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Social Support Moderates the Stigma of Being a Refugee: Findings from African Refugees Living in Mbarara City, Southwestern Uganda

Ronald Bahati[1*], Florence Tutaryebwa[2,3], Eriah Kambere[2], Noel Kansiime[2], Annah Assiimwe Tibazindwa[1,4], Gershom Atukunda[1]

[1]Directorate of Graduate Studies, Research and Innovations, Bishop Stuart University, Mbarara, Uganda
[2]Faculty of Business, Economics and Governance, Bishop Stuart University, Mbarara, Uganda
[3]Faculty of Humanities and Social Sciences, Mountains of the Moon University, Fort Portal, Uganda
[4]Office of the University Secretary, Bishop Stuart University, Mbarara, Uganda
Email: *rbahati@bsu.ac.ug

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Abstract

Background: Social support has been documented as playing an important and positive role in the health and well-being of refugees right from escape from their country of origin to their final new settlement. It relates to the experience of being valued, respected, cared about, and loved by others who are present in one's life. Our study aimed to determine the prevalence of stigma and the association between social support and stigma among African refugees living in Mbarara city, southwestern Uganda. **Methods:** African refugees who had settled in Mbarara city for at least twelve months before the study totaling 343 were assessed on the prevalence of stigma and the role perceived social support in their daily functioning. Stigma was measured by the Discrimination and Stigma Scale-12 while social support was measured using the Multidimensional Scale of Perceived Social Support (MDSPSS). Using SPSS-V26, descriptive statistics were calculated to determine the prevalence of refugee stigma. Linear regression analysis was used to examine the associations between the predictor and outcome variables. **Results:** Most of the participants 84% (n = 288) reported to have experienced stigma. Of these, 122 (36%) were females and 166 (48%) were males. Results revealed that 56% (n = 193) of the participants reported to have experienced enacted stigma whereas 70% (n = 239) experienced internalized stigma. There were no significant differences across gender in the experience of stigma (χ^2 = 4.006, p = 0.940). Results of the hierarchical linear model showed that social support had a statistically significant negative association with stigma (b = −0.44; 95% CI −0.51 to −0.36). **Conclusion:** There is a high prevalence of stigma among African

refugees living in urban areas in Uganda. However, a unit increase in the level of social support reduces the level of stigma experienced. We recommend that interventions that improve social support networks of refugees in urban areas to be designed.

Keywords

African Refugees, Social Support, Southwestern Uganda, Stigma

1. Background

There is an increasing number of refugees in Uganda who are choosing to settle in urban centers rather than refugee settlements, even when this leaves them without access to UNHCR support (Economic Policy Research Center, 2018). Many refugees are professionals with knowledge, skills and abilities which would facilitate their self-sufficiency in urban areas but these capabilities are undermined by the Uganda's refugee policy which promotes self-reliance in rural settlements (Macchiavello, 2011; Refugee Law Project, 2016). In fact, urban refugees are often put under pressure to relocate to rural settlements (Waddimba, 2016).

Refugees who manage to find their way into urban areas are often confronted with issues similar to what the local urban poor encounter such as insufficient disposable income to pay for feeding, transport, housing, school fees, health care, clothing, and other daily utilities (DeCormier Plosky et al., 2017). However, refugees face additional challenges, like adapting to a new culture, learning a new language, stigma, substance abuse, overcoming stereotypes, and living in fear of being returned to their home country or found and harmed by a member of the opposition from their country of origin (Bahati et al., 2022).

It is not surprising, therefore, that researchers have found psychosomatic complaints and clinical mental disorders such as depression and post-traumatic stress disorder to be highly prevalent among refugees when compared to other populations (Bapolisi et al., 2020; Renner et al., 2021; Walther et al., 2020). Stigma has been described by US sociologist Erving Goffman as a quality that significantly discredits an individual in the eyes of others (Goffman, 2009). The experience of stigma associated with refugee status can lead to feelings of shame, drug and substance use and depression (Baranik et al., 2018). Stigma was reported to be associated with higher levels of depression 44% among first generation Iraqi refugees in Canada (Close et al., 2016). Similarly key demographic characteristics such as age, level of formal education, source of livelihood have also been associated to among refugees stigma (Mahmood et al., 2019; Vonnahme et al., 2016). Faced with such interrelated challenges, urban refugees are left in a vicious cycle of psychological distress with no one to offer them hope for their survival (Women's Refugee Commission, 2016). However, in a study conducted among refugees in South Africa it was found that 89% of the refugees used social support as their mechanism of coping with all stress related to refu-

