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Perceived Quality of Life among Young Psychoactive Substance Users in Ndosho

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Abstract

Background and objectives: Quality of life is an indicator of individuals' overall health. Among young people who use psychoactive substances, it is affected by the interaction of psychological, social and environmental factors. This study aims to assess the perceived quality of life of young people who use psychoactive substances living in the Ndosho neighbourhood (Goma, DRC). Method: A quantitative cross-sectional study was conducted among 100 young people aged 15 to 39, recruited using convenience sampling. Two instruments were used: the Structured Assessment Grid for Young People's Living Conditions and the WHOQOL-BREF scale. The data were analysed using SPSS software via descriptive statistics. Results: Almost all participants reported an average quality of life with difficulties (82 per cent) or a low quality of life (18 per cent); none reported a good quality of life. Sociodemographic characteristics did not significantly explain perceived quality of life ($R^2 = 0.052$; $F = 0.856$; $p = 0.530$). Conclusion: The use of psychoactive substances is an independent factor contributing to a decline in quality of life,

beyond objective living conditions. The study suggests that the nature of this independent factor should be analysed in greater depth.

Keywords: Quality of life, psychoactive substances, living conditions, young people, mental health.

Introduction

Quality of life is a multidimensional concept encompassing an individual's physical, psychological, social and environmental well-being (Skevington et al., 2004). It has previously been the subject of studies on addictive behaviours, due to the impact of psychoactive substances [PAS] on various spheres of life (Laudet et al., 2006; Karow et al., 2020). In the contexts of urban precariousness characteristic of post-conflict sub-Saharan African cities, this issue takes on a critical dimension. The report by the United Nations Office on Drugs and Crime (UNODC, 2022) indicates that sub-Saharan Africa is experiencing an alarming rise in PAS use among young people, a phenomenon exacerbated by socio-economic vulnerability, structural unemployment and

inadequate mental health services. In the Democratic Republic of the Congo [DRC], and particularly in the city of Goma, this reality is all too evident; the lingering effects of ongoing armed conflicts have affected people's living conditions, creating fertile ground for addictive behaviours (Munyuli et al., 2018; Ngoyi et al., 2021).

The Ndosho neighbourhood, situated in the Karisimbi commune of Goma, is a prime example of these dynamics. It is characterised by high population density, high unemployment, a prevailing sense of insecurity, and limited access to mental health services. These contextual factors, combined with peer influence and the normalisation of substance use, all contribute to vulnerability in young people's quality of life. Several studies have demonstrated a negative association between the use of psychoactive substances and quality of life among young adults (Karow et al., 2020; Laudet et al., 2006; Foster et al., 2020). However, the vast majority of this research has been conducted in Western contexts. In Central Africa, and particularly in post-conflict urban settings, data remain scarce. The present study seeks to fill this gap by analysing the perceived quality of life of young SPA users in Ndosho using a multidimensional framework.

The assessment of quality of life among young SPA users is grounded in several complementary theoretical frameworks. Engel's (1977) biopsychosocial model, as adapted in the study on addictions (McGue et al., 2018), posits that addictive behaviours result from the dynamic interaction between biological, psychological and social factors, and in turn have a differential impact on each dimension of quality of life. Lazarus and Folkman's (1984) theory of stress and coping helps to explain how young people, faced with precarious living conditions, turn to SPA as a dysfunctional coping strategy, to the detriment of their overall well-being. Furthermore, Bandura's (1977, 2016) work on social learning highlights the role of behavioural models in the initiation into substance use and in young people's identity formation, with direct repercussions on their subjective perception of well-being. The WHOQOL-BREF scale, developed by the WHO (1998), provides an internationally validated operational framework for assessing these interrelated dimensions.

This research seeks to determine the perceived quality of life of young SPA consumers living in Ndosho. The hypothesis suggests that young people in Ndosho have a very low perceived quality of life, depending on socio-demographic factors. The aim of this study is to assess the perceived quality of life of young SPA consumers living in Ndosho.

