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EXPERIENCES OF PHYSICAL AND MENTAL HEALTH AMONG SOME LESBIAN, GAY AND BISEXUAL PEOPLE IN KISANGANI, DEMOCRATIC REPUBLIC OF CONGO

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ABSTRACT

The health of lesbian, gay and bisexual (LGB) people remains poorly documented in the Democratic Republic of Congo, particularly outside Kinshasa. This study describes the physical, psychosomatic and psychological manifestations, as well as certain practices of seeking care, in some LGB people in Kisangani. A quantitative cross-sectional survey with a descriptive purpose was conducted from February to May 2024 with 70 major participants recruited by non-probability purposive sampling with the support of the organization Progrès Santé Sans Prix. Data were collected through a 28-question questionnaire, including open-ended and closed-ended questions. The questionnaire was self-administered to literate individuals and administered indirectly to non-literate individuals. Open-ended responses were categorized and data were described by frequencies and percentages in SPSS version 27. Fatigue was the most commonly reported symptom (50.0%), followed by headache (32.4%), lack of appetite and insomnia (29.4% each). Symptoms of guilt or depression were reported by 25.0% of participants, anxiety by 10.3%, and suicidal ideation by 4.4%. Fear related to sexual orientation was also reported by 25.4% of respondents, although many reported feeling very comfortable (53.7%) or having feelings of normalcy or joy (44.8%). These results describe an accumulation of health complaints and contrasting emotional experiences. They emphasize the value of accessible, confidential and respectful health services.

KEYWORDS: LGB people; mental health; physical health; psychosomatic symptoms

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1. INTRODUCTION

Physical and mental health are closely linked dimensions of well-being. They refer not only to the absence of disease, but also to the ability to cope with daily demands, to maintain social relationships and to seek adequate care. Among people belonging to sexual minorities, the study of these dimensions must avoid two pitfalls, namely pathologizing sexual orientation and ignoring the possible effects of social contexts marked by stigmatization, anticipation of judgment, discrimination or difficulty in accessing welcoming care. Lesbian, gay and bisexual (LGB) people are not a homogeneous group. Their health experiences differ according to age, gender, economic resources, relational networks, living conditions, experiences of violence, quality of social support and effective access to services. Sexual orientation is not a disease and should not be taken as a medical explanation for a physical or psychological complaint. On the other hand, hostile social environments can be significant sources of stress that can influence well-being and the use of care.

In Kisangani, information specifically on the physical and mental health of LGB people remains scarce. Most of the studies we have read are more about HIV prevention, relationship experiences, discrimination or sexual orientation. The lack of specific information limits the ability of community-based organizations and health professionals to identify reported complaints, improve referral to care, and develop privacy-sensitive interventions. The present study aims to describe the health manifestations of some LGB people in Kisangani.

1.1. Status of the issue

The minority stress model proposed by Meyer (2003) provides a useful framework for examining the health inequalities observed among sexual minorities. This model posits that prejudice, expectations of rejection, concealment of identity, and internalized stigma can generate additional stresses, in addition to the ordinary difficulties of life. He does not maintain that sexual orientation is pathological; rather, it helps to understand how adverse social relationships can affect mental and physical health.

International studies frequently report mental health gaps in certain sexual minority populations, particularly in terms of anxiety, depressive symptoms and suicidal thoughts. These results vary depending on the context and the instruments used.

In Western societies, many studies have documented the impact of social stigma on the mental health of LGB people. The minority stress model developed by Meyer (2003, 2015) is now a central theoretical framework. It postulates that discrimination, internalized homophobia, and repeated experiences of social rejection generate chronic stress that can lead to anxiety, depression, psychosomatic disorders, and risky behaviors (American Psychological Association, 2023). Epidemiological data confirm a higher prevalence of anxiety and depression disorders and suicide risk among young people belonging to sexual minorities

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compared to heterosexual populations (World Health Organization, 2022).

