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## Effect of participation in informal social activities and long-term inpatients' mental health outcomes at Panzi hospital, DR Congo

Ntinu Mutama KABESHA, Violet SIMIYU and Mary MUTISYA

### ABSTRACT

The study examines the impact of participating in Informal Social Activities (ISA) of long-term inpatients and Mental Health Outcomes (MHO) at Panzi Hospital, DR Congo. A mixed-methods approach with a parallel convergent research design was utilized, combining standardized tools such as the subjective well-being index, the Kessler psychological distress scale, and Key informant interviews. The results highlight a dual crisis where economic hardship and illness lead to prolonged hospital stays and a lack of effective psychosocial support. Analysis indicates that participation in ISA has no significant effect on improving MHO (distress or well-being:  $ISA \rightarrow Distress \beta = -0.24, p = 0.355, f^2 = 0.062$  for distress and  $ISA \rightarrow WHO-5 \beta = -0.138, p = 0.594, F^2 = 0.019$  for well-being). The ineffective ISA participation demonstrates that the quality of communal life was too poor to generate the healing benefits that a genuinely Ubuntu-informed community (structured, reciprocal, dignified) would be expected to promote. Relationships must be meaningful, reciprocal, and nourishing to the communal fabric (quality and meaning rather than mere participation). Addressing Long-term Inpatients' MHO requires integrated policies that tackle both financial protection and implementation of structured therapeutic or recreational mental health activities grounded in the ubuntu perspective within healthcare settings

**KEY TERMS:** informal social activities, mental health outcomes, Medical Social Work,

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## INTRODUCTION

In times of crisis, such as bereavement or illness, social activities play an important role. In the absence of structured recreational activities or planned social interventions, one might think about the effects of spontaneous exchanges, laughter, spontaneous games, religious gathering (singing, prayers, meditation) or any other form of inventiveness from patients in healthcare facilities. This is in the absence of any structured framework. In this context, mental health issues represent a challenge for support networks or local sources of resilience, such as *chinyabuguma* assistance, and other networks from the Ubuntu perspective. Ubuntu values bring people together to experience mutual support in critical moments of life. In the hospital context, for example, we see sporadic groups of games, religious gatherings or spontaneous group discussions, all without the intervention of professionals. But the big question remains: to what extent do these activities impact long-term inpatients' mental health outcomes? This study answers this question from an Ubuntu perspective.

## BACKGROUND

The impact of poor mental health (MH) on social cohesion, economic loss, early mortality, and the national cost on human well-being has made it a significant issue in low- and middle-income countries (LMICs) (Ngamaba et al., 2024). MH weighs heavily on many aspects of African families, especially in many failed states. It is a cumbersome burden to support while African countries face other challenges. In the context of hospital long stay, while dealing with physical diseases, MH issues weigh heavily on patients and their families. Already weakened by violence, armed conflicts, and poverty, which even affect the quality and access to primary health care. This subject is of particular interest, especially when we know that during the period, the Eastern region of the Democratic Republic of Congo (DRC) was under siege by the rebel groups of the Alliance Fleuve Congo (AFC) and the Movement of 23rd March (M23). From an Ubuntu perspective, individuals, in their vulnerability, can coalesce and transform weakness into transformative energies through local resources and skills.

In the context of mental health (MH), various studies have already been conducted, demonstrating, for example, the positive impact of religious gatherings (Gqibitole, 2021; Awe, 2022), participation in Informal Social Activities (ISA), or Culturally-Grounded Activities (CGA) (Makoae et al., 2019; Musyimi, 2020; Petersen et al., 2021) on mental health outcomes (MHO). Few studies have explored the influence of ISA on MHO within hospital settings without structured social interventions. Given the effects of prolonged hospital stays on MH, social activities can help rebuild connections, restore identity and dignity, or even reassign roles to long-term patients (LTPs). Beyond symptom reduction, it involves recreating an interconnected, resilient, and future-oriented self within a restored community. This represents healing by and for the "we," which is the core of Ubuntu. This study aims to analyze the effect of participating in ISA among LTPs during crises, such as war conflicts in the Eastern region of DRC, and their impact on MHO.

