


# Refugee Stigma and Its Association with Depression Symptom Severity: Findings from Urban Refugees Living in Mbarara City, Southwestern Uganda

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## Abstract

**Introduction:** Refugees in urban areas often face acculturation challenges, stigma, and stereotypes that impact their mental well-being. The aim of the present study was to examine the prevalence of stigma and its association with depressive symptoms among urban refugees living in Mbarara city, southwestern Uganda. **Methods:** This cross-sectional study used snowball sampling and interviewed 343 refugees residing in Mbarara city, southwestern Uganda. The Discrimination and Stigma Scale was used to assess stigma, whereas the Patient Health Questionnaire (PHQ-9) was used to screen for depression symptoms severity. Linear regression models determined the associations between stigma and depression symptoms severity. Data were collected between June 2019 and March 2020. **Findings:** Of the 343 participants, 198 were males and 145 were females; their mean age was 28.8 years ( $SD = 11.0$ ). Most of the participants (95.3%) had attained formal education. Our findings show that 84% ( $n = 288$ ) of the participants had symptoms of stigma. Stigma had a statistically significant positive association with depressive symptoms severity ( $b = 0.11$ ; 95% CI, 0.08 to 0.15). Age had statistically significant positive association with depression symptoms severity ( $b = 0.08$ ; 95% CI, 0.02 to 0.14). Education level had a statistically significant negative association with depressive symptoms severity ( $b = -0.53$ ; 95% CI,  $-0.97$  to  $-0.09$ ). **Conclusions:** Urban refugees experience high levels of both stigma

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and depression. Interventions aimed at reducing stigma could subsequently reduce depression among refugees living in urban areas.

## Keywords

Depression, Stigma, Urban Refugees, Southwestern Uganda

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## 1. Introduction

Worldwide, forced migration has become one of the major public health concerns and the United Nations High Commissioner for Refugees (UNHCR) has described forced migration as a source of the global refugee crisis [1]. Uganda is the largest host of refugees in Africa with approximately 1.5 million refugees that are largely from the Democratic Republic of Congo (DRC), South Sudan, Burundi, Rwanda, Somalia and Ethiopia [2]. Although most refugees in Africa stay in refugee camps and settlements, there is an increasing number of refugees preferring to settle in urban centers [3] [4] [5] [6]. Prior research shows that the urban refugees are largely a “hidden” population, and little is known about their numbers, profiles, status, location and livelihoods [7].

In addition to post migration stressors and traumatic events experienced by these refugees, the refugees also experience other issues such as security threats, limited livelihood opportunities, harsh climatic conditions, violence, and tensions between different clans, ethnic and political groups [8] [9] [10] [11]. Due to the refugee policy in Uganda which gives refugees freedom of movement, gainful employment, and treatment without discrimination nor stigmatization [12], some refugees choose to quit rural refugee settlements and settle in urban centres.

Urban refugees often face challenges of insufficient disposable income, housing, feeding, and daily utilities [6] [13] [14]. In addition, they face acculturation challenges, stigma, overcoming stereotypes, and living in fear of being repatriated as compared to their counterparts in refugee settlements [15]. It is not surprising, therefore, that the prevalence of stigma and depression continues to be high among urban refugees [16] [17]. Stigma was reported to be associated with higher levels of depression 44% among first generation Iraqi refugees in Canada compared to estimates in the general population reported to range between 8 and 12% [17]. Similarly, key demographic characteristics such as age, level of formal education, source of livelihood have also been associated with stigma [18] [19].

Although mental health problems are more common among refugees as a result of war and post migration difficulties [20] [21] [22], there is a small body of research that has investigated the occurrence of stigma as well as its association with mental health problems such as depression [23]. Our study therefore aimed at determining the prevalence of stigma and its association with depressive symptoms severity among urban refugees living in Mbarara city in southwestern Uganda.

## 2. Methods

### 2.1. Study Setting and Design

This was a descriptive cross-sectional study among 343 refugees residing in Mbarara City, Southwestern Uganda. The city has a population of 195,013 residents [24]. 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 the city is unknown by the Office of the Prime Minister and the UNHCR, it is estimated that the city is home to about 3500 refugees mainly coming from the Oruchinga, Nakivale and Rwamwanja refugee settlements in Southwestern Uganda [25]. The majority of the residents in Mbarara city ethnically identify as Banyankole, Bakiga and Baganda, whose economic livelihoods hinge on cattle keeping, agriculture, trading, and casual labor [26].