In France, the report on homophobia in the workplace commissioned by HALDE and published in 2008 reveals that 12% of the homosexuals surveyed say they have been excluded from an internal promotion because of their sexual orientation, while 4.5% believe that they receive a lower salary for the same qualifications. Other surveys indicate that 17% of employees in the private sector and 8% of those in the public sector consider homosexuality to be an obstacle to professional development. These data confirm that discrimination is not limited to the private sphere, but extends to institutional spaces.

Institutional discrimination is also an important factor. Surveys conducted by Borrillo (2009) on homophobia in the workplace have shown that sexual orientation can negatively influence career development, remuneration and access to promotions, which testifies to the structural nature of the inequalities experienced by homosexual people. Such discrimination, by limiting social and economic integration, can indirectly affect physical and mental health.

In sub-Saharan Africa, the issue of homosexuality remains strongly marked by restrictive socio-cultural and religious norms, it is an issue that remains particularly sensitive and largely taboo. The work of Gueboguo (2002), carried out in Cameroon, is one of the first scientific attempts to analyze the manifestations and explanatory factors of homosexuality in an African context marked by economic, social and family crises. The author highlights the role of socio-political transformations, poverty, cultural changes and media flows in the increased visibility of homosexuality, while highlighting the persistence of a strong social stigma.

The literature highlights multiple forms of stigma: insults, exclusion, violence, anticipation of rejection, difficulty in disclosing one's orientation or fear of receiving disrespectful care. These processes can influence health behaviours, including postponement of consultation, self-medication or preferential use of community structures. However, data on the general health and mental health of LGB people remain limited in several countries, and the available studies often rely on convenience or community samples.

In the Democratic Republic of Congo, scientific data remains scarce. A study conducted in Kinshasa showed that attitudes towards homosexuality could be negative, while those affected could express a positive perception of themselves. In this context, a description of the health complaints and emotions reported by LGB people in Kisangani provides useful local insight, while acknowledging that the results are not generalizable to all LGB people living in the city or country.

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1.2. Problem

LGB people may face health challenges similar to those found in the general population, such as common infections, fatigue, pain, or trouble sleeping. They may also be exposed to additional constraints related to the relational climate, anticipated rejection, fear of being revealed or uncertainty about the confidentiality of care. However, in the context of Kisangani, there is little data to describe the physical, psychosomatic and psychological symptoms that these people report experiencing, as well as their orientations for seeking care.

The problem with this study therefore lies in the lack of contextualized empirical knowledge on the physical and mental health experiences of LGB people in Kisangani. This shortcoming makes it difficult to develop appropriate, non-stigmatizing health actions based on the needs expressed by the people themselves.

1.3. Research questions

The general question of the research is as follows: what is the experience of physical and mental health in some lesbian, gay and bisexual people in Kisangani?

The specific questions are:

- What physical and psychosomatic manifestations do the participants report?
- What emotional and psychological manifestations do they declare?
- What are the modes of care used by the participants?

1.4. Objectives of the study

The general objective was to describe the physical and mental health experience of some LGB people in Kisangani.

The specific objectives were:

- Describe the physical and psychosomatic symptoms;
- Describe the emotional and psychological manifestations reported; and
- Identify the modalities of seeking care mentioned by the participants.

1.5. Research hypotheses

Given the descriptive nature of the study, the hypotheses are formulated as research expectations and not as causal relationships. Participants were expected to report a variety of physical and psychosomatic complaints, including fatigue, headache, insomnia, and decreased appetite. It was also expected that some participants would report manifestations of psychological suffering, such as anxiety, guilt, sadness or fear. Finally, it was expected that practices for seeking care would be diversified, including community services, health centres, hospitals and, for some, self-medication.

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II. METHODOLOGY

2.1. Setting, type and period of the study

The study was conducted in the city of Kisangani, the capital of the Tshopo province in the Democratic Republic of Congo. Access to participants was facilitated by the non-governmental organization Progrès Santé Sans Prix (PSSP), which is involved in health promotion, prevention and the fight against HIV. This was a quantitative cross-sectional study with a descriptive purpose, carried out from February to May 2024.

