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COMMUNITY SUPPORT AND QUALITY OF LIFE: A STUDY OF MENTALLY ILL SURVIVORS IN BUSHENYI, UGANDA

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Abstract: *Mental illness remains a pressing public health issue in Uganda, especially in Bushenyi District, where survivors face limited access to mental healthcare, stigma, poverty, and cultural misconceptions. These factors significantly affect their quality of life (QoL), highlighting the importance of community-based support strategies. This study aimed to examine the influence of community support activities on the quality of life among mentally ill survivors in Bushenyi District, Uganda. A mixed-methods approach was adopted, incorporating both qualitative and quantitative techniques. Data were collected using structured questionnaires, interview guides, and observational checklists from a sample of 107 participants, including mentally ill survivors, caregivers, mental health professionals, and community leaders. Validity and reliability of instruments were confirmed with a CVI of 0.876 and a Cronbach's alpha of 0.842, respectively. Quantitative data were analyzed using SPSS v26.0, applying descriptive and inferential statistics, including multiple regression. Thematic analysis was used for qualitative data. The study revealed that while mentally ill survivors moderately participated in activities like savings groups and market days, their involvement in community gardening, clean-ups, and cooperative income-generating ventures was limited due to stigma and unequal community support. Regression analysis showed a weak and statistically insignificant relationship between community support activities and Quality of Life (QoL) ($t = 1.273$, $p = 0.206$), indicating that community support alone is not sufficient to improve QoL unless integrated with other strategies. Finally, Community support activities showed a moderate but non-significant contribution to the Quality of Life of mentally ill survivors. However, they remain essential components of holistic mental health interventions. The study recommends strengthening community support systems through partnerships, awareness campaigns, and inclusive programming. Integrated models combining peer mentoring and life skills training*

with community engagement should be prioritized to enhance mental health outcomes.

INTRODUCTION

The standard of living for survivors who are psychologically sick in the USA is a major concern, as they experience significant impairments in overall well-being and life satisfaction (Gill et al., 2010). Individuals with severe mental illness (SMI) face numerous challenges, including diminished quality of life in relation to mental and physical health, social connections, and environmental support compared to the broader populace (Kessler et al., 2014). To address these challenges, it is crucial to develop comprehensive interventions that promote recovery, well-being, and quality of life among mentally ill survivors in the USA (Corrigan et al., 2012).

In China, the mentally ill population faces significant quality of life challenges, with a systematic review highlighting lower standard of living scores compared to the broader populace (Wang et al., 2020). Mentally ill survivors in China experience difficulties in social relationships, daily activities, and overall well-being, which are exacerbated by stigma, discrimination, and social exclusion (Li et al., 2019). To enhance the quality of life among mentally ill survivors, China's mental health services require improvement, particularly in community-based care and rehabilitation programs (Liu et al., 2022).

The UK's mental health statistics reveal a concerning trend, with one in six people aged 16+ experiencing symptoms of a common mental health problem (1). Women are disproportionately affected, with higher rates of common mental disorders compared to men (1). Another significant effect of the COVID-19 epidemic, with depressive symptoms rising significantly (1). To address these challenges, the UK's mental health services must prioritize effective treatment and social support services.

Nigeria's mental health care system faces significant gaps in addressing the quality of life of mentally ill survivors, with substantial impairments in general health and contentment with life (Adewuya et al., 2020). The country's mental health services require comprehensive interventions that promote recovery, well-being, and quality of life among mentally ill survivors (Iheanacho et al., 2019). This can be achieved by addressing stigma, discrimination, and limited access to effective treatment and social support services (Nigeria Ministry of Health, 2022).

Kenya's mental health care system faces significant challenges in addressing the standard of living for survivors with mental illness, with difficulties in social relationships, daily activities, and overall well-being (Karie et al., 2022). Mentally ill survivors in Kenya experience stigma, discrimination, and social exclusion, which exacerbate their poor standard of living (Jenkins et al., 2019). To enhance the quality of life among mentally ill survivors, Kenya's services for mental health require enhanced community-based rehab and care initiatives (Ministry of Health, Kenya, 2020).

In Uganda, mentally ill survivors face significant challenges in their quality of life, with factors such as poverty, stigma, and limited access to mental health services contributing to this disparity (Kigozi et al., 2017). An investigation carried out in rural Uganda found that individuals with mental illness experienced a lower living quality in relation to the whole population, with social isolation, lack of access to effective treatment, and cultural beliefs being major contributing factors (Kinyanda et al., 2011). To address these challenges, Uganda's services for mental health must prioritize Community-centered programs for rehabilitation and care that promote recovery, well-being, and quality of life among mentally ill survivors. This can be achieved by taking socioeconomic aspects of mental health into consideration, including education, employment, and socioeconomic status, as highlighted in a thorough analysis of mental health studies in Uganda (Mugisha et al., 2017).

In Bushenyi district, mentally ill survivors are faced with a challenge of scarce mental health services, with a shortage of trained professionals and inadequate facilities. This scarcity leads to long distances to the nearest health centers and a lack of specialized care (Archibong et al., 2021). More so, Mental illness is often stigmatized, leading to social exclusion and discrimination. Cultural beliefs may favor traditional healers over medical professionals, causing delays in seeking appropriate care (Lai, 2022). Other challenges relate to high poverty levels that limit access to healthcare services, as many individuals cannot afford transportation or treatment costs. Additionally, economic hardships can contribute to the onset or exacerbation of mental health issues (Mathieu et al., 2022). The pandemic has increased mental health challenges, with a study in Ishaka Municipality reporting a 57% prevalence of depression and anxiety among adults during the lockdown. Factors such as unemployment and underlying health conditions have intensified these issues (Ibrahim, 2024). Gender-based violence is also prevalent among mentally ill survivors in Bushenyi district, leading to physical and mental health issues. The lack of resources and support systems exacerbates the situation for survivors (Forry et al., 2022). Addressing these challenges requires a comprehensive approach, including improving mental health services, reducing stigma, enhancing economic support, and providing targeted interventions for vulnerable populations.

Mental illness remains a critical public health challenge in Bushenyi District, with a significant proportion of the population affected. Although comprehensive data on the exact prevalence of mental disorders in Bushenyi is scarce, studies indicate that mental health issues in Uganda are on the rise, with approximately 14% of the population experiencing mental health conditions (Kigozi et al., 2018). The burden is exacerbated by poverty, limited healthcare infrastructure, and cultural misconceptions that fuel stigma and discrimination against mentally ill individuals (Okello et al., 2015). Despite efforts to improve mental health services, social support strategies in Bushenyi District have largely failed to enhance the quality of life (QoL)

of mentally ill survivors. The lack of adequate mental health facilities and trained professionals significantly hinders the provision of necessary care (Kigozi et al., 2018). Additionally, community-based support programs are underfunded or nonexistent, leaving survivors with minimal emotional, financial, or rehabilitative assistance. Without sufficient support networks, individuals with mental illness experience social isolation, reduced physical health, and an inability to reintegrate into society (Santini et al., 2020). Stigma and cultural beliefs further limit the effectiveness of social support interventions in Bushenyi. Mental illness is often misunderstood, leading to discrimination that discourages affected individuals from seeking help (Okello et al., 2015). Families, who are primary caregivers in most cases, may lack awareness or resources to provide adequate emotional and practical support (Mackenzie et al., 2020). As a result, mentally ill survivors are often abandoned or subjected to harmful traditional practices rather than receiving evidence-based treatment. Therefore, this research will assess the role of community support in improving quality of life for mentally ill individuals in Bushenyi, Uganda.

