOL.I/024, 2nd April 2026), subject to its own confidentiality and ethical safeguarding requirements for clients undergoing treatment. As a qualitative social-science study involving no clinical intervention, biological sampling or experimental manipulation, ethical oversight was exercised through this university- and facility-level clearance process, which functions as the standard ethics-approval pathway for postgraduate social-science and counselling-psychology research within the Tanzanian university system, rather than through a separate biomedical institutional review board (IRB).

For the thirty formally sampled participants, written informed consent was obtained prior to each interview or focus group discussion, using a consent letter that explained the study's purpose, procedures, voluntary nature, right to withdraw at any time without consequence, and the intended academic use of the data, including its dissemination through the author's dissertation and any subsequent peer-reviewed publication drawn from it. Participants were informed that anonymized, non-identifying excerpts of their responses could appear in these outputs, and consent to this academic and publication use was obtained as part of the same consent process; no participant declined participation on this basis. Confidentiality was maintained through coding of participants' identities, secure storage of audio recordings and transcripts, restricted access limited to the researcher and academic supervisors, and the use of pseudonyms and generic role descriptors (for example, "Resident" or "Rehabilitation support officer") in place of names or other identifying information throughout data handling and reporting.

The two non-resident individuals whose accounts appear as supplementary contextual evidence were approached opportunistically during community-based fieldwork in areas surrounding Iringa Sober House, an activity covered by the same research clearance.

Each was given a verbal explanation of the study's purpose and voluntary nature, informed that no identifying information would be recorded and that participation was unrelated to any treatment decision, and gave verbal consent before sharing their account. Consistent with the confidentiality procedures applied to the core sample, only a generic descriptor ("Non-resident") and a general locality are reported, and no names, addresses or other identifying details were collected. Because these encounters fell outside the formal sampling protocol, the accounts were treated throughout as illustrative, non-generalizable supplementary evidence rather than core data, and are explicitly identified as such wherever they appear in the Results.

Potential psychological, emotional, social and legal risks were minimized by ensuring a safe and respectful research environment, given the sensitivity of discussing stigma, substance use, self-harm and family relationships; participants were free to decline any question or end the interview at any time, and the researcher was prepared to refer any participant showing evident distress to Iringa Sober House's on-site counselling staff, although no such referral was required during data collection. Accounts describing sensitive institutional practices, including client admission procedures and self-harm incidents, reflect the perceptions and reported experiences of individual staff participants rather than independently verified clinical or administrative records, and are presented and interpreted accordingly. All information collected was used strictly for academic purposes.

RESULTS

Findings are presented below according to the two study objectives: the impact of internal stigma on treatment access, and the impact of external stigma on treatment access.

Impact of Internal Stigma on Treatment Access

Findings revealed three primary mechanisms through which internal stigma, the internalization of negative societal beliefs about substance use, impeded access to treatment: shame and self-blame as barriers to disclosure, delayed help-seeking, and reduced motivation to sustain treatment.

Nearly all resident participants described profound and persistent shame and guilt attributed to personal weakness or moral failing, independent of any stigma encountered externally. One resident explained:

> I was ashamed of myself. I kept thinking that I am educated, I come from a good family, how did I end up like this? I blamed myself every day. I did not think I deserved help. I thought I should just manage alone.
> (Resident, Iringa Sober House)

Counsellors confirmed that addressing this self-blame was often a necessary precursor to any other therapeutic work, with almost every new client arriving carrying substantial self-blame regardless of education or family background.

Participants reported delays of between six months and over five years between recognizing their substance use problem and seeking formal treatment, with internal stigma identified as a primary contributing factor. One resident described this delay:

> I knew I had a problem when I was 21. I only came here when I was 26. Those five years were terrible. I kept telling myself I could stop on my own. Part of it was shame. I did not want to be seen as someone who needed rehabilitation.
> (Resident, Iringa Sober House)

A family member similarly described years of unsuccessful encouragement before a relative agreed to seek treatment, attributing the delay more to fear of admitting the problem than to the addiction itself. A rehabilitation support officer described a compounding effect between the cognitive impairment associated with active substance use and the psychological weight of stigma:

> Addiction already affects a person's ability to make sound decisions. When you add stigma on top of that, the combination becomes very dangerous. People who are already struggling to think clearly about their situation are also being told, directly or indirectly, that they are worthless. Many respond by hiding their use even more.
> (Rehabilitation support officer, Iringa Sober House)

Internal stigma also affected participants' commitment to completing treatment, with feelings of hopelessness periodically resurfacing during recovery even amid measurable clinical progress. One resident described:

