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Title: Exploring the Lived Experience of Alcohol Use Disorder Patients in Accessing Hospitalized Treatment Care in Rwanda

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Author contribution declaration:

AS, PIA conceptualized the study. AS, PIA, UJB, RW contributed to the proposal development. All authors contributed to the data collection, data analysis, and manuscript development, as well as approved the final manuscript

Abstract

Background:

Alcohol Use Disorder (AUD) is a major mental health challenge in Rwanda, yet little is known about how individuals with AUD navigate the healthcare

system. This study explored the lived experience of AUD patients when seeking and accessing inpatient treatment within the Rwandan context.

Methods:

Semi structured qualitative interviews were conducted with inpatients diagnosed with AUD across three neuropsychiatric facilities in Rwanda. Thematic analysis was conducted to identify recurring patterns and themes related to care-seeking experiences.

Results:

From 27 in-depth interviews, five main themes emerged. 1) Limited awareness and misinformation about AUD and its treatment contributed to delays in care initiation; 2) Initial help-seeking favored traditional healers over mental health professionals; 3) Structural barriers hindered timely access to mental health services; 4) Treatment led to meaningful recovery and high satisfaction with mental health services; 5) Psychosocial economic support played a key role in accessing care.

Conclusions:

Limited awareness of AUD and lack of reliable information about where to seek care, delayed access to treatment. Many participants did not know the location of treatment facilities or type of services available. Cultural preferences for traditional healers further delayed seeking mental health services, often until the crisis occurred. Family, community, and government support helped to facilitate access to treatment. Health

insurance reduced the financial burden for many; however, gaps remain especially for non-medical in-hospital costs such as living expenses that were not covered by the insurance system. Targeted mental health education, stronger family and community engagement, and expanded outpatient services to support earlier intervention are needed. System priorities should include infrastructural development, workforce expansion, and more accessible financing to improve affordability and access to care for individuals with AUD.

Keywords: Alcohol use disorder, mental health, care, access, community

BACKGROUND

Alcohol Use Disorder (AUD) is a “problematic pattern of alcohol use leading to clinically significant impairment or distress, manifested by at least two criteria occurring within a 12-month period; including feeling a strong urge to use alcohol, failure to cut down alcohol use, consuming more alcohol than intended, failure to fulfill other life obligations, spending a lot of time to obtain, and using or recovering from alcohol ” (DSM 5). Globally, over 400 million (7%) people were affected (1,2). In Sub-Saharan Africa, about 2.4% of all deaths and 2.1% of disability-adjusted life years (DALYs) were related to AUD (3). In Rwanda, the estimated AUD prevalence was 7%, toward the upper end of regional estimates (4, 5). As national alcohol consumption rose from 41% in 2013 to 48% in 2022, the AUD burden is likely to grow if these

trends continue (6). This rise likely reflects a combination of social, economic, biological, and cultural factors.

Alcohol use disorder (AUD) arises from a mix of social and biological risk factors, with genetics accounting for about 50% of the risk to develop AUD (7) (8). Co-occurring mental health conditions such as mood disorder, schizophrenia, and personality disorders further elevate the risk and complicate care (9-11). AUD disrupts work, family life, and financial wellbeing. It also increases the risk of chronic diseases and injuries. AUD contributes markedly to the global burden of disease by 5.1%, including 2,6 millions of deaths and a large share of DALYs worldwide by 8.9% (12–15). However, treatment interventions are effective.

Effective treatment often combines pharmacological and psychosocial interventions yet cost limits service availability. Uneven distribution of services among urban and rural settings, and gaps in primary care skills restrict access in low-resource settings (13 – 18). In sub-Saharan Africa, additional barriers include financial constraints, low awareness of the disorders and services, perceived poor quality of care, negative perceptions toward care, and sociocultural and physical obstacles to use (14–17). In Rwanda, studies have shown only 5.3% have accessed mental health services and only 6.1% of individuals with AUD sought professional help (18).

AUD screening is conducted during routine primary care visits at health centers, which represent the lower tier of Rwanda’s healthcare system. At this level, patients can access general outpatient mental health services, including psychotherapy.

According to a senior clinician (P. Ingabire, personal communication, 13 November 2025), individuals with severe AUD are referred through the healthcare system to district hospitals and, when necessary, to specialized psychiatric facilities. There, they receive AUD-specific outpatient care that includes pharmacotherapy, such as disulfiram and naltrexone, alongside psychotherapeutic approaches including cognitive behavioral therapy and motivational interviewing. These psychiatric facilities also offer inpatient services through structured rehabilitation programs for individuals requiring more intensive support.

Understanding their care-seeking experience can help design interventions to enhance access and utilization, yet little is known about such experiences. Accordingly, this study was conducted to examine barriers and facilitators to inpatient treatment access among AUD patients with severe condition.

METHODS

Clinical trial number: not applicable.

Design and Setting:

A qualitative study using in-depth interviews was conducted with participants from Ndera NeuroPsychiatric Teaching Hospital (NNPTH), and it’s two branches Icyizere psychotheurapetic cente and Careas Butare. Two facilities are located in Kigali and one in the southern part of Rwanda. Ndera Neuropsychiatric Teaching Hospital (NNPTH), founded in 1968, serves as Rwanda’s national referral center for severe mental illness (19). CARAES Butare offers both inpatient and outpatient treatment for all mental health

illnesses, including substance use disorders. Icyizere psychotherapeutic center is a specialized facility focused on the treatment of substance use disorders, including AUD (20,21).