gee status (Bos et al., 2019). In a research study conducted among refugees in Durban South Africa, low social support, was the main risk factors for poor mental health outcomes of depression, stigma, and anxiety in this population (Çankaya et al., 2018; Labys et al., 2017). Low social support is one of the predictors of socioeconomic problems experienced by urban refugees (Teodorescu et al., 2016). Social support has been documented as playing an important and positive role in the health and well-being of refugees right from escape from their country of origin to their final new settlement (Regan et al., 2016). Social support relates to the experience of being valued, respected, cared about, and loved by others who are present in one's life (Teodorescu et al., 2016). Therefore we set out to examine the association between social support and stigma of being a refugee. Our study hypothesized that (a) There would be high prevalence of stigma among urban refugees, (b) There would be a significant negative association between social support and stigma among urban refugees in living in Mbarara city Uganda.

2. Methods

2.1. Study Setting and Design

This was a descriptive cross-sectional study among 343 African refugees residing in Mbarara City, Southwestern Uganda. The city has a population of 261,656 residents (Uganda Bureau of Statistics, 2024). The strategic location of Mbarara city makes it easily accessible by refugees from DRC, Rwanda, and Burundi. Though the actual number of refugees residing in city is unknown by the Office of the Prime Minister and the UNCHR, it is estimated that city is home for about 3500 refugees mainly coming from the Oruchinga, Nakivale and Rwamwanja refugee settlements in Southwestern Uganda (UNHCR & OPM, 2020). Majority of the residents in Mbarara city ethnically identify as Banyankole, Bakiga and Baganda, whose economic livelihoods hinge on cattle keeping, agriculture, trading, and causal labor (UBOS, 2020).

2.2. Participants

A total of 343 African refugees participated in our study. In this study, we considered all refugees who had lived in Mbarara city for at least twelve months before the study. We excluded participants with severe psychological disorders and identifiable symptoms of alcohol intoxication during the time of the questionnaire administration to avoid collecting distorted information.

2.3. Recruitment and Sampling Procedure

We considered a 31% stigma prevalence reported by Baranik and colleagues (2018) in a study about the stigma of being a refugee among Afghanistan refugees living in the US (Baranik et al., 2018) and using Saunders, Lewis and Thornhill, (2012) formula we calculated and determined our sample size (Saunders et al., 2012). Data were collected between June 2019 and May 2020.

We used snowball sampling technique where the subjects who we recruited provided referrals to potential other participants. With the help of refugee leaders in the city, we located the participants in their homes. Data were collected by the corresponding author with the assistance of four research assistants who by the time of data collection held a minimum qualification of a Master's degree. These four research assistants were selected first, because they spoke Swahili, Kinyarwanda/Kinyabwisha, and English the languages that are majorly spoken by most of the African refugees in Mbarara city. Two other persons who spoke Somali language were recruited to help with interpretation. The research assistants also offered psychosocial support to any participant who needed psychological help. These research assistants were trained for one week in data collection skills and research ethics before data collection was done. Each interview lasted between 45 - 60 minutes in psychologically private settings within the homes of the participants.

2.4. Ethical Considerations

Ethical clearance was obtained from the Mbarara University of Science and Technology Research Ethics Committee (# 02/12 - 18) and the study was cleared by the Uganda National Council for Science and Technology (# SS4922). Additionally, we sought permission from the Office of the Prime Minister (OPM), a Uganda government department that is responsible for refugees in the country. All participants aged 18 years and above provided written informed consent after explaining the purpose of the study and clarifying that participation would be entirely voluntary. Similarly, participants below 18 years provided assent to participate in the study after their guardians or parents provided consent. Participants were offered a small token of ten thousand shillings—equivalent to 3 USD as compensation for their time taken to participate in the study. Participants were also encouraged to call or meet the project leaders in case they had additional questions. The participants were assured that the interview would be confidential and that they were free to withdraw from the interview at any time without any negative consequences.

