

Use of Reproductive Health Services by Adolescents in Kinshasa, Democratic Republic of the Congo

OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

JANUARY 2014



Democratic Republic of Congo
Ministry of Health





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KEY TERMS

In this report, we use the terms *contraception* and *family planning* interchangeably to denote planning whether and when to have children and the use of any birth control method to implement such intentions. Similarly, the terms *contraceptives*, *contraceptive methods*, and *family planning methods* are interchangeably used to denote birth control methods.

ACRONYMS

| | |
|-------|--|
| ARH | Adolescent Reproductive Health |
| DHS | Demographic and Health Survey |
| DRC | Democratic Republic of Congo |
| FGD | Focus Group Discussion |
| FP | Family Planning |
| IDI | In-Depth Interview |
| NGO | Non-governmental organization |
| PNSA | Programme National de Santé de l'Adolescent (National Adolescent Health Program) |
| RH | Reproductive Health |
| STI | Sexually Transmitted Infection |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

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BACKGROUND AND RATIONALE

The Democratic Republic of Congo (DRC) has one of the youngest populations in Africa and in the world, with 65% of the population under 25, and 50% under the age of 15.¹ Ensuring that these youth grow up healthy, educated and productive will be critical to helping the country achieve long-term development goals and pull itself out of extreme poverty. The country has the second-highest adolescent fertility rate in the world, however,² putting young Congolese women at high risk of pregnancy-related complications and death, making it difficult for them to finish school, and imposing heavy economic burdens on women and their families.

Education levels are currently low. According to the 2013-2014 Demographic and Health Survey (DHS)³ only 18.7% of girls, ages 20-24, have completed secondary school or higher. It is likely that many girls drop out of school when they become pregnant. DRC has one of the highest rates of adolescent fertility in the world—27% of girls, ages 15-19, have already begun childbearing. Adolescent fertility rates vary widely by province—from a low of 13% in Kinshasa to a high of 40% in the Oriental province. The DHS revealed that half of women 25-49 years old had their first sexual relations before the age of 17. Half of men in the same age group experienced their first sexual relations before the age of 18.

There is a high prevalence of violence against women in DRC. According to the DHS, over a quarter (27%) of sexually active women 15-49 years old and 16.4% of women 15-19 years old have been victims of sexual violence at some point in their lives. Over 38% of women ages 15-19 have been the victims of physical

violence since the age of 15, with the violence inflicted most often by a spouse/partner or family member.

Use of modern contraceptives among adolescents is low, however. According to the DHS, only 11% of 15-19 year old women use any contraceptive method, and only 5% use a modern method (condoms are the most popular method).

According to the DHS, many Congolese adolescents also lack basic knowledge about HIV/AIDS. Among 15-19 year olds, only 43.2% of women and 57.6% of men know that the virus can be prevented by using condoms and also know that it can be prevented by having sex with only one uninfected partner. Rates of HIV testing among 15-19 year old adolescents are extremely low—just 7.6% of women and 2.3% of men report ever having been tested and receiving the results. Less than half of adolescent girls and boys even know where to go to get an HIV test (42.2% and 48.2%, respectively).

Access to reproductive health (RH) services in DRC is limited, with only half of the country's 516 health zones offering family planning (FP) services.⁴ Since 2006, the National Program for Adolescent Health (PNSA), with the technical and financial support of UNFPA, WHO and UNICEF, has implemented an integrated package of adolescent reproductive health (ARH) activities within the national health system and at youth centers in four provinces: Kinshasa, Bas-Congo, Bandundu and Katanga. However, these services are very limited in scope and only available in 12 health zones.⁵

In 2013, the PNSA asked C-Change to conduct qualitative research with 15-19 year old adolescents and key informants in order to identify the factors contributing to the low-level use of ARH services in Kinshasa.

1. USAID. Democratic Republic of Congo. Country Development Cooperation Strategy 2015-2019.

2. Ibid.

3. Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique and ICF International. 2014. Democratic Republic of Congo Demographic and Health Survey 2013-14. Rockville, MD, USA: MPSMRM, MSP and ICF International.

4. République Démocratique du Congo. Planification Familiale : Plan Stratégique National à vision multisectorielle (2014-2020).

5. Ibid.

RESEARCH OBJECTIVES

The overall objective of this study was to identify knowledge, attitudes, and current practices of adolescents in Kinshasa related to sexual and reproductive health, the use of health services and the use of modern contraception. More specifically, the study aimed to identify the reasons behind the low utilization of modern contraception and adolescent reproductive health services by exploring the following issues:

- Perceptions of sexual health
- Reasons for early marriage
- Use of ARH services
- Adolescents' perception of quality of ARH services
- Obstacles and opportunities influencing the use of ARH services
- Use of modern contraceptive methods

DESIGN, METHODS, AND DATA MANAGEMENT

This descriptive research study was conducted in two health zones of Kinshasa (N'Sele and Binza) in October 2013. These zones were chosen because the PNSA had established ARH services in 14 health centers in these two zones. According to the PNSA, these included seven “youth-friendly centers”⁶ and seven “social centers.”