Method

This study adopts a descriptive, cross-sectional, quantitative design, in accordance with the methodological standards of epidemiological research in mental health (Creswell & Creswell, 2018). This type of design allows for the description of the prevalence of behaviours at a given point in time. The Ndosho neighbourhood, situated in the commune of Karisimbi (Goma, North Kivu), has a population of approximately 45,000, 65 per cent of whom are aged between 15 and 35 (North Kivu Provincial Division, 2023). It is characterised by a predominantly informal economy, precarious housing conditions, a high density of drinking establishments and a lack of specialist addiction treatment centres. The post-conflict context has led to an influx of internally displaced persons, exacerbating social tensions and the vulnerability of young people. The target population consists of young people aged between 15 and 39 who actually reside in the Ndosho neighbourhood. The sample of 100 participants was selected using convenience sampling. The inclusion criteria were: being an alcohol user, residing in Ndosho, being aged between 15 and 39, and providing informed consent. Individuals with severe cognitive impairments and non-residents were excluded.

Table 1. Sociodemographic characteristics

Variable	Categorical	n	%
Gender	Male	76	76.0
	Female	24	24.0
Age	15–19 years	4	4.0
	20–24 years	60	60.0
	25–29 years	22	22.0
	30–34 years	14	14.0
Level of education	Higher education	98	98.0
	Primary	2	2.0
Employment status	Unemployed	49	49.0
	In education	28	28.0
	In employment	23	23.0
Family situation	Two parents	49	49.0
	Single	15	15.0
	One parent	19	19.0
	Extended family	17	17.0

The tools used in this study are presented in the order in which they were administered. The GESCOVI-J explores the socio-economic, family and environmental dimensions of the participants' lived experiences, enabling the context of their lives to be objectively assessed. The WHOQOL-BREF (WHO, 1998) is the standard reference instrument for assessing health-related quality of life. It comprises 26 items divided into four domains: physical health, psychological

health, social relationships and environment. It exhibits robust psychometric properties, with Cronbach's α ranging from 0.73 to 0.89 depending on the domain. It has also been validated across numerous cultural contexts (Skevington et al., 2004). Data were collected from May to June 2025 through direct administration of the questionnaire in French, following the obtaining of verbal consent from each participant. Data collection took place in public spaces within the neighbourhood, following a procedure that guaranteed the anonymity and confidentiality of responses. The data were analysed using SPSS version 26. The analysis included descriptive statistics to examine the associations between the dimensions of quality of life and consumption. The study adhered to the ethical principles governing research involving human subjects, in accordance with the recommendations of the American Psychological Association (Schwind et al, 2025) regarding informed consent, anonymity, confidentiality and the full right to withdraw at any time.

Results

The results of the data collected provide insights into the quality of life of the young alcohol consumers surveyed.

Table 2. Level of perceived quality of life

Level	N	%
Very low	18	18.0
Average with difficulties	82	82.0
Total	100	100.0

This table shows the distribution of participants according to their perceived quality of life, as assessed using the WHOQOL-BREF scale. The distribution reveals that no participant reported a good quality of life. All respondents fall within the range of a low quality of life (18 per cent) and an average quality of life with difficulties (82 per cent), reflecting a particularly low overall level of perceived well-being. This finding is consistent with studies conducted in similar contexts of precarious living conditions (Karow et al., 2020; Foster et al., 2020).

Table 3. Living conditions of respondents

Level of living conditions	N	%
Low	81	81.0
Good	19	19.0
Total	100	100

This table shows that 81 per cent of the young SPA users surveyed are classified as having poor living conditions, though not extremely precarious, and only 19 per cent enjoy good living conditions. Although not all respondents report a good quality of life, Table 2 nevertheless shows that 19% report a good standard of living. However, this remains insignificant even after verification using Pearson's correlation test.

Table 4. Correlations between living conditions and quality of life

Dimensions	Living conditions	Quality of life
Living conditions	—	-0.166
Quality of life	-0.166	—
SPA consumption	-0.033	-0.202*

$p < 0.05$ (two-tailed).

The results reveal no significant correlation between objective living conditions and quality of life ($r = -0.166$; $p = 0.098$), nor between living conditions and SPA consumption ($r = -0.033$; $p = 0.743$). However, a negative and statistically significant correlation was observed between soft drink consumption and quality of life ($r = -0.202$; $p = 0.043$), confirming that the higher the consumption, the lower the perceived quality of life tends to be.

Taking into account the socio-demographic determinants of quality of life, a multiple regression model was fitted, including gender, age, educational attainment, occupational

status, family situation and perceived neighbourhood safety as predictors.