## LITERATURE REVIEW

Long-term hospital stays combine with medication and social isolation; particularly low social support can be tricky for the patient. ISA has garnered attention among African scholars. Scholars agree that engagement in informal gatherings, community groups, sewing circles, religious fellowships, and CGA impacts LTPs' MHO or patients in long-term health conditions. ISA is viewed as a shield against loneliness, stigma and rejection. The scholars agree that the ISA provides a safe space for patients to share their challenges with confidence and without fear of judgment. Thus, group-based informal activities helped to rebuild connections fractured by an HIV diagnosis, immediately combating loneliness and its effects (Adewuya, 2018; Makoae et al., 2019). The therapeutic value of CGA, as ISA rooted in indigenous cultures and its benefits on MHO, has been highlighted by many African scholars. For instance, Petersen et al. (2021) find that "stokvels" or rotating saving and social clubs) for women with high pressure are saved for both financial empowerment and social psychosocial support strategies. Similarly, Musyimi (2020) in Kenya found that integrating traditional storytelling and dance in care for patients with chronic MH led to improvements in mood, social interactions, and life satisfaction. Findings highlighted the benefits of ISA in emotional expression, rebuilding collective resilience, cultural continuity and human connections, which are components of the African Ubuntu perspective. As ISA, religious and spiritual gatherings play a significant role in MHO. Studies highlight attending church gatherings, prayer groups and faith-based fellowships as crucial psychosocial support for improving positive MHO. For example, a study done in Nigeria by Awe (2022) on diabetic patients found that regular involvement in church activities was a stronger predictor of positive MHO. Participants reported that the fellowships offer hope, meaning and cognitive framework for coping with the burdens of diseases. In accordance, Gqibitole (2021) observed that informal prayer cycles formed a first line of psychological defense for many elderly patients with chronic diseases, offering comfort and reducing the prevalence of anxiety and depressive symptoms. While existing literature has an overwhelming positive impact, there are complexities in analyzing African values and their impact on MHO.

Alexandre et al., (2025) found that musicotherapy programs are associated with significant improvement of MH symptoms for SVS in DRC. But we notice that this is a structured and organized program, different to ISA. The studies listed above provide scientific evidence that the social context in which ISA occurs is fundamental to long-term outcomes, thus validating the observation that even "messy" but accepted activities are inherently therapeutic in Ubuntu culture. This emphasizes the quality and nature of IAS and participation as crucial. There are still gaps in terms of geographical area, methodology and study population. This study addresses the gaps by assessing the positive and negative dimensions of MHO, secondly by focusing on hospital settings, especially on LTPs at Panzi Hospital, in DRC region effected by war conflict, sexual violence and poverty. (*Chinyabungu is a concept derived from the Shie tribe, a majority people in eastern DRC, that refers to solidarity or mutual aid within a group.*)

## THEORETICAL FRAMEWORK

In a healthcare context, Ubuntu represents a pillar of resilience, human dignity and socio-cultural values. This theory offers both a trigger and a challenge of self-affirmation, as a being to assert one's existence (Mugumbate & Chereni, 2020; Tusasiirwe, 2023; Kagola & Abur, 2023). In the logic of decolonizing mental health practices, the implementation of CGA and religious practices or spiritual values is an essential asset in promoting WHO-5 and reducing K10 among hospitalized LTPs. MH issues can be overwhelming through sharing, mutual aid, spiritual prayer and songs and stories. Patients' MHO are not isolated states but are built through integration activities and a sense of community. So, social activities participation is a process of re-humanizing and rebuilding Ubuntu's identity. However, it is obvious to recognize that Ubuntu reflects divergences in values, sometimes difficult to define the limits/contours. Thus, in the face of this challenge, the study turned into ecological theory. The latter structures society into 5 levels of analysis (Teater, 2014). In this study, analyses are situated at the micro-organization level, Panzi Hospital, while recognizing the interdependence of the latter with other broader dimensions of society. In essence, Ubuntu offered the framework to interpret the study's findings. ISA, as a variable itself stems from an Ubuntu-informed perspective posit that an individual's MHO is inseparable from their social bonds and participation in community life, however informal. To produce a healing effect, participation in ISA must be genuine and meaningful, rather than mere participation. Therefore, social connection is important to promote quality communal life in the hospital, which can generate healing effects through genuinely Ubuntu-informed ISA. This supports the need to create a more humane and interconnected care environment.