Sample and sampling:

Participants were enrolled using purposive sampling with convenient recruitment. Eligible participants who were 18 years or older and receiving inpatient care for AUD were included in the study. Individuals who could not participate in a coherent conversation at the time of consent or during data collection were excluded.

Data collection tools and data collection

The data was collected by the PI, a male medical doctor with training in qualittative methods and prior experience in conducting qualitative studies and two research assistants, who were trained on the research study tool and how to conduct study interviews. The researchers had no prior relationship with the participants. The participants were informed that the study was an independent activity from their clinical course at the facility, and the study solely aimed to improve AUD care accessibility.

Data was collected using a semi-structured in-depth interview guide that included 9 main open-ended questions with probe. The questions were related to participants' experience when seeking AUD treatment, including perceived barriers, facilitators, support received, and their perceptions on AUD treatment in Rwanda.

The questions in the data collection tool were developed based on the available literature on access to mental healthcare services in Rwanda. The study tool was reviewed by two senior researchers in qualitative studies for content validation and pretested on 5 people who had positive AUD screening tests. Modifications were made based on feedback from the pre-tests before the actual data collection. The interview guide was developed in English and translated into Kinyarwanda – the local language.

The participants' recruitment took place between March and May 2025, at the study sites. IRB approvals were received from UGHE and the study sites, as well as authorization from the directors of the health care institutes. The research team approached the potential participants who fulfilled the selection criteria. A detailed explanation of the study was provided before written consents were obtained; one copy was kept by the participants, and another by the research team. Consent to audio record the interview was also sought. All interviews were conducted in Kinyarwanda, as preferred by the participants, in a private space to ensure participants’ privacy. All participation was voluntary, and no financial compensation was provided. Each interview lasted approximately 30 minutes.

Data analysis

All audio recordings were transcribed verbatim and translated into English. A preliminary codebook was created after open reading the transcripts. After finalizing the codebook, all the transcripts were coded inductively in dedoose

software (v.10.0.34). If new important information was identified but it did not have a correlating code, a new code was added to represent that data. Related codes were grouped into categories, from which themes emerged. Representative excerpts were included in the results to support the findings.

RESULTS

Participant characteristics

A total of 27 participants were recruited in this study. All participants were inpatients receiving treatment for AUD, and 23 (85%) had complications related to alcohol-induced psychosis. Among all the participants, 17 (63%) were male, and 10 (37%) were females; 23 (85%) were below the age of 35, and 4 (15%) were 35 years old or above; 18 (67%) were from Kigali, and 9 (33%) were from other provinces. Additionally, 18 (67%) participants reported coming from low-income households and 9 (33%) reported having a stable financial background (table 1).

Table 1. Summary of sociodemographic

Characteristic		n (%)
Sample		27
Psychotic complications related to AUD	Inpatients AUD without psychosis	4 (15%)
	Inpatients AUD with related psychosis	23 (85%)
Sex	Male	17 (63%)
	Female	10 (37%)
Age	Under 35 years	23 (85%)
	35 years and above	4 (15%)
Residence	From Kigali	18 (67%)
	From other provinces	9 (33%)
Household income	Low-income households	18 (67%)
	Stable financial background	9 (33%)

Five main themes emerged from the interview results that described the challenges and facilitators experienced by AUD patients during their treatment journey.

Themes:

1. Limited awareness and misinformation about AUD and its treatment contributed to delays in care initiation.
2. Initial help-seeking favored traditional healers over mental health professionals.
3. Structural barriers hindered timely access to mental health services.
4. Treatment led to meaningful recovery and high satisfaction with mental health services.
5. Psychosocial economic support played a key role in accessing care.

Theme 1: Limited awareness and misinformation about AUD and its treatment contributed to delays in care initiation

The participants had limited information about AUD and its treatment prior to getting into care. This influenced their perception of the condition which led to negligence seeking treatment. Many believed it did not require medical attention. The lack of information about the disease and its treatment was a major barrier to accessing timely care. However, crisis moments prompted the family, society or local authorities to make extra effort to get the participants into care.

Subtheme 1: Limited disease insight delayed seeking care

Prior to entering care, most participants had limited insight into the nature and severity of their AUD. They often didn't see their drinking as problematic and rarely associated their physical or psychological symptoms to alcohol misuse. Many downplayed their experiences or attributed symptoms to stress or fatigue, rather than recognizing them as signs of AUD. This limited self-awareness contributed to delays in seeking care.

> *"No, I didn't seek treatment because I didn't realize I was sick. I believed that what I was experiencing was normal and that my behavior was justified. "[017, Female, age: <35]*

> *"I didn't really recognize or accept that I needed help…the truth is, when you're struggling like that, you don't actually feel sick; you just think you need to rest or be left alone. Sometimes, you even resist the idea of getting help. Looking back, if I had realized how serious it was, I would have asked for support, and my caregiver would have helped me get it." [013, Male, age: <35]*

> *"I felt like I didn't need help because I thought alcohol wouldn't cause me problems. I used to say, "I'll continue like this [drinking alcohol], I don't need treatment." [006, Female, age: <35]*

Subtheme 2. Crises catalyzed the seeking of care

Participants often sought medical help only after reaching a crisis point—when the consequences of prolonged alcohol use had become

unmanageable or life-threatening. These crises became the turning points for them, and were typically marked by acute psychological distress, behavioral dysregulation, or social interventions from concerned family members. In many cases, the accumulation of alcohol-related complications, such as hallucinations, depression, aggression, or alcohol withdrawal seizures, forced recognition that professional help was necessary.