### 2.2. Participants

A total of 343 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. Also would be participants who refused to give written consent were also excluded from the study.

### 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 [16] and using Saunders, Lewis and Thornhill (2012), formula; we calculated and determined our sample size [27]. Data were collected between June 2019 and March 2020. We used snowball sampling technique where recruited participants 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 three research assistants who were counselors by profession. These three research assistants were selected first, because they spoke Kiswahili, Kinyarwanda, and English the languages that are majorly spoken by most of the refugees in Mbarara city. Secondly, because they could offer psychosocial support to any participant who needed psychological help. These research assistants were also 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). Addi-

tionally, 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 parents or guardians provided consent. Participants were offered a small token of five thousand shillings (Shs5, 000/=) 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. Participants with severe symptoms of mental health problems were referred for treatment at Mbarara Hospital Psychiatry department.

## 2.5. Measures

All instruments were translated into Kinyarwanda, Kiswahili and Runyan-kole-Rukiga, 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 sections, including the Discrimination and Stigma Scale (DISC-12), the Patient Health Questionnaire (PHQ-9) and a brief demographic questionnaire which captured participants' information concerning age, gender, and education level, place of residence, marital status, time spent in Mbarara city, and source of income. The main outcome variable was depression while the main predictor variable was stigma.

### 2.5.1. 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 [28]. Therefore, the substitution of words did not affect the validity of the scale. The internal reliability for the modified DISC-12 had Cronbach's  $\alpha$  of 0.93. 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.

### 2.5.2. Depression

The Patient Health Questionnaire (PHQ-9) was used to measure depression. The PHQ-9 is a brief, easily administered and scored screening questionnaire that can be used to improve the recognition rate of major depression and facilitate treatment [29]. An advantage of the questionnaire is its exclusive focus on the nine diagnostic criteria for the newly revised DSM-5 depressive disorders

[30]. In this study, the internal reliability for the PHQ-9 had Cronbach's  $\alpha$  of 0.91. The scale has a total score of 27 with each item with options of not at all (0), several days (1), more than half the days (2) and nearly every day (3). A score of 1 - 4 is interpreted as minimal depression, 5 - 9 mild depression, 10 - 14 moderate depression, and 15 - 19 moderately severe depression, and 20 - 27 severe depression. Since its development, the PHQ-9 has established itself as a practical tool for use in assisting with "depression diagnoses, depression severity, and depression outcome".

## 2.6. Analysis

Descriptive statistics were used for demographic and the main study variables. In determining the prevalence of stigma and depression symptoms, 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 stigma and depression was obtained by adding up the responses to the twenty-six DISC items and the nine items of the PHQ-9 respectively. A step wise linear regression analysis was used to examine the associations between stigma and depression symptoms 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 were 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 for stigma and depression was 41.03 ( $SD = 14.97$ ) and 15.3 ( $SD = 5.28$ ) respectively. Details of the socio-demographic characteristics (see **Table 1**).

### 3.2. Prevalence of Stigma among Refugees Living in Mbarara City Southwestern Uganda

Most of the participants 84% ( $n = 288$ ) experienced stigma. The most reported stigma symptoms were being avoided (80%), being treated unfairly by people in the neighborhood (79%) and being treated unfairly in making or keeping friends (77%). A notable (71%) of the respondents concealed the status of being refugees from others. The least experienced symptoms of stigma were being treated unfairly in starting a family (23%) and being treated unfairly in marriage (26%).

**Table 1.** Descriptive statistics of the characteristics of urban refugees in Mbarara city (N = 343).

Characteristic	Frequency	Percent
<b>Gender</b>		
Male	198	57.7
Female	145	42.3
<b>Age</b>		
14 - 24 years	144	42.0
25 - 35 years	107	31.2
36 - 45 years	60	17.5
47 years+	32	9.3
<b>Education level</b>		
No formal	16	4.7
Primary	131	38.2
Secondary	167	48.7
Tertiary	29	8.5
<b>Marital Status</b>		
Never married	169	49.3
Currently Married	141	41.1
Separated	33	9.6
<b>Time spent in Mbarara city</b>		
1 - 5 years	179	52.2
6 - 10 years	106	30.9
11 - 15 years	52	15.2
16 years+	6	1.8
<b>Place of Residence</b>		
Kakoba Area	216	63.0
Nyamitanga Area	83	24.2
Kamukuzi Area	44	12.8
<b>Source of Income</b>		
Business	29	8.5
Casual labor	171	49.9
Professional	3	0.9
Dependent	140	40.8
	M	SD
Stigma, Total score	41.03	14.97
Depression, Total score	15.30	5.28

We found that there was a significant difference between males and females in terms of being treated unfairly in making or keeping friends ( $\chi^2 = 9.07$ ,  $p = 0.003$ ) and being treated unfairly in housing ( $\chi^2 = 4.16$ ,  $p = 0.041$ ) (see **Table 2**).