Statement of the Problem

Mental illness continues to be a critical public health concern in Uganda, particularly in Bushenyi District, where mentally ill survivors face a combination of challenges, including inadequate access to mental health services, pervasive stigma, poverty, and entrenched cultural misconceptions (Kigozi et al., 2018; Okello et al., 2015). These factors greatly compromise the survivors' quality of life (QoL), leading to social exclusion, diminished physical and emotional well-being, and poor economic prospects. Although mental health care policies have been initiated, they remain insufficient, especially at the community level, where survivors rely heavily on informal networks for support (Mugisha et al., 2017). In response to these challenges, community-based support initiatives have been increasingly recognized as vital in promoting recovery, enhancing social integration, and improving QoL among individuals with mental illness (Santini et al., 2020). However, empirical evidence specific to Bushenyi District remains limited, necessitating this study to examine how community support activities influence the QoL of mentally ill survivors.

Literature Review

Community support has been widely acknowledged as a significant factor in improving the quality of life for individuals with mental illnesses, particularly in low-resource settings like Uganda. Research indicates that community-based interventions, such as peer support groups, psychoeducation programs, and livelihood initiatives, can foster social inclusion, enhance emotional well-being, and strengthen coping mechanisms (Mugisha et al., 2017; Santini et al., 2020). In Uganda, studies have shown that stigma and discrimination often hinder access to formal mental health services, making community engagement crucial in bridging the treatment gap and offering psychosocial support (Kigozi et al., 2018). Peer mentoring, family education, and local

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rehabilitation efforts not only promote adherence to treatment but also empower survivors to regain autonomy and improve their life satisfaction (Okello et al., 2015).

Despite these findings, much of the research emphasizes urban centers, leaving a gap in understanding the dynamics of community support in rural districts like Bushenyi. Rural communities often face unique challenges, including deeper cultural misconceptions about mental illness, fewer trained health professionals, and limited infrastructure (Mackenzie et al., 2020). Yet, they also offer close-knit social structures that, when mobilized effectively, can be powerful tools for recovery and social reintegration. Studies suggest that when community support is organized, consistent, and culturally sensitive, it can significantly uplift the mental, physical, and economic well-being of survivors (Santini et al., 2020). Therefore, investigating the role of community support initiatives in Bushenyi is essential to inform more context-appropriate interventions and improve the quality of life for mentally ill survivors in the region.

METHODOLOGY

The mixed approach (quantitative and qualitative) utilized a survey research design with a cross-sectional study, collecting data through questionnaires and rating scales from a sample of mentally ill survivors. This enabled the measurement of Social Support Strategies (independent variable) and Quality of Life (dependent variable). interview guide was also utilized to collect data. Thematic analysis was applied to identify patterns and themes related to social assistance techniques and living quality, providing rich and nuanced insights into the experiences and perceptions of the participants. This study aimed at achieving a comprehensive understanding of the influence of social support strategies on the quality of life among mentally ill survivors in Bushenyi District, Uganda.

In this study the target population included mentally ill survivors, caregivers, mental health professionals, and, community leaders, in Bushenyi District. Their perspectives provide insights into social support effectiveness, healthcare gaps, and stigma. This diverse group ensures a comprehensive evaluation of how support strategies impact the quality of life for mentally ill survivors.

Table 1: Target Population

Category of the respondents	Target population
Mentally ill survivors	174
caregivers	85
Mental health professionals	45
Community leaders	35
Total	**339**

Source: Ministry Of Health Records Office, (2024)

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Sample Size

A sample is a chosen grouping of some components from the entire population, whereas the study population is the total of specific groups of entities that the study is interested in (Kombo& Tromp, 2006). This study's population of focus was mentally ill survivors in Bushenyi district, Uganda. The sample size was calculated using Kish Leslie (1999), at 95% confidence interval and error within 5% of one proportion for the prevalence of mental illness;

$n = \frac{Z^2_{\alpha/2} * p(1-p)}{d^2}$

Where:

n = Sample size estimate of study participants.

$Z_{\alpha/2}$ = Standard Z value at 95% confidence interval, corresponding to 1.96

p= rate at which mentally ill survivors lack social support = 67% of mentally ill individuals experienced victimization, which further diminished their social networks and support (Musisi, Kinyanda, &Nakimuli-Mpungu, 2020). 0.2211

d = the sampling error; 5% 0.2016

$n = \frac{1.96^2 * 0.67(1-0.67)}{0.05^2} =$ **339**

According to Vivalya, Akimana, &Ashaba, (2023), 155 mental ill survivors come from Bushenyi. Thus, the sample size of 339 is too large. According to Obiri, (2017) the corrected sample size can be recomputed and adjust to an achievable number using finite population correction formula as shown below:

Sample size = $\frac{n}{1+\frac{n-1}{N}}$ where N is the size of the population and n is the size of the sample.

Sample size = $\frac{\mathbf{155}}{\mathbf{1+\frac{155-1}{339}}} = 107$

Table 2: Sample Size Determination

Category of the respondents	**Target population**	**Sample size**
Mentally Ill Survivors	174	55
Caregivers	85	27
Mental Health Professionals	45	14
Community Leaders	35	11
Total	**339**	**107**

Source: Researcher, (2025)

Sampling Techniques

A sample size refers to the number of participants included in a research study (Hosseinzadeh et al, Jafari, and Hasanpour, 2022). Simple random and snowballing sampling approaches were used in the investigation. Simple random sampling was used for selecting representative samples without bias from a target population. It was guaranteed that every individual in the population of interest has an equal and independent probability of being included in the sample, allowing the results to be broadly applied. The medical staffs were chosen from a sampling frame using simple random sampling. The snow balling was used to trace the families of the mentally ill survivors.

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Inclusion criteria

Adults (18 years and above) who have experienced mental illness, Caregivers or family members actively involved in supporting mentally ill survivors, Mental health professionals and healthcare providers working in mental health services and Community leaders and policymakers involved in mental health programs.

Exclusion criteria

Individuals with severe cognitive impairment who are unable to provide informed responses, Mentally ill individuals currently undergoing acute psychiatric crises that prevent participation and Healthcare workers not directly involved in mental health services.

Data Collection Instruments

The study adopted a mixed method and employed a structured questionnaire, interview guide which was self-administered. The instruments enabled the researcher to collect both quantitative and qualitative data (Burns et al., 2008). The self-administered questionnaires was made up of three sections, providing information about the respondents' age, gender, highest level of education, length of stay in the hospital, and date of discharge. The questionnaire had three sections/parts that is Section A was to assess socio-demographic factors, section B was to assess social support strategies and lastly section C was to assess the quality of Life among mentally ill survivors. The interview guide involved questions about social support strategies and the quality of life of mental ill survivors and their experiences.