> There were times in treatment when I thought, what is the point? People already see me as a failure. Even if I recover, will I ever be accepted again? Those thoughts made me want to leave. I stayed because of the counselors here who kept telling me I had value.
> (Resident, Iringa Sober House)

Counsellors described actively working to rebuild clients' self-worth as a core, ongoing component of the therapeutic process, describing internal stigma as much a clinical challenge as detoxification itself. Both residents who described nearly leaving treatment linked their crisis specifically to comparing themselves with peers and fearing social judgment, one explaining simply that he felt foolish for being here trying to fix myself, a pattern counsellors noted tended to resurface predictably around the second month of residence, once initial motivation had settled and comparison with life outside the facility became more psychologically salient.

IMPACT OF EXTERNAL STIGMA ON TREATMENT ACCESS

Findings revealed four major mechanisms through which external stigma, discriminatory attitudes and behaviours directed at individuals with substance use disorders, affected access to treatment: social rejection and exclusion, fear of public labelling, institutional barriers within health systems, and stigma disrupting recovery and reintegration.

Participants described how anticipated or experienced social rejection, including withdrawal of friendships and breakdown of business relationships, discouraged disclosure and delayed treatment-seeking. One resident explained:

> If you go to Sober House, the whole neighborhood knows within a week. Then you lose everything. Your friends stop coming. The man you were doing business with stops calling. Your family looks at you differently. I waited until things were very bad before I came.
> (Resident, Iringa Sober House)

Family members similarly described facing pressure from relatives to manage the problem privately rather than seek professional help, in one case delaying a loved one's entry into treatment by nearly a year. A rehabilitation support officer confirmed the weight of this anticipated social cost:

> For many families, the fear of what people will say is sometimes stronger than the fear of the addiction itself. They would rather manage it quietly at home, even if it means the person does not get proper help, than risk the family's reputation being damaged.
> (Rehabilitation support officer, Iringa Sober House)

The fear of being publicly labelled as an addict, extending beyond the individual to family standing and employability, was described by nearly all resident participants as a significant barrier. One resident stated:

> In Iringa, your name is everything. Once people hear you were at Sober House, that label follows you. Employers will not hire you. People will not let their children near you. You are finished in this community. That fear kept me away from help for a long time.
> (Resident, Iringa Sober House)

A rehabilitation support officer, interviewed at Iringa Sober House on 10th April 2026, reported that some clients are brought to the facility without their consent because they refuse to attend once informed, and described specific instances in which clients later attempted to leave, refused to eat, or engaged in self-harm in an effort to be discharged. This account, drawn from one staff member's report of specific remembered incidents rather than from facility incident or medical records, is presented to illustrate the perceived severity of label-related distress rather than to establish the frequency or clinical details of such events. A community leader separately linked the underlying fear of labelling to a broader local equivalence between treatment-seeking and criminality; this view was expressed by one participant and is reported here as an illustration of a locally circulating belief rather than a documented, community-wide norm:

> The problem is that in this community, going to a rehabilitation center is seen the same as going to prison. People think it means you are a criminal or completely lost. Until that perception changes, people will continue to hide rather than seek help.
> (Community leader, Iringa Municipality)

Participants described an absence of referral pathways and routine substance use screening within general healthcare services, leaving clients and families without a clear route into treatment. One family member explained:

> I went to three different health offices asking where I could take my son for his drinking problem. Nobody could tell me clearly. One nurse just told me to take him to church. It was only by chance that a neighbor mentioned Iringa Sober House to me.
> (Family member, Iringa Sober House)

A nurse attributed this gap to insufficient training on substance use disorders within mainstream health service delivery, noting that until addiction is understood at the system level as a health condition rather than a character flaw, stigma within health facilities will continue to block access to care. A rehabilitation support officer described the policy-level roots of this gap:

> Many of the policies we work under do not help us. There are no clear guidelines for integrating addiction treatment with general healthcare, so patients are pushed from one office to another. There is no proper system to protect their confidentiality, and most of us have never received formal training on how to treat patients with substance use disorders without judgment.
> (Rehabilitation support officer, Iringa Sober House)

These accounts of referral gaps, confidentiality weaknesses and training deficits reflect providers' own perceptions and were not corroborated against Ministry of Health documentation or facility administrative records; they are nonetheless broadly consistent with institutional stigma patterns reported elsewhere in the Tanzanian literature (Nyamhanga & Frumence, 2017).