2.2. Population, Sampling and Participants

The target population was adults living in Kisangani who identify as lesbian, gay or bisexual. In the absence of an exhaustive list or sampling frame, non-probability purposive sampling was chosen. The final sample consisted of 70 participants recruited with the support of PSWs. All participants were adults, had received information about the study, and had given informed consent prior to participation.

2.3. Data collection

Data were collected using a 28-question questionnaire that included closed-ended, open-ended and multiple-response questions. The information documented sociodemographic characteristics, sexual orientation, selected relationship experiences, reported health conditions, physical and psychosomatic symptoms, emotions associated with awareness of sexual orientation, current feelings, products consumed, and care use.

The questionnaire was self-administered to literate people. For non-literate persons, indirect administration was carried out by the enumerator, in order to allow their participation. Answers to several health questions were spontaneous and not proposed, so participants could report one or more manifestations. Open-ended responses were grouped into thematic categories for counting. The statements related to the experience since the awareness of sexual orientation.

2.4. Variables and data analysis

Physical health variables included health conditions and physical or psychosomatic symptoms. Mental health variables included emotions and reported psychological manifestations, including anxiety, guilt or depression, sadness, fear, feelings of worthlessness, isolation, and suicidal ideation. The modalities of seeking care were also described.

The data were coded and analyzed in SPSS version 27. Categorical variables are presented in terms of numbers and percentages. For multiple-answer questions, the denominator is the number of citations; The percentage of observations indicates the proportion of participants who mentioned a given response.

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2.5. Ethical considerations

Authorization to conduct the study was obtained from PSWs. Participants were provided with information about the purpose of the survey, the voluntary nature of their participation and the confidentiality of data processing; their informed consent was obtained. No formal ethics opinion number was available. In the presentation of the results, no nominative or individual identification information is reported.

III. RESULTS

3.1. Characteristics of the sample

As for sociodemographic characteristics, four of them were retained in this study, namely the age, biological sex, sexual orientation and level of education of the subjects.

Table 3.1. *Sociodemographic characteristics of the sample*

Feature	Modality	n	%
Age	17 to 26 years old	36	51,4
	27 to 35 years old	23	32,9
	36 to 43 years old	11	15,7
Biological sex	Male	56	80,0
	Female	14	20,0
Sexual orientation	Gay	25	35,7
	Lesbian	13	18,6
	Bisexuals	32	45,7
Level of education	Secondary	32	45,7
	Academic	38	54,3

The majority of participants were between the ages of 17 and 26 (51.4%), were biological male (80.0%), and had a university education (54.3%). Participants who self-identified as bisexual represented 45.7% of the sample, followed by gay (35.7%) and lesbian (18.6%) participants.

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3.2. Health Problems

Table 3.2. *Health problems mentioned by the subjects*

Reported Issue	n	%
Malaria	11	15,7
Headache/fatigue	7	10,0
Anal pain	6	8,6
Hemorrhoids	6	8,6
Itching	5	7,1
Blood pressure	4	5,7
Fever	3	4,3
Appendicitis	2	2,9
Lower abdominal pain	2	2,9
Respiratory/skin problem	2	2,9

Malaria was the most frequently reported health problem (15.7% of participants), followed by headache or fatigue (10.0%), anal pain and hemorrhoids (8.6% each). These reports reflect health problems reported by participants; They do not correspond to diagnoses confirmed by a healthcare professional in the present study.

3.3. Physical and psychosomatic symptoms

Table 3.3. *Physical and psychosomatic symptoms*

Symptom	n	%
Lack of appetite/anorexia	20	13,6
Headaches	22	15,0
Insomnia	20	13,6
Fatigue	34	23,1
Lack of concentration	4	2,7
Anxiety	7	4,8
Guilt or depression	17	11,6
Oversights	3	2,0
Anxiety	1	0,7
Tendency to isolate	3	2,0
Sadness or melancholy	4	2,7

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Dizziness	6	4,1
Feeling worthless	3	2,0
Suicidal ideation	3	2,0

Fatigue was the most frequently reported manifestation, cited by half of the participants (50.0%). Headaches affected 32.4% of participants, while lack of appetite and insomnia were each reported by 29.4%. A quarter of participants reported a category of symptoms described as guilt or depression (25.0%). Anxiety is mentioned by 10.3% and dizziness by 8.8%. Suicidal ideation was reported by three participants (4.4%).