## METHODOLOGY

### Research design

The study gathers understanding through a Convergent Parallel Mixed-Methods Design (Dawadi et al., 2021). It bridges the gap between measurable outcomes and human experience by holistically exploring quantifiable patterns and subjective experiences while triangulating information for validity. The study includes the simultaneous collection of qualitative and quantitative data for the identification of themes and patterns that reveal core concepts.

### Geographic study area

The study was done at Panzi General Referral Hospital (PGRH), Bukavu Town, South Kivu province, DR Congo. Bukavu is a multicultural ethnic city located in Eastern DR Congo. PGRH is a well-known hospital founded by Dr Denis Mukwege (Nobel Peace Prize) for his holistic approach to the survival of SVS. It serves as an internationally acclaimed excellence in rehabilitation care for wartime sexual violence survivors while serving residents. PGRH serves as a referral hospital in eastern DR Congo for the whole community of the area, although internationally, it deserves prizes for caring for SVS. **Target population:** The target population includes long-term inpatients (Particularly adult inpatients hospitalized for more than two weeks) and, secondly, patients' relatives and healthcare providers. The respondents were selected in three units of PGRH, including Gynaecology, Surgery, and Internal Medicine, ideal sites for long stays. To select participants, the study used a census method for LTPs, while it randomly selected patients' relatives and healthcare professionals. In sum, 80 people met the criteria and participated, including 60 long-term patients, 10 family relatives and 10 healthcare providers.

### Materials, procedures and participant selection

Data was collected by combining surveys and interviews. Surveys include standardized tools: subjective well-being index (WHO-5 index) and the Kessler psychological distress tests (K10) to assess LTPs' MHO, and questionnaires to assess perceived effects of participating in ISA. In addition, interviews were conducted with 10

healthcare providers, 10 patients' relatives and 10 LTPs using a semi-structured interview guide. This later provided deeper insights into personal experiences. The WHO-5 index uses 5 brief and non-intrusive items to assess the personal sense of subjective well-being. The K10 uses 10 items to assess non-specific signs of anxiety and depression symptoms. WHO-5 index and K10 stand out as two tools which deliver excellent validation outcomes (Lundquist & Rose, 2002). Instead of defining social activities, we have been guided by the field; participants were led to list all the existing and practiced ISA and the perceived effect on MHO through a Likert scale from 1 to 5. Three moments were taken into account in the data collection: the exploratory interviews, the in-depth interviews and the results validation stage through content analysis. Recruitment and selection were done in the field based on the criteria. Data were collected from May to July 2025 at PGRH, DR Congo. For LTPs to be selected, one must be hospitalized at Panzi Hospital for at least two weeks in one of the three selected units.

### Data Analysis Procedures

The study utilized the Structural Equation Model (SEM) to demonstrate the relationships between independent and dependent variables using Smart-PLS 4.1.4 and SPSS v 27. SEM is used to model complex relationships between directly and indirectly observed (latent) variables (Hair et al., 2021). It helped to check if two variables (dependent and independent) are truly connected or if the pattern may happen by chance. We proceeded by screening errors, modelling, calculating loadings factors, and producing descriptive and inferential statistics, as well as measuring correlations or regression among variables. Qualitative data from interviews were transcribed, then analyzed using thematic analysis by identifying key themes in six steps (Braun & Clarke, 2006).