External stigma was found to persist beyond treatment completion, undermining participants' recovery and reintegration and increasing vulnerability to relapse. One resident described:

> I completed treatment here. I went home feeling strong. But within a month, my old friends were avoiding me, my neighbor was warning people about me and my family was watching me like I was about to break. That pressure made me want to use again just to escape.
> (Resident, Iringa Sober House)

A counsellor linked this continued community exclusion directly to relapse risk, observing that isolation is almost always part of the story when clients return after relapse, since recovery depends on social support that stigma actively erodes. The same counsellor described how stigma-driven mistrust also degraded the therapeutic relationship itself, even among clients still formally in care:

> When clients feel judged, they stop trusting us. They begin hiding important information about their condition, they cooperate less with the treatment plan and some become defensive or even hostile as a way of protecting themselves. Eventually many simply stop coming back. We lose the continuity of care that recovery depends on.
> (Counsellor, Iringa Sober House)

DISCUSSION

The internal stigma findings, characterized by shame, self-blame and years-long delays in help-seeking, are consistent with Corrigan et al.'s (2014) finding that self-stigma is associated with reduced treatment motivation, and with Luoma et al.'s (2007) documentation that individuals entering substance use treatment frequently postpone care due to feelings of personal failure. The internalization described by residents in this study, particularly the tendency to measure themselves against an idealized standard of responsible adulthood, illustrates Becker's (1963) account of secondary deviance, whereby an imposed label is absorbed into self-identity and subsequently shapes behaviour and disclosure decisions.

The external stigma findings align with Livingston et al.'s (2012) observation that perceived discrimination is associated with premature treatment discontinuation, and with Myers et al.'s (2018) South African findings that community-level stigma delays treatment until severe complications emerge. The fear of public labelling documented in this study corresponds to Ahmed et al.'s (2017) East African findings that individuals actively avoided rehabilitation centers located near their communities due to fear of gossip and exclusion, while the institutional gaps in referral pathways identified within general health services correspond to van Boekel et al.'s (2013) systematic review finding that healthcare providers frequently hold negative stereotypes toward people with substance use disorders, reducing patient trust and undermining routine identification of treatment need. The persistence of stigma into the post-treatment period, disrupting reintegration and elevating relapse risk, extends this literature by showing that external stigma does not recede once treatment begins but continues to threaten recovery well beyond discharge, a pattern with direct implications for aftercare programming.

A notable feature of this study, given its entirely male resident sample, was the gendered framing of internal stigma around provider ship and household headship, a pattern that intensified shame in ways not fully captured by Boyd's (2015) research on women with substance use disorders, suggesting that masculine identity norms constitute a distinct, locally significant dimension of internal stigma requiring further attention. Considered together, Goffman's (1963) concept of spoiled identity, Becker's (1963) labelling theory and Link and Phelan's (2001) structural framework offer complementary explanations for how internal and external stigma sustain one another: external discrimination and labelling, documented under the second objective, are progressively internalized as shame and self-blame, documented under the first objective, which in turn reduces individuals' willingness to seek treatment and thereby exposes them to further external discrimination, forming a cyclical relationship rather than two independent processes.

An alternative explanation for the years-long delays documented under internal stigma might attribute them to a straightforward lack of awareness of available services, an informational rather than psychological barrier. The data do not support this as the primary explanation: participants who delayed treatment for years consistently described knowing that help existed but being unwilling to seek it because of anticipated shame, placing the barrier squarely in anticipated judgement rather than a lack of information. Similarly, the social and economic losses that residents attributed to disclosure under external stigma were tied specifically to the moment their treatment-seeking became locally known, rather than to any earlier disruption caused by the substance use itself, indicating that stigma constituted a distinct and additional cost rather than merely a continuation of addiction's practical consequences.

These findings address a gap in the existing literature, which has largely examined stigma broadly across rural and urban Tanzanian settings without linking it to specific community-based rehabilitation facilities, and has drawn primarily on evidence from high-income countries that may not fully align with Tanzanian communities characterized by strong family reputation norms and communal oversight (Nyamhanga & Frumence, 2017; Mushi et al., 2020). By examining how internal and external stigma jointly operate within a single, bounded treatment setting, this study provides context-specific evidence of how these two dimensions of stigma appeared to influence access across the stages of the treatment pathway observed within this single case, from initial recognition of need through to post-discharge reintegration, extending prior work that has typically examined internal and external stigma in isolation from one another.

Taken together, these findings carry direct implications for how addiction treatment services are designed and delivered. If internal stigma resurfaces at predictable points across the treatment trajectory, as this study's finding of heightened vulnerability around the

second month of residence suggests, anti-stigma counselling cannot be treated as a task completed at intake; it instead requires sustained, session-by-session attention throughout the treatment pathway. Similarly, if external stigma re-emerges specifically during the reintegration period, aftercare and follow-up support, rather than in-facility treatment alone, represent the intervention point at which relapse-prevention efforts targeting stigma are likely to be most consequential.