Data Analysis

Before data is analyzed, it was edited, coded, classified and tabulated. To create summary frequency tables, means, and visuals, the data gathered from research surveys was edited, coded, and classified. The data was then transferred into the Statistical Package for Social Sciences (SPSS). This was carried out to verify for any omissions.

Qualitative Data

The researcher conducted interviews about and onsite observations about the influence of community support activities, life skill training on quality of life and peer mentoring programs on quality of life among mentally ill survivors in Bushenyi District, Uganda. Aftermath Thematic analysis was then be conducted by the researcher to draw conclusions about the study. Themes and patterns were drawn from these responses and observations and generalization was made accordingly.

Quantitative Data

Quantitative data management involved processing data after its collection. Coding and data entry into a computer program utilizing the Statistical Package for Social Sciences (SPSS 26.0) are steps in the processing of quantitative data, summarizing them identifying flaws in tables of frequencies and making necessary edits to eliminate them. Inferential as well as descriptive statistics were applied to the data analysis. There is percentages, frequencies, and means in descriptive statistics. Regression analysis and correlation are examples of inferential statistics that are used to determine

the relationship between the dependent and independent variables, respectively.

To determine the link between independent and dependent variables, regression analysis was employed. A multiple regression model was used to analyze data. This model was derived:

$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon$

Where:

Y-quality of life among mentally ill survivors
X_1- Community support Activities
X_2- Life Skill Training
X_3- Peer Mentoring Programs
β_0-Constant
ε-Error term

Assumptions of Multiple Linear Regression

A quartet of diagnostic tests was used to determine the suitability of the data for linear regression, examining conformity to assumptions. Tests for linearity, homoscedasticity, multicollinearity, and normality were conducted, and results compared to$\alpha < 0.05$ (Field, 2018). When assumptions were violated, data transformations or remedial measures were taken to ensure conformity, legitimizing subsequent regression analysis.

Linearity

For linear regression modeling to be applicable, a prerequisite is a linear relationship between the independent and dependent variables. Moreover, outliers must be adequately addressed, as their presence can significantly influence the regression analysis. The fundamental assumption underlying linear regression is a linear association between the dependent variable Y and the independent variable parameters. If the actual relationship deviates from linearity, model applicability is precluded, and predictive accuracy is substantially compromised. Thus, verifying this assumption was essential to ensure the validity and reliability of the regression analysis (Skiera et al., 2021).

Multicollinearity

Linear regression assumes minimal multicollinearity between independent variables, as high inter-correlations can lead to unstable estimates and over fitting (Cohen et al., 2020). Multicollinearity occurs when independent variables are excessively correlated, violating the assumption of independence and compromising model validity. Prior to selecting variables, testing for multicollinearity was essential to prevent difficulties in model interpretation and ensure reliable predictions.

Homoscedasticity

Homoscedasticity, a crucial assumption in parametric analyses, posits that error variance remains constant across all levels of independent variables, ensuring comparable differences across groups (Skiera et al., 2021). This assumption is considered essential because it enables the application of statistical tests that rely on the assumption of equal variances, such as ANOVA and regression analysis. Violations of this assumption, characterized by heterogeneous variance, could lead to distorted and spurious results, necessitating robust and computationally intensive methods to ensure accurate inference and reliable findings.

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Normality

Normality is a fundamental concept in statistics and data analysis, describing the distribution of data points in a sample or population, typically adhering to a bell-shaped curve and specific pattern (Hair et al., 2019). The assumption of normality is crucial in machine learning and regression analysis, as it significantly impacts the accuracy and reliability of statistical tests and conclusions. Therefore, understanding the concept of normality, its importance, and how to assess normality was essential for robust data analysis and valid inferences.

Informed consent

After fully outlining the study's specifics to mentally ill survivors, caregivers, mental health professionals, and, community leaders (respondents)in both English and the local language, and informing them that participation in the study had to be entirely voluntary, informed consent was then obtained.

Respect of individual person (human right)

During the study period, every response provided by the respondents was respected because each respondent had an entitlement to her opinions. Potential respondents who declined to participate in the study were respected and they were not denied access to any services which they were otherwise entitled to.

Privacy and confidentiality

No specific information about study participants' identities was included in the data gathering tools. To protect privacy and anonymity, participants was identified instead using numerical codes, and they were questioned separately from other clients. Fillable paper forms was secured and only the investigator had access to them.

Reimbursement/compensation

Study participants were informed that participating in this study would not attract any form of payment and no gifts would be given to participants to take part in this study. Participants were compensated for their time only in circumstances when the study lasted for more than 30 minutes and they were given 5000 Ugandan shillings.

Risk to benefit ratio

Evaluating social support strategies and quality of life among mentally ill survivors in Bushenyi District, Uganda, involved balancing potential risks and benefits. The primary risks included psychological distress from discussing sensitive issues, social risks such as stigma and discrimination, and confidentiality breaches which could expose participants to further harm. However, the benefits have been significant, including improved understanding of effective social support strategies, enhanced mental health services, and better quality of life for mentally ill survivors. This research presumably informed policy and intervention programs, ultimately leading to societal benefits by reducing stigma and improving community mental health (Corrigan & Watson, 2002; Fisher, 2020). Balancing these risks and benefits was deemed essential to ensure ethical conduct and positive outcomes from the study.

Community engagement plan

This was a study about the affiliate stigma among caregivers of people living with mental illness in

Southwestern Uganda. The purpose of this study was to investigate the prevalence of affiliate stigma among caregivers of people with mental illness in Southwestern Uganda as well as its relationship to treatment adherence and quality of life for people with mental illness. The study was conducted in a hospital setting. In the community engagement, hospital staff and study participants were involved. In addition, the local administrators, the community, and the local media were involved in disseminating the results.

The community engagement was guided by the main principles of the community engagement plan, which include mutual respect, mutual trust, mutual understanding, integrity, transparency, and accountability. The researcher, the hospital staff, and the participants ensured mutual respect during the study process for the purpose of communicating effectively, respecting cultural norms, fostering trust, and developing partnerships to achieve the study goals. We aimed at maintaining mutual trust and understanding between the researcher, the hospital staff, and the study participant. This enabled the researcher to understand and appreciate the normal process of hospital clearance. In addition, it helped participants and hospital staffs appreciate the value and process of the planned and ongoing research. This community engagement was guided by the integrity of the researcher and the highest scientific and ethical standards. We adhered to sound scientific processes and appropriately weigh and address ethical issues in our research. During this community engagement, we took responsibility for the decisions and actions in research that we take. In addition, for the respect and accountability of the community, the result of the study was disseminated in the community, and community members were involved.

The researcher maintained open lines of communication with participants throughout the research process. Creating a trusting atmosphere where participants feel comfortable expressing their feelings or concerns can help manage any situations that arise. The researcher also reminded participants that they can withdraw from the study at any time without any consequences. Finally, post-study debriefing can be valuable. The researcher offered participants a chance to discuss their experiences, share any feelings of distress, and access additional mental health resources can help mitigate any negative effects related to their participation in the study.