2.5. Measures

All instruments were translated into Kinyarwanda/Kinyabwisha, Swahili and Somali, the languages that were spoken by most of the refugees and back translated to English to ensure that the original meaning was not lost. The questionnaire was comprised of different section including the Discrimination and Stigma Scale (DISC-12), the Multidimensional Scale of Perceived Social Support (MDSPSS) and a brief demographic questionnaire which captured participants' information concerning age, gender, educational level, place of residence, marital status, time spent in Mbarara city, and source of income was also included. The main outcome variable was stigma while the main predictor variable was social support.

2.6. Social Support

Social support was measured using the Multidimensional Scale of Perceived Social Support **(**MDSPSS) by (Zimet et al., 1988)**.** This is a brief research tool designed to measure perceptions of social support from 3 sources: Family, Friends, and a Significant Other. The scale is comprised of a total of 12 items, with 4 items for each subscale. The scale is up to a score of 1 - 84 with options 1) Very strongly disagree, 2) strongly Disagree, 3) mildly disagree, 4) Neutral 5) Mildly agree, 6) strongly agree, 7) very strongly Agree. The mean scale score ranging from 1 to 2.9 is considered low support; a score of 3 to 5 is considered moderate support; a score from 5.1 to 7 is considered high support (Zimet, 2016). It is important to note that in this study social support was analyzed as a continuous variable. The MDSPSS has been translated into many languages, including Luganda and using the Cronbach's alpha, the tool demonstrated good internal consistency at 0.83 as well as all sub scales of the MDSPSS were inter-linked (Nakigudde et al., 2009). In this study, the internal reliability for the scale had Cronbach's αalpha of 0.90.

2.7. Stigma

Stigma was assessed using the Discrimination and Stigma Scale (DISC-12). To suit our sample, the scale was modified and the words "mental health problems" were substituted with words "refugee status". The scale measures unfair treatment of people because they are seen to be different from others for any reason (Brohan et al., 2013). Therefore, the substitution of words did not affect the validity of the scale. The internal reliability for the modified DISC -12 had Cronbach's α of 0.93 (Bahati et al., 2023). The scale consists of 34 items, and scores on a 4-point Likert scale from 0 (not at all), 1 (a little), 2 (moderately) and 3 (a lot). For the current study we considered the first 26 items which measure the experience of stigma. A higher score indicated greater occurrence of stigma experienced by a participant.

2.8. Analysis

Descriptive statistics were used for demographic and the main study variables. In determining the prevalence of stigma, chi square tests were conducted for each of the study variables to determine their difference across gender. Frequencies, percentages, and p-values were presented. A sum score of social support was obtained by adding up the responses to the twelve MDSPSS items and the twenty-six items of the DISC respectively. A step wise linear regression analysis was used to examine the associations between social support and stigma while adjusting for demographic characteristics of age, sex, education level, marital status, time of stay in Mbarara city and occupation. All the variables included in the model were considered as continuous variables. The regression model fulfilled all the necessary criteria for linear regression analysis.

3. Results

3.1. Descriptive Statistics

Of the 343 participants, 198 were males and 145 females, their mean age was 28.8 years (*SD* = 11.0). Most of the participants (95.3%) had attained formal education and almost half of them were not married 49.3%. Majority of the participants were from the Democratic Republic of Congo (DRC), and Rwanda (34.1%, 31.8%) respectively. Very few (5%) were from South Sudan and their mean duration of stay in Mbarara city was 6.4 years. Most of them (49.9%) reported that their source of income was casual labor. The mean total score of social support was 57 (SD = 18) and stigma was 41 (SD = 15) respectively.