The study methods included eight focus group discussions (FDGs) with 15-19 year old adolescents and 20 individual in-depth interviews (IDIs) with key informants. Four FDGs with 10 participants were conducted in each health zone, for a total of eight FDGs. Groups were segmented by gender and by educational status (in-school vs. out-of-school). Therefore, in each health zone, one FDG each was conducted with in-school females, out-of-school females, in-school males and out-of-school males. Twenty IDIs were conducted with key informants in each health zone. These included two interviews each with 15-19 year old couples, parents of 15-19 year old adolescents, RH/FP service providers (nurses in

public hospitals), teachers, and youth counselors from non-governmental organizations (NGOs).

C-Change received approval for this study from the Ethical Committee of the University of Kinshasa's School of Public Health and the FHI 360 Protection of Human Subjects Committee. In addition, the PNSA reviewed and validated the study protocol and instruments, including the FGD and IDI discussion guides, which were translated from French to Lingala. Once study approval was granted, the research team worked with the PNSA, local authorities and community health workers to identify study sites and recruit participants.

Participation in the study was voluntary, and oral consent in the local language was obtained individually from each participant. Each participant received refreshments and a small stipend of 1,800 FC (\$2.00). Participants were assigned identification numbers to protect their confidentiality, and no names were used in the notes or transcripts.

The research team received a 3-day training that included a review of the following: research ethics, study objectives and methodology; fieldwork logistics; FGD/IDI techniques; and the discussion guides. The training also included practice facilitation sessions.

Each FGD was led by a trained moderator, accompanied by two note takers. Each IDI was conducted by a trained interviewer, accompanied by one note taker. Each day following a session, the research team reviewed and expanded their notes, with moderators adding their observations.

After the research was completed, a consultant helped the moderators and note takers to conduct a thematic content analysis of the findings. Notes were systematically coded by word and phrase, resulting in the creation of a thematic code book. For FDGs, results were first described by gender and school status, and then by health zone. Findings were then grouped by theme and sub-theme in order to draw conclusions. The research team subsequently employed data triangulation techniques to validate their conclusions, comparing findings from the FDGs and IDIs with each other and with the literature.

6. When the idea was originally conceived by PNSA, youth-friendly centers were supposed to meet the following criteria: 1) Presence of at least two providers trained in ARH; 2) Adoption of a youth-friendly approach, welcoming youth and allowing them to freely express themselves and ask questions; and 3) Availability of

multifunctional space where youth could hang out, receive ARH counseling and interact with each other and with peer educators. However, due to funding cuts, only the first criteria (presence of ARH providers) was met.

KEY FINDINGS

Adolescent Reproductive Health Services

Neither the adolescents nor the key informants were aware of any ARH services in their health zones, although these services were supposedly available in 14 health centers in these zones.

When asked whether or not they would use such services, some adolescents said no, either because they viewed family planning as an “adult matter,” they didn’t view the Ministry of Health as legitimate when it came to youth affairs, or they felt that it would be difficult for youth to go to health centers for pregnancy prevention. These attitudes were especially prevalent among out-of-school youth.

The majority of in-school female adolescents, especially from N’Sele, expressed concerns about their vulnerability to HIV and pregnancy, with some admitting that they did not know where to go for help.

Young girls are currently dying of AIDS because they don’t know how to protect themselves from HIV, and a lot of girls get pregnant and have abortions, with the help of their mothers.

—In-school female adolescent, N’Sele

These young women expressed that they would be interested in using ARH services as long as the staff were well trained and could guarantee confidentiality. A few in-school males felt differently, however, stating that the use of family planning methods by young people was shameful.

Both adolescents and key informants cited similar obstacles to the use of ARH services. First of all, poverty and precarious living conditions drive some parents to ask older children to “manage” on their own (i.e., earn money through prostitution). Some religious leaders (especially pastors) discourage the use of contraceptives. Similarly, parents of adolescents can be barriers—they do not discuss ARH with their children (as was the case with their own parents), nor do they believe that adolescents should be using contraceptives.

I know a family where the wife divorced her husband because he began discussing the

use of condoms for HIV prevention with his children. The pastor of the church where the mother prayed convinced her that her husband would turn her daughters and sons into prostitutes and then sacrifice them using magic.