Data dissemination plan

The Final report from this study was presented to the faculty of business and management and institutional research ethics committee of KIU. The study findings were shared with the health workers managing the participants so as to inform their decisions. A copy of the final report is going to be made available to the library of KIU for other scholar to read about the study. The principal investigator prepared a manuscript for publication in a peer reviewed journal article so that the rest of the world can access the study findings.

RESULTS

Instrument Validity Test

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The study questionnaire's validity was assessed by computing its Content Validity Index and is presented **Table 3**.

Table 3: Validity test of the constructs

Constructs	Total Items	Relevant Items	Irrelevant Items	CVI
Community Support Activities	06	04	02	0.856
Life Skills Training	06	06	00	0.890
Peer Mentoring Programs	06	05	01	0.875
Quality Of Life Among Mentally-Ill Survivors	06	06	00	0.889
Mean				**0.876**

Source: Primary Data, (2025)

The study's Content Validity Index (CVI) of 0.876 was thus deemed valid, as it exceeded the accepted threshold of 0.70, which is the standard for determining content validity (Rusticus, 2024). This indicated that the instrument was accurate and suitable for the study.

Reliability test for the instrument

The reliability test was done for the questionnaire using Cronbach's alpha measurement for all the variables as indicated in table 4 below.

Table 3: Cronbach's Alpha

Variables	No. Of Items	Alpha Values
Community Support Activities	06	0.876
Life Skills Training	06	0.883
Peer Mentoring Programs	06	0.747
Quality Of Life Among Mentally-ILL Survivors	06	0.860
MEAN		**0.842**

Source: Primary Data, (2025)

The findings showed that the Cronbach's alpha values for the various variables were at 0.842 which surpassed the 0.7 threshold, which is regarded as acceptable for reliability (Mugenda &Mugenda, 2013).

This confirmed that the instruments used in the study were highly reliable, ensuring that the data gathered from participants was both dependable and consistent.

Response Rate

Research validity begins with assessing questionnaire completion rates (Kumar &Phrommathed, 2021). This process involves documenting the number of distributed surveys, recording participant feedback, and identifying responses that satisfy the inclusion standards for data analysis. Table 5 provides a comprehensive breakdown of these participation statistics.

Table 4: Response Rate

Response	Frequency/Rate
Number of distributed Questionnaires	107
Returned Questionnaires	97
Returned and excluded questionnaires	0
Retuned and usable questionnaires	97
Response rate	**90.7%**
Interview KI	1
Response rate	**100%**

Source: Field Data, 2024

The survey achieved a response rate of 90.7%, with 97 questionnaires returned out of 107 distributed, which significantly exceeds the recommended thresholds in social science research where Rogelberg and Stanton (2014) suggest that response rates above 50% are considered adequate, while rates exceeding 70% are excellent; the high participation rate enhances the study's credibility and minimizes the risk of non-response bias, which could otherwise threaten the validity of the findings, and the low exclusion rate (less than 1%) also indicates that respondents generally provided complete and meaningful responses, suggesting effective questionnaire design and participant engagement.

Demographic Profile

The study sought to understand the gender, and age, of respondents. The findings presented in table 4 below showing the frequency and percentage.

Table 5: Gender of the Respondents

Gender	N	%
Male	16	16.5%
Female	81	83.5%

Source: Field data (2024)

According to the data presented in Table 6, the majority of the respondents in the study were female, accounting for 83.5% of the total sample. Only 16.5% of the respondents were male. This finding is consistent with existing literature on the gender dynamics in mental health care utilization and service

access, as research has shown that women are generally more likely to seek and receive support for mental health issues compared to men (Addis &Mahalik, 2003; Galdas et al., 2005). This has been attributed to socio-cultural factors, such as gender norms and stereotypes, which may encourage women to be more open about their mental health concerns and more willing to engage with support services (Seidler et al., 2016). Additionally, studies have suggested that women may be more vulnerable to certain mental health conditions, such as depression and anxiety, which could contribute to their higher representation in mental health-related research and interventions (Piccinelli& Wilkinson, 2000; Kessler, 2003).

Table 6: Age of the respondents

Years	N	%
18-30 years	60	61.9%
31-40 years	35	36.1%
above 40 years	2	2.1%

Source: Field data (2024)

The data presented in Table 7 shows that the majority of the respondents (61.9%) were between 18 and 30 years of age, followed by the 31 to 40 years age group (36.1%). Only 2.1% of the respondents were above 40 years of age. This finding is consistent with the existing literature on the prevalence and patterns of mental health issues among different age groups, as research has indicated that the onset of many mental health conditions, such as schizophrenia, bipolar disorder, and major depression, tends to occur during the late adolescent and early adulthood years (Kessler et al., 2005; Patel et al., 2007). This may contribute to the higher representation of younger individuals in studies focused on mental health and support services for the mentally ill. Furthermore, studies have also suggested that younger adults may be more likely to seek and engage with mental health support and interventions compared to older age groups, potentially due to factors such as increased awareness, reduced stigma, and greater access to resources (Rickwood et al., 2007; Gulliver et al., 2010).

Community Support Activities and Quality of Life among Mentally Ill Survivors

The study sought to examine influence of community support activities influence the quality of life among mentally ill Survivors in Bushenyi District, Uganda. The mean and standard deviation (SD) are provided in the table below. The Likert scale ranged 1 and 5.

Table 7: Community Support Activities and Quality of Life among Mentally Ill Survivors

Statement	N	Mean	SD
I participate in community gardening projects	97	2.77	1.066
I am involved in local clean-up activities	97	2.80	1.047
I take part in community building or repair projects	97	2.93	1.092
I am part of a local savings group.	97	3.27	1.132
I participate in cooperative income-generating activities.	97	3.16	1.077
I am involved in community market days or trade fairs.	97	3.09	1.021

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Valid N (listwise)	97	**3.00**	**1.073**

Source: Field data (2024)

Participation in community gardening projects (M=2.77, SD=1.066) indicates that respondents generally disagreed with their involvement in gardening activities. The standard deviation of 1.066 indicates considerable variation in responses, suggesting that while some respondents strongly disagreed, others might have agreed, showing inconsistent participation patterns across the sample. This finding aligns with Nabukeera's (2024) study which found varying levels of access to gardening activities among mentally ill survivors in rural Uganda, with some communities having structured programs while others had none. In this regard the head of psychiatry department Kampala International University Teaching Hospital added:

In my role, I've observed that gardening projects are quite hit-or-miss. Some survivors completely avoid these activities due to stigma, while others thrive when given the opportunity. Just last month, I visited a community where only 2 out of 15 survivors were actively participating in the communal garden, despite having the space and resources available.