3.2. Prevalence of Stigma among Refugees

Most of the participants 84% (n = 288) reported to have experienced stigma. Of these, 122 (36%) were females and 166 (48%) were males. Results showed no significant differences across gender in the experience of stigma ($\chi^2 = 4.006$, $p = 0.940$). When results were analyzed to determine the type of stigma participants experienced, 56% (n = 193) reported to have experienced enacted stigma. Of these, 91 (26%) were females and 102 (30% were males. However, there was a significant difference in the experience of enacted stigma across gender ($\chi^2 = 4.300$, $p = 0.034$). Results also revealed that 70% (n = 239) experienced internalized stigma and of these, 103 (31%) were females and 132 (39%) were males. Results showed no significant differences in the experience of internalized stigma among our participants across gender ($\chi^2 = 2.012$, $p = 0.156$).

3.3. Association between Social Support and Stigma among Urban Refugees

To investigate the association between social support and stigma, the sum scores of the MDSPSS were regressed against the DISC-12 stigma scores. In first step social support was entered in the regression model. The model explained 28% of the variance in stigma ($R^2 = 0.28$), F (1,339) = 131.12, $p < 0.001$). Results in step 1 of this model showed that social support had a statistically significant negative association with stigma (b = −0.44; 95% CI −0.51 to −0.36). In step two we added age, education level, marital status, time spent in Mbarara city, occupation and sex as confounding variables. The results of the regression indicated that social support together with the six socio demographic factors explained 40% in the variance of stigma ($R^2 = 0.40$, $F(12,328) = 20.25$, $p < 0.001$). Age had a statistically significant positive association with stigma (b = 0.21; 95% CI 0.03 to 0.39). Level of education had a statistically negative association with stigma (b = −10.14; 95% CI −16.45 to −3.83 and b = −10.67; 95% CI −18.10 to −3.24) for participants who had attained a secondary or tertiary level of education. Time spent had a statistically negative association with stigma (b = −0.39; 95% CI −0.75 to −0.04). Similarly, occupation had a statistically negative association with stigma (b = −24.54; 95% CI −39.24 to −9.84) for participants who were do-

ing professional work. The results of the regression are presented in Table 1 below.

Table 1. Hierarchical linear regression for the association between social support and stigma among urban refugees living in Mbarara City (N = 343).

Variables	Stigma				
	B	S.E	p-value	95% CI	
***Step* 1**					
Social Support	−0.44	0.04	<0.001	−0.51	−0.36
***Step* 2**					
Age	0.21	0.09	0.002	0.03	0.39
Education Level					
No education	Ref				
Primary	−3.11	3.16	0.326	−9.33	3.11
Secondary	−10.14	3.20	0.002	−16.45	−3.83
Tertiary	−10.67	3.78	0.005	−18.10	−3.24
Marital Status					
Never Married	Ref				
Currently Married	−0.03	1.90	0.988	−3.77	3.71
Separated	−2.45	2.84	0.388	−8.03	3.13
Time spent	−0.39	0.17	**0.027**	−0.75	−0.04
Occupation					
Business	Ref				
Professional	−24.54	7.47	<0.001	−39.24	−9.84
Dependent	2.94	2.51	0.243	−2.00	7.88
Casual Labor	3.40	2.38	0.153	−1.27	8.09
Sex					
Male	Ref				
Female	0.24	1.32	0.854	−2.36	2.84
Social Support	−0.41	0.04	<0.001	−0.49	−0.34

B = Unstandardized Regression Weight, SE = Standard Error, p = Probability Value, CI = Confidence Interval.

4. Discussion

In agreement with our hypothesis, we found a statistically significant negative association between social support and stigma among our participants. In other

words, a unit increase in the level of social support reduced the level of stigma experienced. In a study conducted among refugees in South Africa, found that 89% of the refugees used social support as their mechanism of coping with all stress related to refugee status (Bos et al., 2019). Low social support was one of the predictors of psychological problems and associated with depression, anxiety, attention problems, social problems, somatic complaints, stigma and low self-esteem in a study among refugees living in Norway (Teodorescu et al., 2016). The role of social support is very important because it is considered as a mechanism to buffer against life stressors and promote wellness (Kato et al., 2022).