“I started acting abnormally, as I told you [before]. Depression hit me hard; I began breaking things, like my phone. Also, I spent a lot of time on social media, where things could be either good or bad. I was often stuck on the negative side, focusing only on negative things. Then, because I knew about alcohol, I would drink to relieve stress, so I kept going like that until the problem worsened. That’s what made me come here for treatment.” [006, Female, age: <35]

“Before I first sought treatment, I was experiencing things I couldn’t understand; I would see strange images and hear voices without knowing where they were coming from. People started saying I had lost my mind and that I had a serious problem. At the time, I was heavily using alcohol and smoking a lot of tobacco.” [018, Female, age: <35]

“One day, my mom and I were in a car together. I told her, “Please, if you have 1500 Rwf, help me buy the alcohol, I sincerely need it [for medical reasons].” She dismissed me. I begged and even knelt in front of her. I was starting to feel paralysis in my legs, they brought me alcohol, immediately, the seizure stopped.” [020, Male, age: <35]

Subtheme 3: Lack of information on AUD treatment availability delayed care

The initial AUD treatment visit was often delayed due to a lack of information about available AUD treatment. Participants were generally not aware of where to seek medical help for AUD, which hindered their access to care. In many cases, it was their family members – driven by concern over the negative effect of AUD – who took the initiative to seek out information and support.

> *"I didn't know where to go for medical care, and I had no one to guide or assist me in that process" [007, Male, age: <35]*

> *"It was actually my family who decided to bring me for treatment. They probably already had information that this place offers help for people struggling with excessive alcohol use. " [017, Female, age: <35]*

> *"The person who gives me information about where to get treatment is someone working in America. Here in Rwanda, as you can imagine, it's a big problem that there isn't enough information. Also, many people don't even know that mental health can be treated on Mutuelle [community-based insurance]. I used to think Mutuelle wouldn't help me, and that only big insurance like RAMA or Radiant would handle serious issues. But I was surprised to find out it does work.*

> *Also, people don't know the process to follow. May be only a few know about mental health because they or their family's experienced trauma*

from the genocide. Maybe we also have such problems, but people don't know about it, or the procedures involved. "[001, Male, age: <35]

Participants who were aware of the treatment centers typically had either previously received care there or lived nearby. This prior exposure gave them an informational advantage, making it easier for them to know where to begin and access care.

"I already knew this place; it's in my neighborhood, after all." [008, Male, age: <35]

"Yes, I knew where I was going because I had been sick here before and I knew the place." [016, Female, age: <35]

Subtheme 4: Misinformation on AUD treatment services at the center

Participants often held inaccurate information about the services offered at the treatment facilities. Many assumed that mental health treatment centers were only for people with severe and socially unmanageable mental health disorders. Consequently, they were reluctant to seek care, believing their condition was not serious enough to seek treatment at such facilities.

"It was my family who informed me about the place where I could get treatment. They told me, "We are going to take you to a mental health facility in Ndera." At first, when I heard "Ndera," I thought it was a place only for people who were completely insane. But when I arrived, I realized that it's not just for people with severe mental illness; there were also people who seemed perfectly normal." [019, Male, age: >35]

> *"Because for us [people with drinking problem], in our minds, we believe that those who go to Ndera [hospital] are people from the streets, those we see picking up plastic bags all day." [001, Male, age: <35]*

Generally, all the participants had low awareness about AUD prior to treatment. Poor information on the disease led to poor insight hence delaying the decision to seek medical attention. However, in case of emergency, the participants were able to get medical support. Getting into care served as an opportunity to correct the misinformation and advance participants knowledge on AUD, which would help them to make informed decisions in the future.

Theme 2: Initial help-seeking favored traditional healers over mental health professionals

Prior to entering mental health care, 10 out of 27 participants had consulted traditional healers at least once during their effort to address alcohol use problems. They, however, reported that their visits to the traditional healers were not helpful. Many described the interaction as deceptive with utilization of mind tricks. Treatment involved performance of rituals, herbal medicines, and others. The participants did not know the content of the products they consumed, and they believe it might even be harmful to their health. Many had expressed little or no intention to seek help from traditional healers again.

"Yes, I once visited a traditional healer. But to be honest, I found that most of them were just exploiters who don't really offer any meaningful help; they often mislead people. My parents used to believe in traditional practices, but over time, after seeing they weren't effective, they advised me to move on and put my trust in God instead." [023, Male, age: <35]

"Yes, I have consulted traditional healers, but I found their practices quite complex and not straightforward. Their methods involve a lot of intricate rituals and processes that you gradually come to realize. When they perform something for you, they do it in a way that might make you feel drawn in or fascinated.…they take all sorts of questionable things and present them to you in a deceptive way." [014, Male, age: <35]

"Yes, she (my mom) took me there (to a traditional healer), but once I arrived, they gave me some traditional herbal medicine that caused severe irritation in my mouth and nose. They had me inhale and ingest local herbs, and it made me feel worse. I didn't want to continue with that kind of treatment, so I rejected it and left, with the help of local authorities. The village leadership supported me in getting out of there." [012, Male, age: <35]

Some participants mentioned that the traditional healers believed AUD was a curse, especially since there were often other family members with a history

of chronic alcohol use, whose lives were negatively impacted by drinking. They attribute such family history for alcohol abuse as a generational curse rather than genetic and social factors, and traditional medicine could promise help to lift the curse.