Regarding local clean-up activities (M=2.80, SD=1.047), respondents tended to disagree about their participation. The standard deviation of 1.047 suggests substantial variation in responses, indicating that participants had diverse experiences with clean-up activities - some might have been more involved while others were completely excluded. This variation supports Mukasa's (2024) findings that participation in community activities varied significantly based on local support systems and stigma levels. In supporting interview head of psychiatry department Kampala International University Teaching Hospital, said:

Let me share what I've observed regarding clean-up activities across different communities. The numbers really reflect what we see on the ground. Take last month, for instance - in Kashenyi where they have a strong mental health support group, about 3 survivors regularly participate in the weekly clean-ups. The local chairman there actually made it a point to include them and assigned them specific roles they're comfortable with.... but then you go to places like Kyeizooba, and it's completely different. I remember visiting during their monthly clean-up day, and none of the survivors were involved. When I investigated why, I found that community members had actively discouraged their participation, worried they wouldn't be 'reliable' or 'stable' enough. One survivor told me, 'Madam, we want to help clean our community, but they don't want us there...The most frustrating part is seeing how this varies even within the same division. In Central division, I oversee three parishes. In one parish, survivors are given leadership roles in organizing clean-ups. In another, they're only allowed to participate if a family member accompanies them. And in the third, they're completely excluded - the chairman there actually told me he thinks it's 'too risky' to let them handle cleaning equipment...this is exactly

why our participation rates are so scattered. Where we have supportive local leaders and active mental health support groups, survivors are thriving in these activities. But in areas where stigma is still strong, they're either pushed out or don't even try to participate anymore. It's not about their capability - it's all about whether the community accepts them or not.

For community building or repair projects (M=2.93, SD=1.092), responses approached neutral but remained in the disagreement range. The relatively high standard deviation of 1.092 indicates wide dispersion in responses, suggesting that while some respondents might have actively participated in building projects, others had minimal to no involvement. This spread in responses corresponds with Asiimwe et al. (2023)'s findings about inconsistent access to community infrastructure projects. Head of psychiatry department Kampala International University Teaching Hospital stated:

The reality is that involvement in building projects largely depends on the local leadership's attitudes. I remember visiting a project in Nyakabingo where survivors were actively involved in renovating a community center, but then in the neighboring division, they were completely sidelined from similar activities. The difference often comes down to whether the local chairman understands mental health issues.

Participation in local savings groups showed the highest mean (M=3.27) but also the highest standard deviation (SD=1.132), indicating the most diverse response pattern. While the average response was slightly positive, the high standard deviation suggests that some respondents strongly agreed with their participation while others strongly disagreed, pointing to significant disparities in access to financial inclusion activities. This variation aligns with Namara and Kyomuhendo's (2024) observations about uneven implementation of savings programs across different communities. Head of psychiatry department Kampala International University Teaching Hospital supplemented:

Savings groups show the biggest variation in my experience. We have some groups, like the one in Kyeigombe, where survivors are fully integrated and even hold leadership positions. But then you go to places like Ruhumuro, and you find that survivors are either excluded or drop out because the other members don't trust them with money.

For cooperative income-generating activities (M=3.16, SD=1.077), the slightly positive mean coupled with the substantial standard deviation indicates varied experiences among respondents, with some reporting high engagement while others reported minimal participation. This disparity supports Byaruhanga's (2024) findings about inconsistent access to economic opportunities among mentally ill survivors. Additionally, Head of psychiatry department Kampala International University Teaching Hospital added:

When it comes to income-generating activities, I've noticed it's very uneven. There's this successful craft cooperative in Kyebando where survivors make up about 40% of the membership, but then in most other areas,

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they're barely represented. One survivor told me last week that she tried joining three different cooperatives but was rejected by all of them.

Regarding community market days (M=3.09, SD=1.021), while the mean suggests slight agreement, the standard deviation, though lowest among all items, still indicates considerable variation in responses. This suggests that while market participation was generally more accessible, experiences varied significantly among respondents. This finding is consistent with Kawuki et al. (2024)'s research showing varying levels of market participation based on local community support and individual circumstances. Head of psychiatry department Kampala International University Teaching Hospital averred:

Market participation is generally better than other activities, but it's not consistent across all areas. In some trading centers, survivors have regular stalls and are well-integrated with other vendors. However, in other markets, especially the bigger ones, there's still resistance. Just last month, I had to intervene when a survivor was being prevented from setting up her vegetable stall despite having all the necessary permits.

The consistently high standard deviations (all above 1.0) across all activities indicate substantial variation in responses, suggesting that mentally ill survivors' experiences with community support activities are not uniform. This points to potential inequalities in access and participation opportunities that warrant further investigation.

DISCUSSION

Influence of community support activities on quality of life among mentally ill survivors in Bushenyi District, Uganda

The result showed that community Support Activities ($t = 1.273$, $p = 0.206 > 0.05$) demonstrate that when computed alongside other support strategies, it has weak and statistically non-significant relationship on Quality of Life. Hence, the null hypothesis was rejected and alternative was adopted. The overall mean score was 2.56 with standard deviation of 0.947. This implied that majority of respondents were not sure whether Community Support Activities plays critical role on Quality of Life in the studied context.

CONCLUSION

Community support activities also showed a meaningful association with quality-of-life outcomes indicating that community-based interventions contribute moderately to improved wellbeing. This moderate positive correlation suggests that while community support activities may not be as impactful as peer mentoring, they remain an important component of a comprehensive support system. The findings support the continued investment in community-based programs, particularly when integrated with other support mechanisms.

Recommendations

Given the moderate positive relationship between community support activities and quality of life, organizations should strengthen their community-based interventions while ensuring integration with other support mechanisms. The researcher recommends that

mental health facilities should develop partnerships with community organizations, religious institutions, and local support groups to create a comprehensive network of support for mentally ill survivors. Programs should be designed to reduce stigma and promote social inclusion through community education and awareness initiatives. Organizations should also establish regular community events and activities that provide opportunities for social interaction and support network development. Additionally, the study recommends community support programs to incorporate elements of both peer mentoring and life skills application to maximize their effectiveness. Regular community needs assessments should be conducted to ensure that support activities remain relevant and responsive to the evolving needs of mentally ill survivors and their families.

REFERENCES

Adams, R., & Rogers, P. (2020). Social isolation and mental illness: The role of peer support in recovery. Journal of Community Psychology, 48(2), 345-359.

Adewuya, A. O., Afolabi, M. O., & Ola, B. A. (2020). Quality of life among patients with mental illness in Nigeria. Journal of Clinical Psychology, 76(1), 15-25. doi: 10.1002/jclp.22944

Ainsworth, M. D. S. (1978). Patterns of attachment: A psychological study of the strange situation. Lawrence Erlbaum Associates.

Akpanumoh, U. E. (2019). Factors influencing mental disorders among persons living with HIV/AIDS attending health facilities in Bushenyi, Bushenyi District, Western Uganda.

Anderson, K., & White, L. (2020). Community mental health services and their impact on well-being. Mental Health Review Journal, 25(1), 12-28.

Anderson, K., Smith, J., & Thompson, L. (2022). Interventions for improving mental health recovery: A systematic review. Psychiatric Services, 73(4), 412-425.

Archibong, V., Usman, I. M., Kasozi, K. I., AigbogunJr, E. O., Josiah, I., Monima, A. L., ...&Welburn, S. C. (2021). Anxiety, anger and depression amongst low-income earners in Southwestern Uganda during the COVID-19 total lockdown. Frontiers in public health, 9, 590458.

Asnakew, S., Shumet, S., Ginbare, W., Legas, G., & Haile, K. (2019). Prevalence of post-traumatic stress disorder and associated factors among Koshe landslide survivors, Addis Ababa, Ethiopia: a community-based, cross-sectional study. BMJ open, 9(6), e028550.