### 3.3. Association between Stigma and Symptoms of Depression among Urban Refugees

In step 1, we regressed depressive symptoms with the six demographic characteristics of age, sex, education level, marital status, occupation and time of stay in Mbarara as explanatory variables; age had a statistically significant positive association with depression symptoms severity ( $b = 0.12$ ; 95% CI, 0.04 to 0.19). In

**Table 2.** The prevalence of stigma among urban refugees living in Mbarara City (N = 343).

Items	Total		Female		Males		$\chi^2$	p
	n	%	n	%	n	%		
Being avoided by people	275	80	120	35	155	45	1.06	0.304
Treated unfairly by people in neighborhood	272	79	113	33	159	46	0.29	0.593
Treated unfairly in making or keeping friends	264	77	100	28	164	49	9.07	0.003
Treated unfairly in social life	259	76	106	31	153	45	0.79	0.375
Treated unfairly in any other areas of life	258	75	108	32	150	44	0.07	0.787
Treated unfairly when using public transport	247	72	99	29	148	43	1.74	0.187
Treated unfairly in housing	245	71	112	33	133	39	4.16	0.041
Concealed being a refugee from others	244	71	111	32	133	39	3.59	0.058
Treated unfairly in getting welfare benefits	234	68	97	28	137	40	0.2	0.652
Treated unfairly in physical health problems	224	65	94	27	130	38	0.03	0.873
Treated unfairly in your personal safety	212	62	90	26	122	36	0.01	0.932
Stopped self from having a close personal relationship	212	62	88	26	124	36	0.13	0.715
Treated unfairly in your education	197	57	80	23	117	34	0.53	0.468
Treated unfairly in keeping a job	188	55	86	25	102	30	2.05	0.152
Treated unfairly in finding a job	176	51	81	24	95	28	2.08	0.149
Treated unfairly in intimate relationships	163	46	71	21	92	27	0.21	0.647
Stopped self from applying for education	150	44	68	20	82	24	1.02	0.312
Stopped self from applying for work	145	43	67	20	78	23	1.59	0.207
Treated unfairly in your religious practices	139	41	50	15	89	26	3.81	0.051
Treated unfairly by mental health staff	139	41	61	18	78	23	0.25	0.618
Treated unfairly in your levels of privacy	137	41	61	18	78	23	0.25	0.618
Treated unfairly by the police	133	39	54	16	79	23	0.25	0.618
Treated unfairly by family	128	37	58	17	70	20	0.77	0.379
Treated unfairly as a parent to your children	104	30	48	14	56	16	0.92	0.337
Treated unfairly in marriage	88	26	43	13	45	13	2.11	0.147
Treated unfairly in starting a family	78	23	37	11	41	12	1.1	0.294

**Table 3.** Hierarchical regression for the association between stigma and depression symptoms among urban refugees in Mbarara City (N = 343).

Variable	Depression				
	B	S.E	<i>p</i>	95% CI	
<b>Step 1</b>					
Age	0.12	0.03	<0.001	0.04	0.19
Education level	-0.82	0.23	<0.001	-1.27	-0.37
Marital status	-0.63	0.42	0.135	-1.45	0.20
Time spent in Mbarara	-0.15	0.07	0.044	-0.29	-0.004
Occupation	0.29	0.17	0.093	-0.05	0.63
Sex	0.16	0.58	0.789	-0.98	1.29
<b>Step 2</b>					
Age	0.08	0.03	0.015	0.02	0.14
Education level	-0.53	0.22	0.018	-0.97	-0.09
Marital status	-0.71	0.40	0.076	-1.50	0.08
Time spent in Mbarara	-0.05	0.07	0.483	-0.19	0.09
Occupation	0.32	0.17	0.054	-0.01	0.64
Sex	0.09	0.55	0.871	-1.00	1.17
Stigma	0.11	0.02	<0.001	0.08	0.15

B = unstandardized regression weight, SE = standard error, *p* = Probability value, CI = Confidence Interval.