## RESULTS

### Socioeconomic characteristics of respondents and contextual variability.

Respondents were predominantly female (56.7%), with an overrepresentation of surgery (48.3%), internal medicine (30%), and Gynaecology (21.7%). Married patients (48.3%) are the largest group, followed by singles (36.7%), with a few divorced/widowed or separated (16%), indicating a family-oriented stability. Most of the LTPs were former residents of Bukavu (68%) and have a medium to high level of education (51.7%), suggesting moderate literacy. The length of stay varies between 2 and 4 months, with an average stay of 43.3%. The main reason for prolonged stays is the inability to pay bills. Therefore, 58.3% of patients are detained for unpaid bills, significantly outnumbering those detained mainly for treatment (41.7%). This suggests that patients are detained due to financial hardship, as expressed by patients in the following statement:

*For three months now, I'm not receiving any treatment, but detained because of money (Patient 1, Internal Medicine ward).*

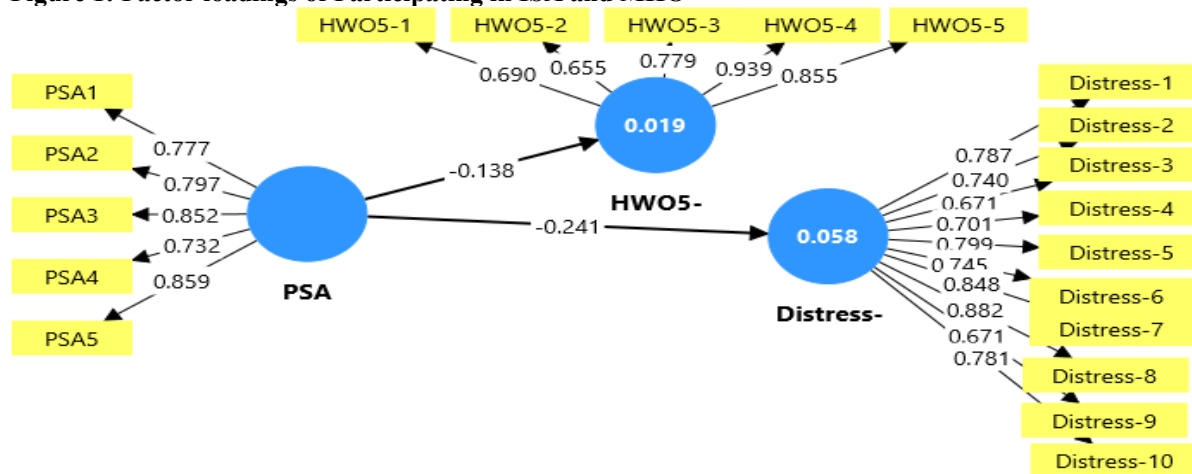
*My husband went to look for money, and I can't afford the bills since I gave birth 2 months ago. Consequently, I'm detained for medication bills (Patient 3, Gynaeco ward).*

These verbatim highlights a stark reality of poverty, serving as a major obstacle to healthcare access. The high rate of middle education levels without practical skills indicates limited economic opportunities. The mixture of a very long stay (43.3% for 2-4 months and 10% for above 11 months), combined with unpaid bills, raises serious ethical and human rights concerns and a dilemma for healthcare providers. The most affected population includes youth and the elderly, who are economically vulnerable, among them females (56.7%), which warrants attention regarding gender-specific vulnerabilities. This data raises a concern, most LTPs are long-term Bukavu's residents of Bukavu (72% born or living over 10 years), suggesting this issue affects the local settled population, not transient individuals. The high volume in Surgery (48.3%) highlights a significant demand for surgical services within the population. These results paint out systematic failures in the healthcare system and social protection, where environmental and economic disadvantages are leading to extended, involuntary hospital stays, rather than medical necessities.

### The effect of participating in informal social activities on the LTPs' MHO.

Through the SEM, this section examines the effects of Participation in Informal Social Activities (PSA) and MHO in terms of positive MHO (WHO-5) and negative MHO (K10).