The prolonged delay periods documented under internal stigma can also be understood through the Health Belief Model, a widely used framework in health behaviour research that identifies perceived barriers as a key determinant of whether individuals seek care for a given health condition. Within this framework, anticipated stigma functioned as one of the most significant perceived barriers to treatment-seeking identified by participants, in some cases outweighing their own perception of the severity of their condition, as illustrated by the resident who recognized his problem at age 21 but did not seek treatment until age 26. This suggests that stigma-reduction messaging in this setting may be most effective when designed specifically to reduce perceived social barriers to care, rather than focused solely on raising awareness of the health consequences of untreated substance use, since awareness of severity was, for many participants, already present well before treatment-seeking began.

These findings should be interpreted in light of the study's single-facility, qualitative design and its entirely male resident sample, which limit statistical generalization and the ability to capture gendered dimensions of stigma experienced by women. The most sensitive claims reported, concerning involuntary admission, self-harm, healthcare-system deficiencies and specific community practices, rest on individual participants' first-hand accounts rather than on independently verified clinical, administrative or community-level records, and should accordingly be read as evidence of how stigma was experienced and perceived by this study's participants rather than as documented facility statistics or generalized community norms. Nonetheless, the case study approach yielded rich, contextually grounded insight into how internal and external stigma operate and interact within this setting.

CONCLUSION

Within the bounded case of Iringa Sober House, this study found that stigma constitutes a pervasive and multi-dimensional barrier to accessing addiction treatment services. Regarding internal stigma, the study found that shame, guilt and self-blame produced protracted delays in help-seeking, discouraged disclosure and reduced motivation to sustain treatment once begun, a pattern intensified among the male participants of this study by gendered expectations of providership. Regarding external stigma, the study found that social rejection, fear of public labelling, institutional barriers within the health system and continued community exclusion after discharge combined to constrain access across the stages of the treatment pathway observed in this case, including the post-treatment period, where continued stigma was associated with heightened vulnerability to relapse. These two sets of findings were closely interconnected: external discrimination and labelling were progressively internalized as shame and self-blame, which in turn reduced individuals' willingness to disclose their condition or sustain treatment, exposing them to further external discrimination, indicating that interventions addressing only one dimension of stigma are unlikely to be sufficient on their own. The study further concludes that, while Iringa Sober House functions as a vital community-based resource for individuals with substance use disorders, its capacity to support sustained recovery is substantially constrained by the stigmatizing social environment surrounding it; the facility cannot resolve, through clinical intervention alone, a set of barriers that are produced and sustained at the level of family, community and institutional life.

Healthcare providers and counsellors should treat internal stigma as a continuous clinical priority throughout treatment, rather than a concern limited to initial assessment, incorporating structured shame-reduction interventions at multiple points across the treatment trajectory, including around the second month of residence when this study found renewed vulnerability to be most likely. Rehabilitation facilities should establish structured family engagement and post-treatment reintegration programs, including peer support and follow-up monitoring, given that the post-treatment period represents a critical window of vulnerability to relapse. Given the institutional gaps identified within the general health system, including the absence of clear referral pathways, limited routine screening and inadequate provider training on substance use disorders, health sector planners should prioritize integrating basic screening and referral protocols into routine primary care services, alongside in-service training for health workers on non-judgmental, evidence-based approaches to addiction. Community and religious leaders should be engaged in public education and dialogue initiatives that reframe addiction as a treatable health condition rather than a moral failing, and local media should be supported to adopt responsible, non-criminalizing reporting practices. Policymakers should consider developing a coordinated stigma-reduction strategy that integrates health, legal and educational responses to substance use, and formally recognize community-based facilities such as Iringa Sober House within the public health system. Future research should include women undergoing residential treatment, given the entirely male sample of this study, and should further investigate the experiences of non-resident individuals with untreated substance use disorders.

AUTHOR NOTE

This article is derived from the author's MSc dissertation, "The Impact of Stigma on Access to Addiction Treatment Services in Iringa Municipality: A Case Study of Iringa Sober House," submitted to the University of Iringa (2026) in partial fulfilment of the requirements for the degree of Master of Science in Counselling Psychology. The manuscript has been substantially condensed and

reworked from the original thesis text for journal publication and narrowed to two objectives (internal and external stigma); it has not been previously published or submitted elsewhere in its current form. The author declares no conflict of interest.

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