other words, depression increased with increase in age. Education level and time spent in Mbarara had a statistically significant negative association with depression symptoms severity ( $b = -0.82$ ; 95% CI,  $-1.27$  to  $-0.37$  and  $b = -0.15$ ; 95% CI,  $-0.29$  to  $-0.004$ ) for education level and time spent in Mbarara respectively and explained 7.4% of the variance in the depression (Table 3). In step 2, we added stigma, the results of the regression indicated that stigma together with the six socio demographic factors explained 16% of the variance in depression ( $R^2 = 0.16$ ,  $F(7,333) = 10.06$ ,  $p < 0.001$ ). Stigma had a statistically significant positive association with depressive symptoms severity ( $b = 0.11$ ; 95% CI, 0.08 to 0.15). Age had statistically significant positive association with depression symptoms severity ( $b = 0.08$ ; 95% CI, 0.02 to 0.14). Education level had a statistically significant negative association with depressive symptoms severity ( $b = -0.53$ ; 95% CI,  $-0.97$  to  $-0.09$ ). Results of this regression are presented in Table 3.

#### 4. Discussion

Our study aimed to examine the association between stigma and depressive symptoms among urban refugees living in Mbarara city, southwestern Uganda. We found high prevalence of stigma among our study participants. We also found a strong association between stigma and depressive symptoms. Our find-



ings are similar to previous studies for example; Schweitzer and colleagues (2005) reported a stigma prevalence of 59.8% among refugees living in Austria [31]. Similarly, 44% of Afghanistan refugees in the U.S. experienced stigma [16]. The disparity in the prevalence levels could be attributed to differences in study settings, tools used, and cultural differences between groups.

The most reported experienced stigma symptoms were being avoided by people, being treated unfairly by people in the neighborhood and being treated unfairly in keeping or making friends. These findings agree with the findings of [32], who found that 81.9% of their participants in Nairobi, Kenya were unfairly treated in making or keeping friends, 68.6% were unfairly treated by people in their neighborhood and 68.1% were avoided or shunned by people. Our findings suggest that many urban refugees encounter daily social discrimination or unfair treatment from the community in which they live. These findings are in agreement with [33], who argues that refugees suffer from stigma in form of racism, social exclusion and perceived low status from the broader community.

Additionally, a significant percentage of our participants reported that they concealed their identity of being refugees from others. [32] and [34] respectively found 72.2% and 88% of participants report concealing their identity. Because of such internalized stigma, it is not surprising that at least 43% of the participants in the present study reported avoiding applying for work. A study conducted in Kenya found 59.2% and 40.8% of participants stopped themselves from applying for work, applying for education or training courses, respectively [32].

The least reported symptoms of stigma were being treated unfairly in starting a family and being treated unfairly in marriage. We argue that the low report about unfair treatment in starting a family and unfair treatment in marriage was because most of our participants married amongst themselves and therefore could have experienced very limited with-in group stigmatization. It is probable that even those who reported stigmatization in starting a family or unfair treatment could have been in intimate relationships with natives. Participants reported high prevalence of stigmatization symptoms in other areas of life such as using public transport, housing, and education. These findings are in line with the arguments of [35] who contend that stigma limits a person's educational opportunities, employment, housing, and social relationships, as well as adversely affect, the health outcomes of individuals who experience stigma.

The current study revealed a significant difference between males and females in terms of being treated unfairly in making or keeping friends and being treated unfairly in housing. More males reported having been treated unfairly in housing 39%, as compared to their female counterparts at 33%. These findings are in contradiction with [32] who reported that more women experienced unfair treatment compared to men in finding accommodation. Such contradiction could have come because of the differences in gender distribution of each study but also differences in ethnic backgrounds. In the current study we had 57.7% males and 42.3% females, whereas in the former study 30.6% were males and

69.4% were females. Incongruent gender distribution could explain the differences in the results. But also, we need to take cognisance of the fact that men tend to migrate to urban places more often than women, thus raising implications that our study sample may have been atypical yielding, but not necessarily, inaccurate findings [36].

In agreement with our hypothesis, results indicated a significant positive correlation between stigma and depressive symptoms. Our findings are similar to other studies; for example, [37] found that depression among forced migrants was associated with stigma. Other research [35] suggests a significant association between stigma and compromised quality of life and poorer functioning across daily routines. Our findings show that many participants concealed their identity of being refugees, which may explain why stigmatized individuals may fail to seek help even when they are aware of their needs. Almost three quarters of our participants reported feeling down, depressed, or hopeless, and feeling tired or having little energy as their major depressive symptoms. These are classic symptoms of depression which often require intervention. Moreover, stigma may set up a perpetuating cycle of increased symptoms and psychopathology [38].