Figure 1: Factor loadings of Participating in ISA and MHO



The factors loading for the PSA (Participating in social activities) are generally > 0.70, confirming a good construction and a strong contribution of the indicators to their constructions. Also, factor loadings for MHO, in terms of the K10 and WHO-5 are relatively > 0.70, except for the items Distress-3, Distress-9 and WHO5-1, WHO5-2 with factors loading <0.70, but with acceptable thresholds, indicating a good quality of the measurements and a strong contribution of the indicators to their constructs.

Table 1: Path coefficient and relationship PSA and MHO, SEM

Relation	Coefficient	Standard Deviation	T.stat.	P-value
PSA→ Distress	-0.241	0.261	0.924	0.355
PSA→ WHO-5	-0.138	0.259	0.534	0.594
HWO-5→ Distress	-0.217			
	<b>R-square</b>	<b>R<sup>2</sup> adjusted</b>	<b>F<sup>2</sup></b>	<b>Correlation Spearman's rho</b>
PSA→ Distress	0.058	0.042	0.062	-.163
PSA→ HWO-5	0.019	0.002	0.019	-.071

Analysis from the above findings suggests that there is a negative, non-significant and mediocre effect between PSA → Distress ( $\beta = -0.24$ ,  $p = 0.355$ ,  $f^2 = 0.062$ ), meanwhile, there is a negative, non-significant with a weak effect between PSA and WHO-5 ( $\beta = -0.138$ ,  $p = 0.594$  and  $F^2 = 0.019$ ). Indicating, contrary to what one might imagine, participation in informal social activities showed no significant effect on MHO, in terms of psychological distress or subjective well-being. In fact, participation only has an effect if the quality of the commitment and the meaning given to it (structural and organized) are probably more important than mere participation. At PGRH, the result does not mean that PSA are useless nor don't exist, but that their current nature has not had a measurable impact. More explanation was found in qualitative data, as summarized below in some extracts from LTP and Healthcare

providers:

*Here, it is worse than a prison; nothing can distract you, except for a part religious activity. People sing and pray every time here; it is the only thing which you can engage in. Unfortunately, these religious activities seem a disorder because they are played at any time, people don't wonder if they sleep or not, in pain or not [...].*

*There are no planned MH activities here; patients distract themselves with what they want, but I think that if there could be some structured activities, they could help them cope better with distress. There is a need for integrating all patients into recreational activities [...].*

From interviews, participants recognized that social activities provide comfort, but they rely on spiritual or religious activities only. Certain social activities are practiced in a freeway, including singing, exchanging stories (that can cause smiles or laughter), regular early morning dancing, prayer, and listening to the Lord's word. LPTs reported that these activities are largely spontaneous and unstructured (except organized worship sessions early morning and Sunday afternoon), permitting participation from any individual at any time. Major ideas from interviews in accordance with quantitative data emphasize the informal initiative and are summarized in the table below.

**Table 2: Prolonged hospitalization, PSA and MHO**

<i>Dominant's themes</i>	<i>Major ideas</i>	<i>Psychological effects</i>
Reliance on spirituality, and the absence of distractive activities.	Prayers and worship provide hope, joy, and healing.	Spiritual comfort, reduce anxiety, bring hope
Beneficial Effects	Distraction, stress reduction, and community feelings	Activities provide moral comfort. Sense of belonging
Structural Gaps	Few organized activities	No recreational programs, idleness,
Informal Initiatives	Creativity (do-it-yourself), distractions	Games (cards, checkers), crafts, and worship.
Urgent Needs	Literacy programs, therapeutic workshops, and Income-Generating Activities.	Need for something to keep patients busy

In terms of gender, married patients (female) were more involved in existing social activities, especially in religious gatherings and spontaneous discussions due to their social support networks (e.g., presence of the spouse) and their curiosity or mind opened ability. Thus, mere participation in ISA has no direct significant effects on WHO-5 nor on Distress. Although the immediate effects like comfort, hope, and a feeling of belonging, are provided in participating, in fact, the effects are measured in the short term (short-lived). In addition, most often, ISA rely on spiritual activities. Other activities such as games and spontaneous discussion are often sporadic and almost non-existent.

