

Social Capital and Quality of Life among the Refugees residing in Mbarara City Southwestern Uganda

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Abstract

Introduction:

Globally, social capital is considered a significant resource in improving quality of life among human beings. In this study, we aimed at assessing the proportions of forms of social capital and their association with the quality of life among the refugees living in Mbarara City southwestern Uganda.

Methods

This cross-sectional study used consecutive sampling method to select 344 refugees that were living in Mbarara city at the time of data collection. Refugees were assessed on their social capital using the World bank Social Capital Integrated Questionnaire. Quality of life was assessed using the World Health Organization questionnaire of quality of life. Data were analyzed using STATA. Descriptive statistics determined the occurrence of social capital while linear regression model determined the association between social capital and quality of life.

Results

Almost all participants endorsed one form of social capital, with majority of the participants [251(73%)] endorsing sociability, followed by trust and solidarity 186(54%), groups and networks were the least endorsed [170(49%)] within our sample. Our findings further showed that having high levels of trust and solidarity, positively correlated with quality of life ($b = 0.80$; 95% CI, 0.09 to 1.51; $p = 0.027$).

Conclusions

High social capital is likely to be associated with quality of life among refugees. Interventions aimed at building strong social capital are encouraged.

1. Background

Living a life of forced migration can be imprinted by disengagement that destroys the ability to build social capital in form of social cohesion, trust, enhancing solidarity and impairs psycho-social functioning [1]. While other studies have shown that refugee's experiences of war undermine their ability to engage in social networks, social cohesion, trust in others and could result into a cycle of violence [2–4]. Establishing social capital in post-conflict communities is of a paramount importance for the refugee communities in order to access significant resources and integration with the host communities while accessing employment opportunities, education for their children and acquiring housing [5]. However, refugee's unpleasant experiences are likely to pose severe hinderances to establishing strong social capital [6, 7]. Moreover, urban refugees are more likely to rely on the strength of their individual social

capital than those refugees living in the refugee settlement [8]. Studies on the existence of social capital among the refugees in Africa especially within the urban context are scarce. Yet existence of social capital among the refugees has been shown to reconstruct the lives of the refugees [9]. Studies on the relationship between social capital and quality of life have however recently gained popularity in biomedical and behavioral medicine [10, 11]. Social capital theory is premised on the fact that the more the social capital (trust, networks, connections) within the community, the healthier the community would be [12, 13]. Previous research has shown that the well-being of a community is dependent on the extent to which social capital exists [13, 14]. One study that examined the association between social capital and quality of life among survivors of stroke in China concluded that social capital is likely to enhance quality of life [15]. The association of social capital and mental well-being has also been documented [16–18]. For example, a systematic study that reviewed 55 studies exploring the association between mental health and social capital among the children and adolescents concluded that networks significantly improve the mental well-being of children and adolescents [19].

Although social capital remains a significant protective factor in the area of preventive medicine, many of the studies exploring its association with quality of life and other domains of health are majorly found in high income countries and largely scattered across different settings [15, 20, 21]. In this study, we sought to assess the existence of social capital and its association with quality of life among the refugees living in Mbarara City southwestern Uganda. We hypothesized that; (a) Refugees would have low social capital (b) there would be a positive association between high social capital and quality of life among the refugees living in Mbarara City southwestern Uganda.

2. Methods

2.1. Study setting and design

This was a cross-sectional study that utilized quantitative methods of data collection among 344 refugees in Mbarara city, Southwestern Uganda. Mbarara city can easily be accessed by refugees from the Democratic Republic of Congo (DRC), Rwanda and Burundi. The city has a population of approximately 195,013 residents and is a home to about 3500 refugees from the surrounding settlements of Nakivale, Oruchinga and Rwamwanja.

2.2. Participants and recruitment procedure

The age of the range of the 344 participants was between 18–65. The majority of our participants were from the central business area of the city i.e., Kakoba, Kakiika, Kamukuzi and Nyamitanga. All refugees who had lived in Mbarara city for at least six months before the study were recruited. Following permission from the Research Ethics Committee and the Office of the Prime Minister. These, helped in enrolling eligible study participants into the study. Given the versatile nature of urban refugees, snow sampling was preferred for the study. One legible participant provided referrals to other potential participants. These potential participants were assessed on their eligibility and if they met the inclusion

criteria, then they were asked to voluntarily take part in the study. Data were collected from October 2022 to April 2023.

2.3. Ethical consideration

Approval to carry out research was obtained from the Bishop Stuart University Research Ethics Committee (BSU-REC-2022-18) and the Office of the Prime Minister, a government department which oversees refugees and any activity among them. Before the interview, informed written consent was obtained from all participants. They were informed about their right to or not to take part in the study, the right to withdraw from the study at any time without any repercussions, confidentiality issues were also discussed. Interviews were carried out in places which were considered by both the participant and the researcher as being ethical and would not pose any danger to the participants. Each participant was given 1.5USD as a modest compensation for their time spent attending the study interview. Participants with severe psychological problems were excluded from the study however, they were referred to a free counselling center within the city.