3.4. Products consumed

Table 3.4. *Products consumed*

Product consumed	**%**
Cafe	24,3
Alcohol	22,1
Tea	20,1
Chili/pili-pili	19,5
Beer	18,8
Cigarettes, wine and strong drugs	< 5.0 each

The reported consumption was mainly for coffee, alcohol, tea, chilli pepper and beer. Cigarettes, wine and strong drugs were reported in small proportions. These data are descriptive and do not allow a relationship to be established between the consumption of these products and the symptoms reported.

3.5. Seeking care

Table 3.5. *Experiences of LGB respondents on the use of care*

Method of seeking care	**n**	**%**
PSWs	15	21,4
Personally Chosen Health Center	12	17,1
General Referral Hospital	3	4,3
Self-medication	2	2,9
Not specified	38	54,3

Of the modalities mentioned, the use of PSWs (21.4%) and a personally chosen health centre (17.1%) are the most frequent. A significant proportion of participants did not provide their usual place of care (54.3%). This non-response may reflect the sensitivity of the question, the absence of a recent need for

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care, or a reluctance to reveal personal practices; The present study does not distinguish between these explanations.

3.6. Feelings during awareness

Table 3.6. *Feelings when becoming aware*

Reported sentiment	n	%
Difficulty in explaining	42	60,0
Joy	23	32,8
Pleasure or pride	10	14,3
Comfortable	8	11,4
Disgust	8	11,4
Very comfortable	2	2,9
Pride	1	1,4
Not specified	3	4,3

When they became aware of their sexual orientation, 60.0% of participants reported difficulty explaining their experience. Positive feelings are also present: joy is mentioned by 32.8% of participants and pleasure or pride by 14.3%. Disgust was cited by 11.4% of participants.

3.7. Current feelings related to sexual orientation

Table 3.7. *Feelings when becoming aware*

Current Sentiment Reported	n	%
Very comfortable	36	53,7
Normality or joy	30	44,8
No particular feeling	22	32,8
Fear	17	25,4
Not very cheerful	10	14,9
Pride	5	7,5
Comfortable	2	3,0
Pleasure or pride	2	3,0
Disgust or surprise	1	1,5

Current feelings are mixed. More than half of participants report being very comfortable (53.7%) and 44.8% report an experience of normalcy or joy. However, fear was reported by 25.4% of participants and 14.9% said they were not very happy. These results highlight the coexistence of experiences of self-

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acceptance and emotional vulnerabilities.

IV. DISCUSSION

The objective of this study was to describe the physical and mental health experience of some LGB people in Kisangani. The results show that participants report a variety of physical, psychosomatic, and psychological complaints. Fatigue, headache, insomnia and lack of appetite are the most frequently mentioned manifestations. On the emotional level, fear, anxiety, guilt or depression, sadness and suicidal ideation are reported by part of the sample. These results should be understood as data of lived experience and self-reported health: they do not allow for a medical or psychiatric diagnosis.

Fatigue, cited by one in two participants, can have many non-specific causes, including workload, infections, socioeconomic conditions, sleep disorders, diet, stress, health problems or other factors of daily life. Headaches, dizziness, insomnia and lack of appetite are also common complaints in the general population. Their presence in this sample should not be automatically interpreted as a consequence of sexual orientation. A comparative clinical or epidemiological study, using validated instruments and a comparison group, would be needed to estimate the extent of possible health inequalities.

Nevertheless, the accumulation of certain physical and emotional complaints deserves public health attention. Insomnia and lack of appetite were both reported by 29.4% of participants; Symptoms grouped under the category of guilt or depression are reported by 25.0%. Fear also concerns 25.4% of respondents. In the literature, the minority stress model explains how discrimination, anticipation of rejection, concealment, and internalized stigma can contribute to a specific stress load in sexual minorities (Meyer, 2003). This is an interpretive framework and not causal evidence produced by the study data.