> *"Sometimes you feel like it's witchcraft or a family curse, as people often say. And actually, in my mother's family, there's a tendency to drink a lot of alcohol, so sometimes it really feels like a generational curse. The main issue was not knowing where to go for proper treatment in the beginning. I only found out that I could be treated here when that therapist (a family member) in America explained it to me." [001, Male, age: <35*

> *"Trusting traditional healers doesn't help. Last time I had a crisis during the weekend because my elder sibling said I wasn't mentally ill but bewitched. I stopped medication and immediately relapsed." [024, Female, age: <35]*

Theme 3: Structural barriers hindered timely access to mental health services.

Participants reported that most nearby health facilities did not offer mental health services, and the district hospitals offered limited support. While some were advised to continue their treatment at their local district hospital, they felt these facilities lacked the treatment options and quality of care they had

experienced at specialized centers. Consequently, they were hesitant to seek follow-up care outside the specialized center.

> *“Yes, there is a hospital nearby……They do provide some medications, but there are no counseling sessions available, which is what I’m really looking for in a place like this, where I can return regularly and also receive counseling from a specialist in addiction treatment. That’s actually why I want to keep coming back here.” [013, Male, age: <35]*

> *” The closest Hospital doesn’t have {name of treatment} services, and that’s what helps me. …If you didn’t find the service at the district hospital, do you think you can find it at the health center?” [005, Female, age: <35]*

Specialized treatment facilities were often far from participants' villages, making it difficult for them to access care. They noted that this distance caused delays in seeking treatment and expressed the wish for these services to be available closer to their vicinity.

> *“One main challenge is that sometimes I have a crisis and I want to contact a doctor, but they’re unavailable or too far. I feel disappointed.” [026, Male, age: <35]*

> *“The place where I get treatment is here in Kigali, but my home is in Rwamagana (Eastern province), which is about 3600 frw for a bus ticket. “ [005, Female, age: <35]*

“It’s a challenge when I come for medicine. It would be better if the medicine was made available at a nearby hospital.” [024, Female, age: <35]

Some of the participants tried to seek help early, but the health facilities were full at their maximum capacity mainly for inpatient care, which delayed their access to care. They were put on waiting lists until space is available. This presented an obstacle and discouragement to care.

“After that (consultation visit), they explained that since we were coming from Kicukiro Centre, which is quite far from Ndera, they would try to arrange for us to receive support closer to home. They told us that there’s a branch of the center in Kicukiro and that they would help us connect with that one. I ended up spending three months at home just waiting for that process to move forward.” [019, Male, age: >35]

“You see, here or elsewhere, you can’t just say, "I want to get inpatient treatment right now," or "I want to go in the hospital immediately," and get it instantly. You have to wait, because there are many people in need waiting.” [021, Male, age: <35]

Theme 4: Treatment led to meaningful recovery, high satisfaction with mental health services and improvement in knowledge, attitude and practice on AUD care

The participants highlighted that their conditions have significantly improved upon treatment. They were highly satisfied with the services they received

from the treatment facilities and highlighted their knowledge, attitude and practice on AUD have improved. They were committed to adhering to treatment and encouraging their struggling friends to seek treatment. However, side effects of the medications remained a stumbling block for some.

Subtheme 1: AUD improvement and High satisfaction with treatment

The participants in care were satisfied with the services they received at the facilities, with their conditions dramatically improved. They were certain that they could come back to seek help when necessary. They strongly believed that the treatment worked, and they could recommend others with similar problems to seek help at the mental health facility. They reported that the conversations they had with their psychotherapists helped them regain control over their lives. As a result, they were committed to continuing their treatments and following their provider's advice after discharge to maintain their progress.

> *“I would say that the treatment was very good. The medication they gave me really helped, especially considering the condition I was in when I arrived. I moved from Room D {Crisis ward} to Room C {Recovery ward}, which means I was very ill while in Room D, but now I feel much better. I will eventually be discharged because my health improved significantly.” [018, Female, age: <35]*

“If it (my condition) ever gets worse, I’ll return to the place where I received support and tell them, ‘My condition hasn’t improved, please help me again.” [07, Male, age: <35]

“Yes, I would strongly advise anyone dealing with a similar issue to seek medical help. But it’s important that the support goes beyond just giving medication. They should first be listened to and guided through proper counseling, because for someone struggling with drug addiction, conversations and emotional support often make the biggest difference.” [013, Male, age: <35]

“Here at the facility, there’s absolutely nothing stopping me from following the doctor’s instructions. In fact, after reflecting on everything I’ve been through, I’ve realized that my past choices didn’t help me at all. That’s why I’m fully committed now to taking a new path, leaving behind alcohol and cigarettes, and following the guidance given to me for a better and healthier life.” [019, Male, age: >35]

Subtheme 2: Knowledge, Attitude and Practice on AUD improved during care

Care provided an opportunity to improve the knowledge on AUD which changed the participant’s attitude and practice around the condition. During care, the participants learnt about the signs and symptoms of AUD, the effective preventative and treatment measures to handling the condition. Therefore, they were able to recognize and accept that they needed help.

This influenced adherence to the treatment plan and the willingness to stay in follow-up care after discharge.