2.5. Measures

All instruments were translated into Kiswahili and Kinyarwanda and back translated to English. Demographic questions enquired into gender, age, country of birth, religious affiliation, education level, marital status, number of children, group belonging and employment status.

Social capital was assessed using the world bank Social Capital Integrated Questionnaire.

2.6. *Social capital*

Social capital among the participants was assessed by the Social Capital Integrated Questionnaire (SCIQ) [22]. This tool has been used on various settings and has yielded reliable psychometric measures. The measure is composed of three domains of social capital (i.e., Trust and Solidarity, Groups and Network and Sociability) yielding a total of 31 variables that seek to quantify the participants' relationships with neighbors, family members, friends, and communities. The first domain (Groups and networks) measured social networks (relationships and networks with friends, neighbors and colleagues) with 19 variables; the second domain (Trust and Solidarity) assessed cohesion within the community and neighborhood e.g., participation in neighborhood activities and sense of belonging and contained 6 variables. The third domain (sociability) assessed social interactions and contained 6 variables. Based on the previous studies [23]. The three domains of social capital (i.e., Trust and Solidarity, Groups and Network and Sociability) were dichotomized into high and low (i.e., low for a scoreless or equal to the domain's mean score and high for a score more than domain's mean score).

2.7. Quality of life

The World Health Organization Quality of Life (WHOQOL-BREF) questionnaire was used to assess Quality of Life. This tool has 26-items and has been widely used in a variety of cultural settings and with displaced populations (Correa-Velez et al., 2020). The WHOQOL-BREF consists of four domains, Physical

health, Psychological, Social relationships, environment domain, and other two questions related to overall quality of life and satisfaction. This tool yields good psychometric measures and has been used in various setting [24, 25]. The four domain scores are scored in a positive direction with higher scores indicating a higher quality of life with three items (two under physical health and one under the facet of mental health) scored on a reverse order with a possible total score of 100. For analysis, we computed the total score to yield the variable Quality of Life as a dependent variable.

Data analysis

Descriptive statistics were used for demographic characteristics and social capital. A linear regression model was used in assessing the association between social capital and quality of life while controlling for demographic factors of age, gender, education level, marital status and nationality.

3. Results

3.1. Demographic characteristics and social capital

Of the 344 participants, 215 (62%) were female. The majority of the participants were Congolese, 94 (27%) were Rwandese, 13 (4%) were Burundian and only 7 (2%) were Somalis. Almost a half of our participants 126 (63%) were jobless, 50 (25%) had small businesses, 21 (11%) were students and only 3 (2%) were professionals.

More than half of our participants 183 (53%) were married, 145 (42%) were single and only 16 (5%) were widowed. The majority of the participants, 174 (51%) endorsed being in high groups and networks, 186(54%) belonged to high trust and solidarity and 251 (73%) had high sociability (Table 1). The mean score of Quality of Life was 10 and a standard deviation of 3.29 with a maximum score of 21 and minimum score of 3.

Table 1
 Showing demographic characteristics and social capital of the refugees (n = 344)

Characteristic	n(%)
Gender	
Male	129 (38)
Female	215 (62)
Age	
< 31	180 (52)
31–40	68 (20)
41–50	36 (10)
51–60	16 (5)
> 60	44 (13)
Level of Education	
None formal	83 (24)
Primary	79 (23)
Secondary	161 (47)
Tertiary	21 (6)
Occupation	
Small Business	50 (25)
Jobless	126 (63)
Profession	3 (2)
Students	21 (11)
Nationality	
Congolese	230 (67)
Burundian	13 (4)
Rwandese	94 (27)
Somalis	7 (2)
Marital Status	
Single	145 (42)

Characteristic	n(%)
Married	183 (53)
Widowed	16 (5)
Groups and networks	
Low (< = 3)	170 (49)
High (> 3)	174 (51)
Trust and solidarity	
Low (< = 8)	158 (46)
High (> 8)	186 (54)
Sociability	
Low (< = 4)	93 (27)
High (> 4)	251 (73)
	Mean (SD)
Quality of life, Total Score	10 (3.29)

3.2. Association between social capital domains and quality of life

To estimate the association between social capital and quality of life, we carried out with predictors x, y, z and response variable of Quality of Life. The model was significant with $F(16,327) = 3.04, p = 0.001$. Our results revealed that only 12.9% ($R^2 = 0.129, F(16,327) = 3.04, p \leq 0.001$) of the variations in quality of life were explained by the model fit. Only high levels of trust and solidarity were positively associated with quality of life ($b = 0.80; 95\% \text{ CI}, 0.09 \text{ to } 1.51; p = 0.027$). Refugees in age bracket of 31, 41–50, 51–60 and above 60 years had significantly low quality of life compared to those who were 30 years and below ($b = -1.76; 95\% \text{ CI}, -2.81 \text{ to } -0.70; p = 0.001, b = -1.90; 95\% \text{ CI}, -3.25 \text{ to } -0.55; p = 0.006, b = -1.93; 95\% \text{ CI}, -3.78 \text{ to } -0.09; p = 0.04, b = -1.64; 95\% \text{ CI}, -3.07 \text{ to } -0.21; p = 0.025$) for 31–40, 41–50, 51–60 and above 60 years respectively (Table 2)