Results of the regression indicated that social support together with socio demographic factors explained 40% of the variance in stigma symptoms. This is in agreement with a study of Clark (2018), which showed social support as a key facilitator among refugees in accessing mental health services and easing mental health illnesses like stress, stigma, depression and anxiety in everyday life (Clark, 2018). Social support also provided encouragement in help-seeking behavior for mental health services and improved self-efficacy and autonomy of refugees (DeSa et al., 2022). Our findings demonstrate the role of social support in enhancing the mental health of urban refugees irrespective of their demographics. For example, results of the regression revealed a significant positive correlation between age and stigma symptoms. That is to say an increase in age, increased the level of stigma experienced. We argue that this trend could be explained by the fact that most of the young urban refugees were in school where inclusion is highly promulgated through use of a common language and interaction with fellow learners who are largely nationals. This argument is supported by a study done in Spain about the positive influences of social support on sense of community, life satisfaction and the health of refugees where results showed that social supported provided by native friends significantly reduced stigma among refugees (Hombrados et al., 2019). It should be noted that language and cultural differences were key factors reported in a systematic review about which hampered proper interaction between refugees and natives moreover as already noted, refugees who are highly engaged in the host culture are more likely to gain acceptance and experience minimal levels of stigma (Horyniak et al., 2016).

Our results also revealed that, level of education had a statistically significant negative association with stigma for participants who had attained a secondary or tertiary level of education. Meaning that the higher the level of education one had the higher the level of social support they got and therefore the lower the level of stigma they experienced. These findings are in agreement with a study by Brandt and Hagge (2020), which found that higher levels of education lead to an increased quality of social networks meaning that larger amounts of material and immaterial resources, like social support, are exchanged between the members of these networks. They continue to argue that low education is often accompanied by stressful social networks, which affect individuals' mental and

physical health status negatively (Brandt & Hagge, 2020). Almost similar findings were reported in a study about social support perceptions and hopelessness levels of refugee women in Türkiye where, refugee women who graduated from high schools and higher institutions, having a profession with regular income, with higher economic status and social security, reported higher scores of social support and lower scores of psychological distress (Çankaya et al., 2018).

Lastly, occupation had a statistically significant negative association with stigma for participants who were doing professional work. It should be observed that levels of psychological distress have been reported as being high among urban refugees who have no clear source of income (Bahati et al., 2022). This argument is based on urban refugee stress factors such as unemployment, violence, marginalization, discrimination, and increased exposure to health-risk behaviors which are more prevalent among low income urban refugees (Seruwagi et al., 2022).

4.1. Limitations

The study adopted a cross-sectional design and was conducted in one city, therefore, limiting us to make firm inferences from our findings. We recommend a longitudinal study to be conducted on a larger scope of urban refugees for enhancing more concrete conclusions. The participants were undocumented, urban refugees who may have had safety and legal documentation related issues which may have increased participants' levels of anxiety and self-consciousness during data collection thus, affecting their responses about stigma and social support. The findings of this study could have been affected by social desirability and recall biases since responses solely depended on participants' self-reports.

4.2. Conclusion

Study results indicated that social support had a statistically significant negative association with stigma. Results also showed that older participants, those with low education levels, those who had spent little time in Mbarara city and those with low economic status were associated with low levels of social support and therefore experienced a lot of stigma. This implies that whereas social support lessened stigma, the social demographic characteristics contributed to the level of social support our participants received. We therefore recommend that interventions be designed that improve the social status of refugees. It is envisioned that these will increase their (refugees) odds of having strong social support networks and in turn have their levels of stigma suppressed.

Ethical Approval and Consent to Participate

Approval to conduct the study was obtained from Mbarara University of Science and Technology Research and Ethics Committee (MUST-REC 02/12-18). Further approval to conduct the study in Uganda was sought from the Uganda National Council for Science and Technology (UNCST SS4922). Informed consent

was also obtained from all study participants.

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Authors' Contributions

RB, FT, EK, DA and AAT conceptualized the study, analyzed the data and wrote the initial manuscript draft, NK, and GA, supervised, guided the entire study and revised the manuscript back and forth. All authors approved the final version of the manuscript for publication submission.

Availability of Data and Materials

The datasets generated and/or analyzed during the current study are not publicly available due to research ethics board restrictions but are available from the corresponding author on reasonable request.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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