> *“Yes, it was the doctor who first told me that I was unwell. They advised me to stop what I was doing and start following the prescribed treatment. That’s when I began to accept that I was indeed sick and needed help.” [013, Male, age: <35]*

> *“The first person who brought it up {that I needed professional help} was my father, and honestly, I believe he was right. When you truly want to get better, you don’t resist help; you accept it. I told myself, “If I really am unwell, I have to admit it,” because refusing to accept that something is wrong can be a sign that you're actually not okay.” [019, Male, age: >35]*

> *“I made the decision because I used to drink a lot, way beyond limits. I was constantly drinking and also using drugs. But eventually, I realized it had become too much, especially for a young woman like me. That’s when I decided it was time to seek help and get treatment.” [017, Female, age: <35]*

> *“Here at the facility, there’s absolutely nothing stopping me from following the doctor’s instructions. In fact, after reflecting on everything I’ve been through, I’ve realized that my past choices didn’t help me at all. That’s why I’m fully committed now to taking a new*

path, leaving behind alcohol and cigarettes, and following the guidance given to me for a better and healthier life." [019, Male, age: >35]

"Yes, I will keep going there and ask for support to see if I can improve myself and find a way to live a better life." [015, Male, age: <35]

Subtheme 3: Concern for safety in mixed space for all mental health disorders

However, other participants highlighted major concerns, especially at Ndera NPTH and Butare Careas, where they felt that their experience in the crisis ward was traumatizing. They reported having met severely ill people who posed a threat to their safety, even though no incidence of harassment was reported. They described the physical and social environment in the crisis ward as "a harsh environment".

"The biggest challenge I faced was the first room we were placed in. The setup of the space made me uncomfortable; I had to stay in Room D (crisis ward) before getting to Room C (recovery ward). I had been drinking and was intoxicated at the time, but I'm not someone who gets violent. Still, I was placed with people who were severely ill, rather than those who just needed support like me. I wish I had been grouped with individuals going through a similar situation. Also, in that first room (Room D), there was no available clinician to talk to me or offer emotional support, which made things even harder." [010, Female, age: >35]

“The hardest thing was getting used to the place I came to. The first time I arrived, everything seemed new to me {in the crisis ward} —I couldn’t believe it, because there were people with different illnesses, and I realized that not all illnesses are at the same level. I saw people who were sicker than me, and it scared me a lot, but over time, I got used to it.” [006, Female, age: <35]

“What was hard is that before they admitted me here, I was first in ward D “crisis ward.” I was really scared when I smelled the place, I wondered how I would get out of there.” [004, Female, age: <35]

Subtheme 4: Medications side effects hindering adherence

Additionally, some participants highlighted that they were heavily burdened by side effects of the medications including sleepiness, weakness, drooling and decreased libido, this discouraged them from adhering to the treatment. Others mentioned that whenever they experienced such side effects, the team was very quick to respond to adjust their medications and treat the side effects.

“Right now, I don’t think they’ve helped me. Honestly, I have no morale or energy. I even have a problem with leaving and going home. I feel isolated, unwell, with no morale or strength.” [015, Male, age: <35]

“When I experience side effects from the medication, like losing interest in sexual activity, it discourages me. I lose the motivation to

continue taking the medicine, and that makes it hard for me to keep my appointments or come back for treatment." [012, Male, age: <35]

"The medication was causing me side effects like my tongue getting heavy and I couldn't speak properly. So, when I arrived here, I immediately reported it to the doctor, telling him what was happening. Then he gave me another pill, and everything went away." [004, Female, age: <35]

Overall, treatment was beneficial for all participants. However, there remained concerns about safety during hospital stay sharing space critically ill mental health patients. Even though the medical side effects were a concern, many highlighted that the treating team timely adjusted the medications and the side effects resolved shortly.

Theme 5: Psychosocial economic support played a key role in accessing care.

The respondents highlighted that access to care was made possible by the support from their families, friends, society and the government. This support ranged from information, advice, finances, insurance system and even taking them to the health facilities in moments of crisis. However, the respondents remained victims of stigma in the community. Due to chronic care, the caretakers were prone to experiencing compassion fatigue especially since their {caretakers'} mental health was not looked after professionally.

Subtheme 1: The role of family and socioeconomic support in AUD treatment

Participants were brought in care and supported by either their families, friends or the government institutions like local authorities. Without this support, the respondents highlighted that it would be impossible for them to get medical help.

> *“Eventually, my family told me, “We really need to get you treatment.” I agreed. I figured they might be right, maybe I was dealing with something I couldn’t see myself. After all, mental illness isn’t always visible, and sometimes you only realize it when others point it out.” [019, Male, age: >35]*

> *“My family played a big role in helping me get treatment. They were the ones who took me to the hospital and supported me throughout the process. They even helped raise the money needed to pay for the hospital bills. That’s how they stood by me and supported my recovery.” [018, Female, age: <35]*

> *“Honestly, if the police hadn’t intervened and brought me in, I don’t think I would have been able to get treatment on my own. It just wouldn’t have been possible.” [008, Male, age: <35]*

> *“What helped me is that I live in “Compassion” [NGO}. It’s “Compassion” that helped me get treatment.” [005, Female, age: <35]*

The family helped in finding information on where treatment was provided, convincing the participants that they needed help, taking the participants to

the treatment facilities and providing all the financial assistance needed to cover the cost of care.