Table 5. Regression on quality of life

Model	R	R ²	Adjusted R ²	Standard error	F	p
1	0.229	0.052	-0.009	11.465	0.856	0.530

Predictors such as gender, age, educational attainment, current status, family situation and perceived safety. The regression model is not statistically significant ($F = 0.856$; $p = 0.530$), and the explained variance is very low ($R^2 = 0.052$). No sociodemographic predictors reached the significance threshold. These results indicate that traditional individual characteristics are not significant determinants of quality of life in this sample, suggesting the importance of other factors, particularly psychosocial and contextual ones.

Discussion

The results confirm that all the young people surveyed reported a low perceived quality of life, with not a single case of a good quality of life. This finding is of critical concern and is consistent with the observations of Foster et al. (2020), who report significantly lower well-being scores amongst young people who use SPA and live in contexts of urban poverty. Similarly, Karow et al. (2020), in a systematic review of 47 studies, confirm that problematic use of SPA is a robust predictor of a decline in quality of life across all cultures. In the specific context of Ndoshoh, this finding must be viewed in the light of the local circumstances: an unemployment rate of 51 per cent, a sense of insecurity reported by 65.7 per cent of residents, and the almost total absence of mental health support services. These contextual factors, whilst not directly associated with quality of life in our model, constitute a framework of vulnerability that amplifies the deleterious impact of PAS on young people's well-being (Lazarus & Folkman, 1984; Breslin et al., 2020).

The strong intercorrelation between the physical, psychological and social dimensions of quality of life ($r = 0.698$ to 0.919) is consistent with the holistic approach advocated by the WHO (1998). These findings are consistent with those of Skevington et al. (2004), who reported similar intercorrelations in a multinational study using the WHOQOL-BREF across 23 countries. The particularly strong relationship between physical health and psychological well-being ($r = 0.919$) illustrates the principle of psychosomatic

unity: the physical damage caused by chronic use of psychoactive substances, such as liver, cardiovascular and neurological disorders, inevitably affects mental health, and vice versa (McGue et al., 2018). Furthermore, the high correlation between psychological well-being and social relationships ($r = 0.896$) highlights the central role of social capital in young people's mental health, in line with Keyes's (2002) work on the mental health continuum. In contexts characterised by insecurity and precariousness, such as Ndoshu, the breakdown of the social fabric linked to the stigmatisation of substance users exacerbates their isolation and undermines their psychological well-being (Bandura, 2016; Munyuli et al., 2018). The significant negative correlation between psychoactive substance use and quality of life ($r = -0.202$; $p = 0.043$) establishes that, even in the absence of a direct association between objective living conditions and quality of life, substance use constitutes a factor in itself that undermines well-being. This finding is consistent with the conclusions of Laudet et al. (2006), who, in a longitudinal study of 343 individuals in remission, showed that perceived quality of life improves linearly as consumption decreases. The lack of a link between objective living conditions and perceived quality of life warrants particular attention. It can be explained by the theory of hedonic adaptation (Diener & Lucas, 2006), according to which individuals adjust their expectations and their perception of well-being in line with their environment. In a neighbourhood where precariousness is the norm, the benchmarks for the subjective assessment of quality of life are recalibrated, reducing the variability attributable to objective conditions. It is the consumption of SPA, as an active behaviour that alters psychological state, which constitutes the most salient differentiating factor.

Several limitations should be noted. Firstly, the sample size ($N = 100$), whilst adequate for an exploratory study, limits the statistical power and generalisability of the results. Secondly, the cross-sectional design does not allow causal relationships to be established. Thirdly, self-reported data carry a risk of social desirability bias, particularly regarding the consumption of SPA, which is often under-reported due to stigma. Finally, the absence of a control group comprising non-consumers limits intergroup comparisons.

Conclusion

This study makes an original empirical contribution to understanding the quality of life of young soft drink consumers in a post-conflict urban context in Central Africa. The results show that all young people in Ndoshu report a low to moderate perceived quality of life, and that soft drink consumption is an independent factor contributing to its deterioration, beyond objective living conditions. The three

dimensions of quality of life are highly interdependent, arguing for a holistic intervention approach. These findings have significant practical implications. In terms of prevention, they highlight the need for targeted interventions incorporating psychosocial support, harm reduction and improvements to living conditions. This research suggests that qualitative analyses are needed to deepen our understanding of the causal mechanisms linking substance use and quality of life in this context.

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