The results concerning emotions illustrate an experience that cannot be reduced to suffering. At the time of awareness, a majority of participants report difficulty explaining their experience, while joy, pleasure and pride are also expressed. At the time of the survey, 53.7% said they felt very comfortable and 44.8% associated their situation with normality or joy. These findings are consistent with approaches that emphasize resources, self-acceptance, and resilience of sexual minority people. However, the simultaneous presence of fear in a quarter of the participants reminds us that well-being can be fragile, contextual and influenced by family, social or institutional relationships.

The reporting of suicidal ideation by 4.4% of participants requires responsible interpretation. The study does not allow for an assessment of severity, frequency, timeliness or acting, as no validated suicide risk scale was administered. It would therefore be inappropriate to conclude that there is a clinical prevalence of suicidality. Nevertheless, any mention of suicidal ideation in a health investigation calls for the

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availability of confidential referral mechanisms to appropriate psychosocial or clinical assessment, particularly when services are accessible through community-based organizations.

Data on care utilization suggest that PSWs and personally selected health centres are important options for participants who responded to this question. However, the high non-response regarding the place of care limits interpretation. In contexts where individuals fear judgment or unwanted disclosure of their orientation, confidentiality, respect, quality of reception and the competence of providers may influence the decision to consult. Health actions should therefore aim at the relational and ethical competence of services, rather than simply multiplying the number of care offers.

The consumption of coffee, alcohol, tea, chili pepper and beer was reported by some of the participants. These data do not allow us to infer that the products consumed are stress management strategies, nor that they explain the physical or psychological symptoms. Their presentation only meets the descriptive objective of the study. Further research, with standardized measures of consumption and mental health, could examine possible links between these variables.

This study has several strengths. It provides localized data on a subject that is poorly documented in Kisangani; it includes LGB adults; it was carried out with the support of a community organization facilitating access to a population that is not very visible; and it presents physical, psychosomatic, emotional manifestations and practices of recourse to care.

As a limitation, this study used purposive non-probability sampling and PSW recruitment exposes to selection bias and does not allow the results to be generalized to all LGB people in Kisangani. Second, the 70-participant population limits the accuracy of the estimates. Third, symptoms were and were not based on validated clinical instruments; no diagnostic conclusion is therefore possible. Fourth, multiple responses and large non-responses for some variables complicate the interpretation of percentages. Fifth, the temporal reference of symptoms was broad—since the awareness of sexual orientation—and does not distinguish between current difficulties and older experiences. Finally, the lack of individual-level data available for this reanalysis precluded the conduct of valid tests of association between symptoms, sociodemographic characteristics, experiences of discrimination, and family relationships.

V. CONCLUSION

This study describes the physical and mental health experiences of 70 LGB adults in Kisangani between February and May 2024. Fatigue, headache, lack of appetite and insomnia are among the most frequently reported physical and psychosomatic manifestations. On an emotional level, positive experiences of well-

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being, ease, normality and joy coexist with statements of fear, anxiety, guilt or depression, sadness and, for some participants, suicidal thoughts.

These results do not allow symptoms to be attributed to sexual orientation, nor do they diagnose mental health disorders. However, they highlight the importance of health services that are accessible, confidential, non-stigmatizing and able to respond to the physical complaints as well as the psychological and social needs expressed by LGB people.

As recommendations, that community organizations and health structures in Kisangani could strengthen confidential listening spaces, voluntary referral to medical and psychological care, as well as procedures for responding to situations of distress or suicidal thoughts. The training of health professionals should include respectful welcome, confidentiality, non-discrimination and needs-based care for all people, regardless of their sexual orientation.

Future research should use more diverse samples, validated mental health and quality of life instruments, an explicit baseline period for symptoms, and mixed methods combining questionnaires and qualitative interviews. Analytical studies could then examine, with comprehensive individual data, the links between health, social support, experiences of stigma, access to care and living conditions.

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