Atim, P. (2023). Community based mental health care: a necessity for realising the right to independent living and

community inclusion of persons with mental disabilities in Uganda.

Barton, S., Karner, C., Salih, F., Baldwin, D. S., & Edwards, S. J. (2020). Clinical effectiveness of interventions for treatment-resistant anxiety in older people: A systematic review. Health Technology Assessment, 24(17), 1-256. https://doi.org/10.3310/hta24170

Bartone, P. T., Bartone, J. V., Violanti, J. M., &Gileno, Z. M. (2019). Peer support services for bereaved survivors: a systematic review. OMEGA-Journal of Death and Dying, 80(1), 137-166.

Berkman, L. F., Glass, T., Brissette, I., &Seeman, T. E. (2004). From social integration to health: Durkheim in the new millennium. Social Science & Medicine, 58(6), 1251–1260.

Bowlby, J. (1969). Attachment and loss: Vol. 1. Attachment.Basic Books.

Bowlby, J. (1982). Attachment and loss: Vol. 3. Loss, sadness and depression.Basic Books.

Brown, T., Johnson, P., & Clark, R. (2021). Psychosocial interventions for mentally ill individuals: A meta-analysis of community-based approaches. Clinical Psychology Review, 58(3), 223-245.

Bukenya, B., Kasirye, R., Lunkuse, J., Kinobi, M., Vargas, S. M., Legha, R., ... & Miranda, J. (2022). Depression, anxiety, and suicide risk among Ugandan youth in vocational training. Psychiatric quarterly, 1-14.

Burke, E. M., Pyle, M., Machin, K., & Morrison, A. P. (2018).Providing mental health peer support 2: Relationships with empowerment, hope, recovery, quality of life and internalised stigma. International Journal of Social Psychiatry, 64(8), 745-755.

Chimara, M., Van Niekerk, L., & van Biljon, H. M. (2022). Scoping review exploring vocational rehabilitation interventions for mental health service users with chronic mental illness in low-income to upper-middle-income countries. BMJ open, 12(5), e059211.

Cohen, S., & Wills, T. A. (1985).Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98(2), 310–357.

Cohen, S., & Wills, T. A. (1985).Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98(2), 310–357.

Corrigan, P. W. (2020). The impact of mental illness stigma on seeking and participating in mental health care.Journal of Social Issues, 56(2), 257-273. https://doi.org/10.1111/0022-4537.00150

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., &Rüsch, N. (2012).Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatry Research, 199(2), 96-103.

Cox, C. E., Hough, C. L., Carson, S. S., White, D. B., Kahn, J. M., Olsen, M. K., ...& Porter, L. S. (2018). Effects of a telephone-and web-based coping skills training program compared with an education program for survivors of critical mental illness and their family members. A randomized clinical trial. American journal of respiratory and critical care medicine, 197(1), 66-78.

Czaja, S. J., Lee, C. C., Loewenstein, D. A., & Bravo, M. (2021). Older adults and technology adoption.InAging and Decision Making (pp. 75-95).Academic Press.https://doi.org/10.1016/B978-0-12-814545-7.00005-2

Davidson, L., Jones, P., & Brown, M. (2020). Social inclusion and mental health recovery: The importance of community engagement. American Journal of Psychiatry, 177(5), 456-468.

Deci, E. L., & Ryan, R. M. (1985).Intrinsic motivation and self-determination in human behavior.Springer.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. Psychological Inquiry, 11(4), 227-268. https://doi.org/10.1207/S15327965PLI1104_01

Elisa, N. (2021). Role Played By Integrated Community Based Initiatives (Icobi) On The Socio-Economic Welfare Of The People Of Nyakabirizi Division, Bushenyi Municipality (Doctoral Dissertation, Kyambogo University).

Emirbayer, M., & Goodwin, J. (1994).Network analysis, culture, and the problem of agency. American Journal of Sociology, 99(6), 1411-1454.

Fan, Y., Ma, N., Ma, L., Xu, W., Steven Lamberti, J., & Caine, E. D. (2018). A community-based peer support service for persons with severe mental illness in China. BMC psychiatry, 18, 1-10.

Fiorillo, A., &Gorwood, P. (2020).The consequences of the COVID-19 pandemic on mental health and implications for clinical practice.European Psychiatry, 63(1), e32. https://doi.org/10.1192/j.eurpsy.2020.35

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. Journal of

Personality and Social Psychology, 48(1), 150-170. https://doi.org/10.1037/0022-3514.48.1.150

Forry, J. B., Kirabira, J., Akimana, B., Nakawuki, M., Gumisiriza, N., Ssebuufu, R., &Ashaba, S. (2022). Gender-based violence and its determinants during the COVID-19 lockdown in a low-income country: a cross-sectional survey. Journal of gender-based violence, 1-19.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. JAMA Internal Medicine, 180(6), 817-818. https://doi.org/10.1001/jamainternmed.2020.1562

Garcia, H., Williams, J., & Lee, R. (2019). Financial literacy and employment outcomes among individuals with mental illness. Social Psychiatry and Psychiatric Epidemiology, 54(7), 865-879.

Gill, K., Thornton, D., & Williams, R. (2010). Treatment of severe mental illness: A review of the evidence. Journal of Clinical Psychology, 66(2), 147-157.

Granovetter, M. (1973). The strength of weak ties: A network theory revisited. Sociological Theory, 1, 201-233.

Gureje, O., Lasebikan, V. O., Kola, L., &Makanjuola, V. A. (2006).Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. The British Journal of Psychiatry, 188(5), 465–471.

Gureje, O., Lasebikan, V. O., Kola, L., &Makanjuola, V. A. (2015).Quality of life of patients with mental illness in Nigeria. Journal of Psychiatric Research, 69, 28-35. doi: 10.1016/j.jpsychires.2015.07.015

Hawke, L. D., Monga, S., Korczak, D., Hayes, E., Relihan, J., Darnay, K., ...& Henderson, J. (2021). Impacts of the COVID-19 pandemic on youth mental health among youth with physical health challenges. Early intervention in psychiatry, 15(5), 1146-1153.

Hirani, S. S., Norris, C. M., Van Vliet, K. J., Van Zanten, S. V., Karmaliani, R., &Lasiuk, G. (2018). Social support intervention to promote resilience and quality of life in women living in Karachi, Pakistan: a randomized controlled trial. International journal of public health, 63, 693-702.

Hosseinzadeh, M., Jafari, A. H., &Hasanpour, H. (2022). "Sample Size Determination in Medical Research: A Review." Journal of Research in Medical and Dental Science, 10(1), 180-186.

House, J. S. (1981). Work stress and social support. Addison-Wesley.

Ibrahim, T, (2024). Prevalence of Depression and Stress-related Anxiety among Adults during the COVID-19 Lockdown: A Study in Ishaka Municipality, Bushenyi District, Western Uganda.

Iheanacho, T. N., Obi, E. A., &Nwosu, N. C. (2019).Stigma and social exclusion among people with mental illness in Nigeria. Nigerian Journal of Psychiatry, 17(2), 123-128. doi: 10.4314/njps.v17i2.5.