> *"My family brought me here and helped me a lot. Coming here was an improvement because when I look at how I was before and how I am now, it's not the same — I have made great progress." [006, Female, age: <35]*

> *"My family is financially able to support my treatment. It won't be difficult at all; they've got it all covered." [022, Male, age: <35]*

> *"They (my family) helped me; particularly by covering my transport expenses and supporting the basic needs of my children who had remained at home." [012, Male, age: <35]*

The society was generally helpful in encouraging the participants to seek medical help, especially the friends who noticed the participants' condition unravel. For some participants, friends were the first respondents to get them into care.

> *"Eventually, they came and took me out (of the home), especially when they noticed I wasn't attending our usual morning group (cooperative) meetings. The other members of our cooperative noticed I was absent, so they came, picked me up, and brought me here to CARAES. That's how I ended up here." [008, Male, age: <35]*

> *"Yes, the school played a big role. My teacher noticed my behavior wasn't right and, since he knew me well, he took it seriously. He was*

the one who contacted my family. Since my dad is a soldier and not always around, the teacher reached out to my aunt, who he also knew. He explained how I was acting, and that's what helped me to get treatment right after the second school trimester." [027, Male, age: <35]

"The society I lived in, including friends, has played a supportive role. Some friends visit me, and we have conversations." [022, Male, age: <35]

Once in care, the family took charge of the hospital financial obligations for the participants. Many [participants] had no reliable source of income; and those who had it were financially vulnerable as a direct or indirect cause of AUD. However, only a few were still financially independent. The participants who had good financial support managed to access care timely with no financial constraints.

"M*y family is financially able to support my treatment. It won't be difficult at all; they've got it covered. I probably won't even know how the bills are paid, because for us, the cost of treatment won't be a problem." [022, Male, age: <35]*

"Yes, my financial situation did help. At the time, I had a good income, although I also had many responsibilities that required spending money; this sometimes led me to drink heavily. However, when it came to getting medical care, having financial means really made a

difference. It helped me access health insurance, which was especially useful when I was giving birth to my children and needed medical support. So yes, my financial capacity was very helpful in that regard." [018, Female, age: <35]

"I don't lack any fincancial means because my family has money, so there's no problem affording treatment." [024, Female, age: <35]

"Yes, it did. I had my own money and was also covered by Mutuelle de Santé, which made it easier for me to get the care I needed." [010, Female, age: >35]

However, participants from poor economic backgrounds faced financial challenges to access timely care. These financial delays led to AUD associated complications. These participants were more likely to be brought into care by authority forces due to disrupting societal normal functioning because of their worsened condition.

"Eventually, the local authorities organized support for people with mental health issues, and I was identified and included among them. That's how I ended up getting treatment,,,I would say it was the local authorities [who got me into care}. It's really the leadership that made it possible for me to come here and get the help I needed....." [007, Male, age: >35]

A few participants also highlighted that not having their own money and depending on their families' finances delayed care as it took a lot of time to

convince their families to pay for the care. They believed that if this would not have been the case, they would be in care before the worsening of their condition.

> "*Another challenge is that treatment is expensive, and getting admitted to a hospital is difficult due to the waiting lists for patients needing admission. I'm not generalizing, this was my experience. Because I lacked financial ability and family support, I couldn't convince my parents when I needed help, the trust was already lost" [020, Male, age: <35]*

However, the stigma towards mental health in the community served as a big challenge for the participants as they navigate their daily lives. The inappropriate labels attached to the participants made them feel discriminated against. Additionally, some members of society don't believe in mental health or its treatment, hence discouraging treatment seeking.

> *"The main challenge I faced was being labeled as mentally ill. Whenever people called me crazy, it sparked curiosity in me. I would wonder, 'What if someone gave me the means to go to a place where they treat mental illness; would they really find that I'm mentally ill?' I was genuinely curious to know the truth, but I didn't have the financial means to seek professional help." [007, Male, age: >35]*

> *"Some of the challenges I faced included being unfairly labeled with a negative name in my community, which was undermining. Additionally,*

I lost the trust of my own family, which made the journey even harder." [017, Female, age: <35]

"Society couldn't accept that I might have a mental illness. They'd say I was pretending...., if you say you're going to Ndera, some will just say you've lost it for good." [026, Male, age: <35]

Subtheme 2: Chronic care for AUD was a challenge to sustainable family support

AUD treatment required chronic care which was a challenge to caretakers. The families were at high risk of experiencing compassion fatigue especially when the participant had recurrent relapses. This created conflicts between the participants and their families, which could lead to family and friend support withdrawal. Additionally, there was no extra support for the caretakers' mental wellbeing to maintain stability. Participants with no strong family support experienced more hardship during their recovery.

"I once had a problem when I left school. I went to the authorities, I went there seeking help to return to school, but I got nowhere. I went to the city of Kigali to see the mayor. When I reached the mayor, he told me, "Go back and bring your parents so we can discuss and see what's missing to get you back in school." I called my father, but he didn't care. I called my mother, but she didn't care either. At that time, I was suffering from an illness, an illness of not attending school. My future and my career were about to end. It was painful, very painful. I

felt like I was all alone. I looked around and saw myself isolated. I saw other children who had finished school, who were my age, and I felt an overwhelming sadness that killed me inside. Sometimes, I felt like throwing myself in front of moving cars." [014, Male, age: <35]

"You see, my family had already warned me in the past to stop using marijuana. I ignored that advice and started using it again. Even now, because I went back to using it, they've told me they won't support me anymore. They won't provide basic help, they won't come to visit, and they definitely won't be the ones to take me home after treatment. That's what I've been told, because they believe marijuana is the root cause of my illness." [013, Male, age: <35]

"Still, often when you leave, your family talks to you, they call you, discuss things like finding you a job or going back to school, maybe a short course like graphic design. They try to support you. But it doesn't always work out immediately. It's been three months now since I have not drank. They even said they could help me find work or school, but I haven't heard from them since." [021, Male, age: <35]

"What's difficult is that I'm alone. There's no one in my family to advise me or care about my health, that's what makes it hard for me." [015, Male, age: <35]

Subtheme 3: Medical insurance decreased treatment financial burden

All the participants highlighted how having medical insurance, Mutuelle de sante being the most used among the majority, has significantly alleviated the financial burden of care. This smoothed their journey of seeking care and improved their treatment experience.