Table 2
Association between domains of social capital and Quality of life

Quality of Life				
			95% CI	
Characteristic	b	p	LCI	UCI
Groups and Network				
Low	ref			
High	0.66	0.072	-0.06	1.37
Sociability				
Low	ref			
High	0.34	0.406	-0.47	1.16
Trust and Solidarity				
Low	ref			
High	0.80	0.027	0.09	1.51
Age, years				
< 30	ref			
31–40	-1.76	0.001	-2.81	-0.70
41–50	-1.90	0.006	-3.25	-0.55
51–60	-1.93	0.04	-3.78	-0.09
Above 60	-1.64	0.025	-3.07	-0.21
Marital Status				
Single	ref			
Married	0.05	0.908	-0.87	0.97
Divorced	-0.90	0.35	-2.79	0.99
Gender				
Male	ref			
Female	-0.07	0.85	-0.83	0.68
Education				

Note: b = regression coefficient, p = p-value, CI = confidence interval

Quality of Life				
None Formal Education	ref			
Primary	-0.45	0.41	-1.53	0.63
Secondary	-0.12	0.829	-1.23	0.99
Tertiary	0.10	0.906	-1.57	1.77
Nationality				
Congolese	ref			
Burundian	-1.22	0.185	-3.02	0.59
Rwandese	-0.09	0.824	-0.91	0.73
Somalis	1.50	0.253	-1.08	4.07
Note: b = regression coefficient, p = p-value, CI = confidence interval				

4. Discussion

The present study focused on documenting the estimates of social capital and its association with quality of life among the refugees residing in Mbarara city Southwestern Uganda. Our findings show that there is high social capital among refugees with majority of the participants scoring high in sociability plus groups and networks. We also found that high levels of trust and solidarity were positively associated with quality of life with in our sample. Findings that the refugees depicted high levels of social capital are in line with a study, which found that asylum seekers relied more on social support and social networks to survive [11]. Another study that explored urban Congolese refugees' use of social capital to promote resilience during a period of political violence in Nairobi Kenya found out that, refugees used social capital across different contexts to access and distribute resilience-promoting resources [26]. The above study observed that refugee women particularly relied on informal bonding forms of capital while men exhibited greater degrees of access to formal bridging and linking networks.

Our findings are also in line with findings from a study that was carried out among the Congolese refugees in Kampala that found a sense of belonging multiple social groups with in their communities [27]. In agreement with previous findings [6], the high social capital found in our study could be as a result of many organizations involved in enhancing the refugee social cohesion. We argue, that the high level of social capital found in our sample, could have been as a result of the many non-governmental organizations (NGOS) involved in the lives of these refugees in Uganda.

Our findings that high levels of trust and solidarity are positively associated with quality of life agree with one study that carried out research among Syrian refugees in Lebanon[28]. In this study, the authors

observed that positive social capital constructs were associated with better health and higher levels of social support and being more optimistic.

Similarly, results from our sample correspond well with findings from a study that found a positive correlation between social capital and quality of health among the refugee communities in Australia[29]. In line with the above findings, our results also agree with findings from another previous study that observed positive correlation between social capital and improvement in mental health among the refugees[9]. It is possible that participants from our sample drew all these connections from their cultural and host communities. These connections provided them with the necessary assistance and useful information that they need. We recommend that, interventions focused on building the refugees networks such as sociability, trust and solidarity be established in post conflict communities.

Limitations

We acknowledge that our results could be limited by the following limitations (1) The cross-sectional study design does not allow for the establishment of causality the reported associations should be interpreted with caution. Longitudinal and prospective studies are needed to shed light on the causal relations. The convenience sample may have resulted in a selection bias which limits the generalizability of our findings. Finally, although, the participants talked very openly about their experiences and feelings, potential biases such as social desirability can never be ruled out for subjective reports.

Conclusion

Our findings provide further support to earlier findings especially from high income countries that social capital is associated with good quality of life. Based on our findings, we recommend that, interventions focused on building the refugees networks such as sociability, trust and solidarity be established in post conflict communities.

Declarations

Ethics approval and consent to participate

Ethical approval for the study was given by Bishop Stuart University Research Ethic Committee (BSU-REC).

Availability of data and material

The data sets used and analyzed during the current study are available from the corresponding author on request.

Conflict of Interest and Disclosure Statement

The authors declare that they have no competing interests.

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Authors' contribution

KB participated in the conception and design of the study, collected the data, performed data analyses, interpreted the data, and drafted the manuscript. BH, AN and SN participated in the conception of the study and revised the manuscript. HEA participated in the conception of the study, supervised data collection/analysis and provided substantial revision of the manuscript. All authors read and approved the final manuscript.

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