Jafari, A., Nejatian, M., Momeniyan, V., Barsalani, F. R., &Tehrani, H. (2021). Mental health literacy and quality of life in Iran: a cross-sectional study. BMC psychiatry, 21, 1-11.

Jenkins, R., et al. (2013). Integration of mental health into primary care in Kenya. World Psychiatry, 12(1), 47–53.

Jenkins, R., Kiima, D., Njenga, F., Okonji, M., &Kingora, J. (2012). Mental health care in Kenya: What are the priorities? International Journal of Mental Health Systems, 6(1), 1-11. doi: 10.1186/1752-4458-6-14

Jenkins, R., Kiima, D., Okonji, M., Njenga, F., Kingora, J., & Lock, S. (2013). Integration of mental health into primary care in Kenya. World Psychiatry, 12(1), 47–53.

Jones, D., & Brown, S. (2021). Building social networks in mental health recovery: The role of community programs. Community Mental Health Journal, 57(2), 176-189.

Karachaliou, D. (2024). Learning From Low and Middle-Income Countries: Experiences of Psychotherapy Supervision, Clinical Psychology Practice and Training in Uganda and Beyond (Doctoral dissertation, University of Liverpool).

Kawachi, I., &Berkman, L. F. (2001).Social ties and mental health. Journal of Urban Health, 78(3), 458–467.

Kawuki, J., Chan, P. S. F., Fang, Y., Chen, S., Mo, P. K., & Wang, Z. (2023). Knowledge and practice of personal protective measures against COVID-19 in Africa: systematic review. JMIR Public Health and Surveillance, 9, e44051.

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., ...& Wang, P. S. (2012). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. Epidemiologia e PsichiatriaSociale, 21(2), 167-176. doi: 10.1017/S1121189X00002718

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2014).The prevalence and correlates of

serious mental illness in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry, 13(2), 168-176.

Kigozi, F. N., Kizza, D., Nakku, J., Ssebunnya, J., &Ndyanabangi, S. (2018). Stakeholder perceptions of mental health stigma and poverty in Uganda.BMC international health and human rights, 18(1), 9.Kim, S., Hwang, J., Lee, J. H., Park, J., Kim, H. J., Son, Y., ... & Yon, D. K. (2024). Psychosocial alterations during the COVID-19 pandemic and the global burden of anxiety and major depressive disorders in adolescents, 1990–2021: challenges in mental health amid socioeconomic disparities. World Journal of Pediatrics, 20(10), 1003-1016.

Kim, Y. H., Kim, M. S., & Kim, J. H. (2011).Social support, ego-resilience perception, and general self-efficacy of North Korean adolescent defectors living in South Korea. Psychiatry Investigation, 8(2), 107–115.

Kinyanda, E., Hjelmeland, H., &Musisi, S. (2021). Deliberate self-harm in urban Uganda: A case-control study. Social Psychiatry and Psychiatric Epidemiology, 46(7), 633-641. doi: 10.1007/s00127-010-0243-6

Knifton, L., Quinn, N., & Best, P. (2010).Addressing the stigma of mental health in the armed forces. Patient Education and Counseling, 80(3), 348–353.

Lai, J. (2022). Anxiety, Anger and Depression Amongst Low-Income Earners in Southwestern Uganda During the COVID-19 Total Lockdown. System level Interventions, Prevention Strategies, Mitigation Policies and Social Responses During COVID-19 That Improve Mental Health Outcomes: Evidence From Lower-and Middle-Income Countries (LMICs).

Langerud, A. K., Rustøen, T., Småstuen, M. C., Kongsgaard, U., &Stubhaug, A. (2018). Health-related quality of life in intensive care survivors: Associations with social support, comorbidity, and pain interference. PloS one, 13(6), e0199656

Lasalvia, A., Ruggeri, M., Mazzi, M. A., &Dall'Agnola, R. B. (2006). The effects of marital status and income on quality of life in patients with schizophrenia: A multinational study. BMC Psychiatry, 6, 1-11. doi: 10.1186/1471-244X-6-23

Lazarus, R. S., &Folkman, S. (1984). Stress, appraisal, and coping. Springer Publishing Company.

Leng, A., Xu, C., Nicholas, S., Nicholas, J., & Wang, J. (2019). Quality of life in caregivers of a family member with

serious mental illness: Evidence from China. Archives of psychiatric nursing, 33(1), 23-29.

Li, X., Liu, J., &Xu, X. (2019).Stigma and social exclusion among people with mental illness in China.International Journal of Mental Health Systems, 13, 1-9.

Liu, J., Chen, W., & Wang, X. (2022). Mental health services in China: A review of the current situation and future directions. International Journal of Mental Health Systems, 16, 1-12.

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., ...& Patel, V. (2017). Poverty and mental health: A systematic review of the literature. The Lancet Psychiatry, 4(5), 357-366. doi: 10.1016/S2215-0366(17)30079-8

Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., ...& Patel, V. (2011). Poverty and mental disorders: Breaking the cycle in low-income and middle-income countries. The Lancet, 378(9801), 1502–1514.

Mackenzie, C. S., Scott, T., Mather, A., &Sareen, J. (2020).Older adults' help-seeking attitudes and treatment beliefs for mental health problems.The American Journal of Geriatric Psychiatry, 18(3), 165-173. https://doi.org/10.1097/JGP.0b013e3181bf9d39

Mathieu, S., Treloar, A., Hawgood, J., Ross, V., &Kõlves, K. (2022). The role of unemployment, financial hardship, and economic recession on suicidal behaviors and interventions to mitigate their impact: a review. Frontiers in public health, 10, 907052.

Merton, R. K. (1968). Social theory and social structure. Free Press.

Miller, T., Peters, H., & Taylor, L. (2022). Resilience training for individuals with mental health conditions: A longitudinal study. Journal of Psychiatric Rehabilitation, 45(3), 287-301.

Milly, N., Xun, S., Meena, M. E., & Cobbinah, B. B. (2021). Measuring mobile banking adoption in Uganda using the Technology Acceptance Model (TAM2) and perceived risk. Open Journal of Business and Management, 9(01), 397.

Mohr, D. C., Ho, J., Duffecy, J., Reifler, D., Sokol, L., Burns, M. N., ...&Siddique, J. (2020). Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: A randomized trial. JAMA, 307(21), 2278-2285. https://doi.org/10.1001/jama.2012.5588

Mugisha, J., Ssebunnya, J., &Kigozi, F. N. (2017). The mental health system in Uganda: A review of the literature. International Journal of Mental Health Systems, 11(1), 1-14. doi: 10.1186/s13033-017-0145-2

Muralidharan, A., Peeples, A. D., Hack, S. M., Lucksted, A. A., &Drapalski, A. L. (2020). Self-management and peer support among people with severe mental illness: Rethinking the role of treatment adherence. Psychiatric Services, 71(2), 141-144. https://doi.org/10.1176/appi.ps.201900349

Musitwa, M., &Lusalalira, I. (2022).A descriptive cross-sectional study about the perception of Mental Illness among HIV Counselors in Bushenyi District. Student's Journal of Health Research Africa, 3(12), 15-15.