**Table 3: Reliability and validity**

	Cronbach's alpha	Composite reliability (rho_a)	Composite reliability (rho_c)	Average variance extracted (AVE)
Distress	0.927	0.998	0.934	0.586
WHO-5	0.882	0.954	0.891	0.625
PSA	0.873	0.916	0.902	0.648

Cronbach’s alpha for variables was greater than 0.8, indicating excellent validity. This confirms that the model measured what it is supposed to measure. In addition, for the reliability of the composite (rh c), the values were greater than 0.7, confirming excellent reliability. The values of Composite reliability are closer to 1, acceptable. For the AVE, all values are greater than 0.5, indicating that each construct explains more than half of the variance of its indicators, which is a good sign of convergent validity.

**Table 4: Model fit**

	<i>Saturated Model</i>	<i>Estimated Model</i>
SRMR	0.105	0.131
d_ ULS	2.334	3.612
d_ G	1.369	1.384
Chi-square	359.469	363.435
NFI	0.633	0.629

The fit of the model is the smallest of all, indicating that it distorts the reality of the data. Thus, the supposed relationship between variables does not optimally measure the reality of observed covariances. The adjustment indices all converge to indicate that the overall structural model has a poor fit to the collected data. Indeed, respondents' viewpoint was based on sentimental judgment, which can affect the quality of the model, and also, N was small. Nevertheless, data from interviews facilitated interpretation and strongly helped in the interpretation of quantitative data.

**Table 5: Fornell-Kacker criterion**

	<i>Distress-</i>	<i>PSA</i>
Distress-	0.758	
PSA	-0.206	0.820

Based on the analysis, this table indicates that each construct is different from the others, and they have satisfactory discriminant validity. Meaning, every indicator measures a different thing than another.

**Table 6: Model selection criterion**

	<b>BIC (Bayesian information criterion)</b>
<b>Distress-</b>	3.576
<b>WHO-5</b>	6.025

Used to compare different models, the BIC for Distress is lower than the BIC for WHO-5, suggesting that the K10 model predicts validity better and is directly pasted with R<sup>2</sup> rather than path coefficients. Thus, despite the imperfect structural model, the measurements are good, reliable, and valid, distinguishing themselves from each other.

## DISCUSSION

The activities primarily consist of informal, optional and spiritual relaying. Spiritual gathering, culturally grounded discussion without the help of a professional, is meaningless. ISA is guided by the do-it-yourself principle in the absence of a run-of-the-mill MH program. ISA, as a variable itself stems from an Ubuntu-informed perspective, posits that an individual's MHO is inseparable from their social bonds and participation in community life, however informal. Thus, the non-significant quantitative results are deeply filtered through an Ubuntu lens: the quality over mere presence, explaining why mere participation failed. Additionally, the observation that married patients participated more suggests that social support networks play a crucial role in encouraging engagement, which may lead to better MHO, a connection that the direct Participating in ISA model doesn't fully capture (Smith et al., 2024). The null effect makes sense given the limited structure and diversity of the activities offered, as highlighted by Baraka et al. (2021) in Tanzania and Shyirambere (2022) in Rwanda. The fact that women perceive the hospital space as a prison cancels out the positive effects of the other factors. And the absence of structured, meaningful, and varied programs likely limited their therapeutic effectiveness.

This suggests that simply participating isn't enough. From the Ubuntu perspective, the ineffective ISA participation was not evidence that social connection is unimportant, but rather as proof that the quality of communal life on the ward was too impoverished to produce the healing effects that a true Ubuntu-informed community (structured, reciprocal, dignified) would be expected to foster. Scholars (Cacioppo et al., 2015; Cranshaw & Mulley, 2018) advocate for recreational therapy, structured and adapted activities, such as art therapy and group occupational therapy, which are the most effective in positive MHO.