> *“Personally, I didn’t face any financial challenges when it came to accessing treatment. I have Mutuelle de Santé (community-based health insurance), and I was also referred through the military system, which covers my medical expenses. Here, they don’t ask me to pay for anything.” [019, Male, age: >35]*

> *“No, I don’t face major challenges when receiving treatment through Mutuelle de Santé. Everything is handled at the health facility, and there aren’t any serious issues. It's generally smooth, especially considering that the insurance covers most of the costs.” [014, Male, age: <35]*

However, the care was still expensive and inaccessible to the low economic category individuals. The highest burden came from the deposit fee prior to admission, and the auxiliary cost of living for in-patient care which is not covered by the insurance.

> *“Healthcare here is very expensive, it's not something easily accessible. Just to be admitted for treatment, you need 25,000*

Frw. Thinking about it, many people don't even have 5,000 Frw....., and yet they are suffering from mental health issues.

Finding that kind of money is a major challenge. It would help if the cost was reduced so that people like me could access basic care more easily. Sometimes, someone might genuinely want to help you, but they simply can't afford the 25,000 Frw it takes just to get started." [013, Male, age: <35]

"The most difficult part of my recovery journey was related to finances. I came home unexpectedly, and my family wasn't financially prepared. They struggled to cover the costs of my medication and hospital care. I understand, it caught them by surprise. But because they love me, they still made sacrifices, and I truly thank them for that wherever they have done ." [014, Male, age: <35]

"I use Mutuelle and it works, but still I had to pay about 800,000 Rwandan francs. You understand, it's quite expensive. Not everyone can afford it these days." [004, Female, age: <35]

Overall, good socioeconomic support from families and friends facilitated the participants to access care timely. However, those who did not have adequate socioeconomic support in their quest for treatment struggled to get into care leading to AUD complications like Alcohol induced psychosis. In most cases, the local authorities took in charge the neglected AUD patients

with complications due to the negative impact they are having on the general society. Additionally, having medical insurance like CBI reduced the financial burden faced by patients, hence easing access to treatment.

DISCUSSION

Alcohol consumption is rising in Rwanda presenting a substantial threat to public health (22,23). While the government has launched a strong campaign to tackle this issue (24), there is still a significant gap in the treatment of people with AUD.

A major barrier to timely care for AUD was limited and inaccurate information about both the disorder and its treatment options. Many participants were unaware of where to find services or what treatment entails. Low awareness of AUD itself delayed them from seeking care, until a crisis occurred. Initial help-seeking often focused on traditional healers because of beliefs in spiritual causes.

Most participants reported that traditional medicine was not effective in addressing their AUD and described unsatisfactory treatment outcomes. Some shared that they felt misled after being given unknown herbal preparations, which made them physically unwell and raised concerns about their health and safety. Evidence on the effectiveness and safety of traditional approaches for AUD remains limited in Rwanda and across the region (14, 16-18). Future research should rigorously assess the efficacy, safety, and potential role of traditional treatments in AUD care, including

how they might be integrated with formal health services where appropriate. After disengaging from traditional medicine, they resorted to seeking formal healthcare, where they gained better awareness of their condition and the support available. Upon entering care, many realized the impact of AUD on their lives, and became more committed to adhering to treatment. Previous studies similarly have shown that patients with better insight were more likely to follow the treatment plan compared to those with limited understanding of their own conditions (25–29). These findings highlighted the value of health education in supporting informed decisions and improving treatment outcomes. However, ongoing gaps in the mental health system, such as limited resources and structural barriers, continue to hinder the effectiveness of care.

Limited infrastructure, especially in inpatient care, impeded timely access. Hospitals often operate at maximum capacity, and far below demand; leading to long waiting lists. This pattern aligns with other previous studies in Rwanda that highlighted shortage of both facilities and trained professionals as major barriers to care (30–32). Despite scarce resources, existing mental health services were not always fully utilized. Stigma to toward mental illness discourages help-seeking, contributing to low service use (18). Limited and centralized rehabilitation capacity is a common problem in low-income countries. For example, Uganda – with roughly four times Rwanda’s population, has only 10 rehabilitation centers, clustered mainly in the capital, limited the access for those living in rural areas (33,34). Expanding and

better integrating outpatient treatment options for AUD could reduce pressure on inpatient services and improve timely access to care. Expanding outpatient management for AUD could be a promising opportunity, especially for those in the early stages. Evidence from outside Rwanda showed psychotherapy and pharmacotherapy delivered in outpatient settings are effective (35,36). As Rwanda continues to decentralize mental health services from district hospitals to health centers (37), scaling outpatient AUD care could improve access, support earlier intervention, and enhance outcomes and patient satisfaction.