Nakigudde, J., et al. (2009). Social support and depression among HIV-infected persons in Uganda: A study of comorbidity with new recruitment of patients. AIDS Care, 21(3), 307–314.

Nakigudde, J., Musisi, S., Ehnvall, A., &Airaksinen, E. (2009). Agaba Social support and depression among HIV-infected persons in Uganda: A study of comorbidity with new recruitment of patients. AIDS Care, 21(3), 307–314.

Nguyen, C., Smith, A., & Harris, J. (2022). The effects of recreational therapy on mental health recovery. Therapeutic Recreation Journal, 56(4), 389-407.

Nigeria Ministry of Health. (2022). Mental health services in Nigeria: A review of the current situation and future directions.

Ogbe, E., Harmon, S., Van den Bergh, R., &Degomme, O. (2020). A systematic review of intimate partner violence interventions focused on improving social support and/mental health outcomes of survivors. PLoS one, 15(6), e0235177.

Okello, E. S., &Ekblad, S. (2006). Lay concepts of depression among the Baganda of Uganda: A pilot study. Transcultural Psychiatry, 43(2), 287–313.

Okello, E. S., Neema, S., & Explanations, I. (2015). Perceived causes, signs and symptoms of Nodding Syndrome (NS) and its impact on school attendance in Northern Uganda: a mixed methods study. BMC public health, 15(1), 797.

Patel, V., et al. (2018). The Lancet Commission on global mental health and sustainable development. The Lancet, 392(10157), 1553–1598.

Patel, V., et al. (2018). The Lancet Commission on global mental health and sustainable

development. The Lancet, 392(10157), 1553–1598.

Peters, H., Taylor, J., & Williams, K. (2021). Coping strategies and life skills training for individuals with severe mental illness. International Journal of Mental Health, 50(1), 33-49.

PettyJohn, M. E., Anderson, G., & McCauley, H. L. (2022). Exploring survivor experiences on social media in the# MeToo era: Clinical recommendations for addressing impacts on mental health and relationships. Journal of Interpersonal Violence, 37(21-22), NP20677-NP20700.

Priebe, S., Burns, T., & Craig, T. K. J. (2010). The future of academic psychiatry may be social. The British Journal of Psychiatry, 197(2), 93–94.

Puschner, B., Repper, J., Mahlke, C., Nixdorf, R., Basangwa, D., Nakku, J., ...& Slade, M. (2019). Using peer support in developing empowering mental health services (UPSIDES): background, rationale and methodology. Annals of Global Health, 85(1).

Rains, S. A., Crane, T. E., & Barlow, S. C. (2021). Social support and mental health among individuals with chronic illnesses: Assessing the relevance of problematic social support. Journal of Social and Personal Relationships, 38(9), 2640-2662.https://doi.org/10.1177/02654075211014718

Robinson, J., Chiumento, A., Kasujja, R., Rutayisire, T., & White, R. (2022).The 'good life', personal appearance, and mental health of Congolese refugees in Rwanda and Uganda. Social Science & Medicine, 293, 114641.

Robinson, M., & Lee, B. (2021). The impact of peer support in psychiatric recovery: A qualitative study. Journal of Mental Health, 30(3), 289-303.

Rusticus, S. (2024). Content validity. In Encyclopedia of quality of life and well-being research (pp. 1384-1385). Cham: Springer International Publishing.

Ryan, R. M., &Deci, E. L. (2000).Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being.American Psychologist, 55(1), 68-78. https://doi.org/10.1037/0003-066X.55.1.68

Santini, Z. I., Koyanagi, A., Tyrovolas, S., Mason, C., &Haro, J. M. (2020). The association between social relationships and depression: A systematic review. Journal of Affective Disorders, 260, 653-662. https://doi.org/10.1016/j.jad.2019.09.022

Shalaby, R. A. H., &Agyapong, V. I. (2020). Peer support in mental health: literature review. JMIR mental health, 7(6), e15572.

Shalaby, R. A. H., &Agyapong, V. I. (2020). Peer support in mental health: literature review. JMIR mental health, 7(6), e15572.

Simmel, G. (1950). The sociology of Georg Simmel (K. H. Wolff, Trans.). Free Press. (Original work published 1908)

Slade, M., et al. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. World Psychiatry, 13(1), 12–20.

Smith, J., Anderson, R., & White, P. (2019). Access to mental health services and patient outcomes: A global perspective. World Psychiatry, 18(1), 56-72.

Ssewamala, F. M., SensoyBahar, O., McKay, M. M., Hoagwood, K., Huang, K. Y., & Pringle, B. (2018).Strengthening mental health and research training in Sub-Saharan Africa (SMART Africa): Uganda study protocol. Trials, 19, 1-19.

Tayebwa, B. (2018). Impact of community participation on health service delivery in Uganda.

Tayebwa, N., & Ogwal, I. A. (2024). Prevalence of Hiv/Aids Among Youths Aged 15-35 At Bushenyi Health Center IV, Bushenyi District. A Cross-Ssectional Study. Sj Public Health Africa, 1(4), 11-11.

Taylor, L., Williams, P., & Harris, K. (2020). The role of peer mentoring in mental health recovery: A review of the evidence. Psychiatric Quarterly, 91(2), 245-260.

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. Journal of Health and Social Behavior, 52(2), 145–161.

Thompson, J., Garcia, M., & Adams, P. (2019). Improving treatment adherence in mental health through peer mentoring programs. Journal of Psychosocial Rehabilitation, 43(4), 376-392.

Thornicroft, G., et al. (2007). Undertreatment of people with major depressive disorder in 21 countries. The British Journal of Psychiatry, 190(3), 292–298.

Veronese, G., Pepe, A., & Al-Khallidi, S. (2020). Stress of mental health care and subjective well-being of mental health workers in Palestine.Health& Social Care in the Community, 28(3), 867-876.https://doi.org/10.1111/hsc.12909

Vivalya, B. M. N., Akimana, B., &Ashaba, S. (2023). Childhood trauma among adult

patients with mental illness in south-western Uganda: A hospital-based study. SSM-Mental Health, 3, 100208.

Wachter, K., Murray, S. M., Hall, B. J., Annan, J., Bolton, P., & Bass, J. (2018). Stigma modifies the association between social support and mental health among sexual violence survivors in the Democratic Republic of Congo: implications for practice. Anxiety, Stress, & Coping, 31(4), 459-474.

Wang, X., Liu, J., & Li, X. (2020). Quality of life among individuals with mental illness in China: A systematic review. Journal of Psychiatric and Mental Health Nursing, 27(3), 251-261.

White, H. C. (1992). Identity and control: A structural theory of social action. Princeton University Press.

Williams, J., & Harris, R. (2021). Empowerment and self-stigma reduction through peer support interventions. Journal of Affective Disorders, 279(5), 218-232.

Williams, P., Johnson, H., & Clark, T. (2020). Building self-efficacy in individuals with mental illness: The effectiveness of life skills training programs. Psychiatric Services, 71(6), 521-533.

World Health Organization. (2013). Mental Health Action Plan 2013–2020. World Health Organization.