The paradigm turned a quantitative negative into a qualitative mandate for building a more humane and interconnected care environment. Informal and sporadic activities aren't enough to create a measurable impact on mental health, especially when compared to more structured programs like occupational therapy or art therapy (Niyonsenga, 2023). For instance, Alexandre et al. (2025) found that a musicotherapy program is associated with significant improvement of MH symptoms for SVS. Similarly, Nielsen et al. (2021) discovered that participation in social leisure activities, especially in groups in sports associations, art clubs, book clubs, running groups, card game clubs, and cultural or political groups was positively correlated with mental well-being, but negatively with depression and anxiety symptoms. These interventions emphasize professionalism, continuity and regularity. The quality and meaning, rather than mere participation, reflect Ubuntu's core tenet that relationships must be meaningful, reciprocal, and nourishing to the communal fabric. Superficial or "disordered" interactions (as described in the quote about chaotic religious activities) do not fulfil the criteria for genuine, Ubuntu-style communal support.

The identified lack of organized activities and the prevalence of "idleness" are seen as failures to foster a community environment that upholds human dignity and mutual support, core principles of Ubuntu. The demand for structured, therapeutic group activities reflects an application of Ubuntu, aiming to turn the hospital space into a purposeful, caring temporary community. Current research in recreational therapy highlights that for activities to genuinely benefit on MH, they need to be structured, voluntary, and customized to fit individual interests (Cacioppo et al., 2021). This emphasizes the importance of having professionally run, diverse, and structured activity programs instead of relying on spontaneous efforts.

The finding that patients primarily relied on spontaneous religious gatherings is interpreted through Ubuntu's affinity for collective rituals that reaffirm shared humanity and hope. In fact, religious meetings are just a habit, culturally grounded and do not involve any professionalism. Also, religious activities can be helpful, but they need more variety and creativity rather than a routine. These activities, even when unstructured, represented the closest available form of communal cohesion and meaning making, aligning with the Ubuntu spirit.

## IMPLICATIONS

Looking at the global environment in DRC, LTPs' MHO are affected by various factors, including political, socio-economic, and biological. In a community affected by various challenges, MH interventions involving social work practices are essential and relevant (Kagola & Abur, 2023). In this context, people need more than even someone on whom they can rely. By his skills and human qualities, a professional social worker may help LTPs in building their coping strategies, and a strength-based approach, although facing challenges. Many countries have adopted social worker practices in medical settings to foster patient mental well-being. There is still a gap in DRC's hospitals where the medical social work (MSW) department has yet to play a significant role in helping LTPs to cope with stressors. Social work practices can foster ubuntu values by encouraging positive discussion, bringing people together, and eliminating loneliness among more vulnerable patients, especially LTPs. To be a living space and meet his vision, "becoming a hospital of excellence at the national and international level", strategic planning at PGRH should integrate MSW with structured programs, involving MH activities, CGA, and distraction programs. This draws from the evidence-based, in accordance with existing evidence.

## **LIMITATIONS**

This article has a few limitations; it is observational and does not establish the cause-and-effect relationship. The paper focused on one of four variables in the hospital social environment. This article does not capture the full hospital MH environment. To get a full explanation, there should be the following articles focusing on other hospital social environment aspects and LTPs' MHO.

## **CONCLUSION**

While the hospital may not be the origin of the MH issue, it can contribute to its management, especially for LTPs. Despite the existence of ISA, nevertheless they have no positive effects in reducing psychological distress, nor in increasing the subjective well-being among LTPs. The existing sporadic ISA, rooted in religious and goalless discussions, are seen as a hobby and meaningless. The absence of structured MH interventions is more harmful for LTPs, looking at the holistic environment in DRC. Thus, there is a call to make hospitals a safe space, more accessible, inclusive and supportive for all patients. This needs a healthcare policy shift from a biomedical focus to a psychosocial, biopsychosocial model grounded in the Ubuntu perspective. This integration and fostering connections to participating in ISA is not merely beneficial but is essential for holistic, sustainable, and effective LTPs care. This study advocates structured recreational MH activities serving as therapeutic experiences, helping LTPs to cope with MH issues.

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