Results of the regression indicated that stigma together with socio demographic factors explained 16% of the variance in depressive symptoms. Our findings demonstrate the role of stigma in compromising the mental health of urban refugees irrespective of their demographics. Results of the regression also revealed a significant positive correlation between age and depressive symptoms. Depression symptoms were highly prevalent among older participants as compared to the young ones. Higher rates could have been due to their stressful experiences before migration, during migration, post migration and social adjustment challenges, as well as worries about daily survival mechanisms amidst limited social support. The culmination of stress and worry and related impact over time for older people is more likely to be higher than it would be for younger people. Older urban refugees are faced with chronic stress related to poor social support, legal uncertainty, and material insufficiency about their existence in the urban areas; this insecurity exposes them to a higher risk of developing depression [7].

The results also revealed a significant negative correlation between the level of formal education and depressive symptoms, *i.e.*, refugees who had no or had lower levels of formal education were more likely to bear depressive symptoms compared to those with higher formal education levels. The investigators opine that those with higher formal education are often skilled or professionals who could more easily interact with the nationals, in most cases were economically better-off, and able to seek help as compared to their counterparts with no or low levels of formal education [19]. Their study among Bhutanese refugees in the United States, found that inability to read and write a host country's language increased the odds of symptoms of depression four times compared to those who could read. Moreover, daily stressors such as living in unsafe places,

lack of access to basic needs, absence of social support and living conditions in the host country contributed to higher levels of depression among Rohingya adult refugees who were semi or illiterate in Bangladesh [18]. These findings are in line with the Diathesis-Stress Model of Robert P. Liberman (1960), a psychological theory that explains behavior as both a result of biological and genetic factors (“nature”), and life experiences (“nurture”) [39]. The experience of stigma by refugees coupled with other environmental and biological their genetic factors may result in mental health problems including depression.

Results revealed a significant positive association between stigma and depressive symptoms. In addition to war-related violent events experienced in their country of origin, refugees are exposed to danger and potentially traumatic events during their flight [18]. When they arrive at camps or host countries, many already suffer from psychological and physical impairment. [40] argue that refugee camps often generate meager conditions and constraints of living, urging the influx of refugees to urban areas in an effort to increase their stability, autonomy and security. When they get to urban centers, refugees are often confronted with living challenges ranging from physical, economic, social, and mental constraints. We argue that the high prevalence of stigma among urban refugees is partly due to the fact that urban refugees have a lot of interaction with the local population (host communities) and this created a divide between them and the local population as compared to their counterparts in the settlements who are largely interacting with fellow refugees. In general, mental disorders are more prevalent in metropolitan cities; thus it may be anticipated that specific conditions such as anxiety and depression are also more prevalent among urban refugees than those in rural areas [41]. These findings point to the need for the provision of acceptable, accessible, and timely mental health interventions to enhance recovery of refugees living in urban areas. Our study adds to support the growing body of evidence that urban refugees have a burden of managing daily stigmas that contribute to depression and other mental health conditions.

#### **4.1. Limitations**

The study adopted a cross-sectional design, therefore, limiting us from drawing causal inferences from our findings. We recommend a longitudinal study to be conducted enabling more concrete conclusions. We adopted a snowball sampling method which may have resulted in a selection bias and decreased sample representativeness. 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 depression. We solely depended on participants’ self-reports, participants may have over or under-reported their experience of stigma and depression symptoms and as such, we expect a certain amount of measurement error.

## 4.2. Conclusion

Stigma among urban refugees is positively associated with depression and may lead to a greater experience of psychopathology, specifically depression. Further studies that adopt exploratory and mixed epidemiological methods are needed to ensure that the needs of this population are factored into the study designs.

## Ethical Approval and Consent to Participate

Approval to conduct the study was obtained from the 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.

## Authors Contributions

BR, conceptualized the study, collected the data, analyzed the data and wrote the initial manuscript draft. HEA, CDS, SA, and GZR supervised, guided the entire study and revised the manuscript back and forth. All authors approved the final version of the manuscript for publication submission.

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## 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 upon reasonable request.

## Competing Interests

Authors declare they have no any conflict of competing interests.

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