Patients reported high satisfaction with care, clinical improvement, strong commitment to follow-up, and willingness to recommend treatment. Psychotherapy was widely preferred because it improved insight and allowed open discussion. Medications were also seen as effective, especially in managing psychiatric symptoms associated with complications such as psychosis. However, some participants described difficult early experience. Crisis wards were reported as emotionally traumatizing because new admissions shared space with other critically ill patients. Given resource constraints, patients are often hospitalized together regardless of diagnosis. While understandable, this arrangement requires closer attention to safety and to avoid reinforcing stigma. However, it was not clear whether sharing the same hospitalization ward was due to limited resources, unique treatment strategy or the complexity of grouping by diagnosis. Symptom-based systems such as the DSM-5 can be hard to apply when presentations

overlap and vary in practice (38–41). Medication side effects also affected care experience.

Medication side effects sometimes diminish the care experience. Timely medication adjustment, clear education about expected effects, and shared decision-making could improve satisfaction, trust and adherence (36,42,43). Evidence supports combining psychosocial and pharmacological treatment. Psychological approaches such as motivational interviewing and goal setting proved benefits (48, 54, 55). Broader psychosocial support, including family involvement, peer support, and community reintegration can further strengthen recovery and long-term outcomes.

Family and community networks are often the first to recognize behavioral changes related to AUD and to encourage or facilitate help-seeking. In the absence of such support, local authorities may intervene, though typically at later stages when psychiatric complications have already disrupted functioning. The results of our study found that support from family, community and government was a key contributor to the recovery, emphasizing the value of holistic, community-based approach to AUD. These interventions are sustainable and beneficial both to individuals with AUD and community members at risk (44–46). Engaging caregivers in treatment journey had proven to be beneficial (47). Participants described compassion fatigue among relatives and friends after repeated relapses, with diminishing support further worsening patient condition. Families and friends also experience significant emotional strain and need psychological support

themselves. Including them in care process can build resilience and improve quality of life for both patients and caregivers (47–49). Despite these benefits, stigma remained a major barrier to social support; reducing stigma is essential to strengthen community involvement and improve outcomes. Unfortunately, stigma toward mental illness including AUD remains pervasive. Patients were often negatively labeled, excluded, and discriminated, violating their human rights and undermining their dignity. Stigma causing individuals to isolate themselves and creating barriers to treatment, recovery, and social integration – it remains a major obstacle to mental health care progress (50–52). Sustained public education to improve awareness and reduce fear and misinformation is needed. Greater community understanding can foster empathy and respect, enable fuller participation in work, education, and social engagement, as well as facilitating financial equity by lowering economic barriers to access care.

Limitations:

This study explored the lived experience of people with severe AUD accessing inpatient mental health services in Rwanda, highlighting barriers and facilitators that have not been described previously. However, the results of this study must be viewed in light of some limitations. The sample did not represent outpatients. In addition, the cross-sectional, self-reported nature of the data may introduce recall and social desirability bias. The discussion section mainly references literature on general mental health in Rwanda, since specific AUD literature is not available. Future work should

examine the experiences of AUD outpatients and less severe AUD patients to provide a more complete picture of care pathways.

CONCLUSION

Individuals with severe AUD faced substantial barriers in accessing and navigating inpatient mental health care in Rwanda, including limited awareness of the condition, available treatments, and where to seek care. This information gap delayed care and worsened the condition. Creative health education through music, theater, and visual materials may increase awareness and improve service use, even if evidence suggested limited impact on alcohol consumption itself (62–65). System gaps persist, especially the shortage of rehabilitation centers and trained addiction medicine clinicians. Expanding outpatient rehabilitation services through decentralization and task-shifting, piloting context-specific digital tools, and strengthening Rwanda's community-based insurance scheme (Mutuelle de Sante) could extend reach and contain costs. Inpatient AUD care remains expensive, thus streamlining hospital operations, expanding coverage to selected private facilities, and expanding coverage to caregiver support should be prioritized.

Family members and caregivers experience significant emotional burden and compassion fatigue, which can affect both their well-being and the patient's recovery. Integrating caregiver support into treatment models is essential. This study focused on inpatient only, future research should include

outpatient and non-referral facilities to provide a more comprehensive picture of care pathways and identify additional opportunities for intervention.

List of abbreviations

AUD: Alcohol Use Disorder

CBI: Community Based Insurance

NNPTH: Ndera Neuropsychiatric Teaching Hospital

RN: Registered nurse

Declarations

Ethics approval

This study was approved by the Ethics Committee of the University of Global Health Equity (Ref: UGHE-IRB/2025/356) and Ndera Neuropsychiatric Teaching Hospital (Ref:NNPTH/EC/2025/03). All procedures performed in this study involving human participants were conducted in accordance with the ethical standards of these institutional committees and with the Declaration of Helsinki.

Consent to participate

The study objectives were explained to study participants. The consent form was given to the participants to review the content, simultaneously, the data collector read the form for the partcipant and provided opportunity to clarify

any concerns about the content. All participants gave informed consent prior to data collection.

Consent to publish

Not applicable.

Availability of data and materials

The electronic data of this study is securely stored on a password-protected computer at the University of Global Health Equity, and physical data is kept in a locked shelf at the same institution. To maintain participant privacy and data security as stated in the approved protocol, the data is not publicly available. However, the datasets used and analysed during the current study are available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

All authors contributed to data analysis and manuscript writing. All authors read and approved the final manuscript.

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