—Teacher, N’Sele

One female adolescent in Binza, interviewed together with her partner, cited stigma as an obstacle to using reproductive health services. She cited her own experience of going to prenatal services where other older mothers made her feel uncomfortable, saying that she was “still a young girl.” One health provider in Binza felt that youth would not be interested in attending discussion groups in health centers, preferring instead to listen to music or go out with friends.

Sexual Health and Sexual Debut

For a majority of adolescents, sexual health is associated, on the one hand, with pleasure, and on the other hand, with pregnancy and disease. Key informants talked about sexual health more in terms of taking care of their bodies, either to keep them healthy for childbirth or to prevent sexually-transmitted infections (STIs).

Adolescents viewed sexual relations “mutual help”, whereby the boy provides material support in exchange for sex.

It’s mutual assistance—the boy gives money and the girl satisfies the boy sexually. In other words, the expenses that the boy agrees to are always compensated with unprotected sex.

—Out-of-school male adolescent, N’Sele

Although this question was not specifically asked, out-of-school male adolescents in N’Sele reported that girls are the ones who think of sex first, because they know that boys will not be able to resist.

According to the adolescents in the FGDs, girls have their sexual debut between the ages of 10 and 18, while boys begin a bit later—between the ages of 15 and 19. Social conditions play a role in the early initiation of sexual relations for girls, with street orphans starting between 10 and 13 years, young girls in charge of their families starting between 14 and 18 years, and in-school adolescent girls starting at 18 years of age (or older). For some young girls, sexual initiation begins when they are raped by adult men.

Key informants gave a narrower age range for sexual debut, between 10 and 15 years old, specifying that girls initiate sex earlier than boys. Key informants gave a number of reasons for this, ranging from the bad influence of older adolescents, to economic necessity, to a lack of parental communication:

Girls begin to have sex at 12 years of age because boys are already asking them to. This is due to the bad company of big sisters in their neighborhood or because of a lack of dialogue between parents and their children.

—*Health provider, Binza*

The daughter of my neighbor is 14½ years old and she goes out with a man who is as old as her father, but the father doesn't say anything because she is the one who feeds the family.

—*Teacher, N'Sele*

Many key informants morally disapproved of the early initiation of sexual relations among adolescents today, stating that their generation waited until marriage before having sex.

The majority of female and male adolescents in both health zones cited poverty as the primary reason for early sexual relations. Some parents force their older daughters to exchange sex for money. Other girls have sex with their boyfriends in exchange for school fees. Working parents are often absent from the home for long periods of time, providing opportunities for adolescents to have sex with their boyfriends and girlfriends. Adolescents also take advantage of community celebrations, birthday parties and other events outside the home to have sex without their parents' knowledge.

Some adolescents also mentioned being influenced by adults, who encourage both boys and girls to become sexually active early, either to prove their virility (for boys) or their fertility (for girls). They also mentioned being influenced by seeing older adults having sex:

When my parents are absent, my grandfather has sex with his girlfriends at our house. This encourages us to experiment.

—*In-school female adolescent, Binza*

Other adolescents stated that their peers have sex after watching pornographic films at home or on their telephones. It's worth noting that many adolescent males said that boys are influenced by the way that girls dress, implying that the girls are deliberately being provocative:

If young women dressed like nuns, nobody would have any negative thoughts. But when you see a girl dressed in skimpy clothing that shows the outline of her figure, this pushes a boy to approach her with the intention of "going far," up to the point of having sex.

—*In-school male adolescent, Binza*

Early Marriage

The Congolese law does not specify a legal age of marriage, but says instead that a girl is ready to be married when she starts menstruating. Adolescents themselves distinguish between two types of marriage:

- "Imposed" marriage, because of an unplanned pregnancy; and
- "Real" marriage, where a boy seeks to marry a girl following national customs and laws.

Out-of-school girls in both health zones cited reasons for early marriage. According to girls in N'Sele, some girls get pregnant on purpose if their boyfriend drives a motorcycle taxi or has money, in order to ensure that they have money for themselves. Girls in Binza stated that families are proud to marry off their girls early, as this protects them from the risks of unwanted pregnancies and STIs.

Family Planning Knowledge and Practices

Adolescents of both sexes had poor knowledge of modern contraceptive methods—the condom was the only method that they were able to name. Most had never used condoms even though they were sexually active. Boys in particular were resistant to the idea of using condoms, as they are thought to reduce sexual pleasure. Some boys, however, said that they would use condoms with girls who were menstruating, or with casual sex partners—this was true regardless of school status and across both health zones.

When the young man is with a partner that he doesn't carry in his heart or an occasional partner, he uses a condom, especially if he knows that this girl has multiple partners. Because he doesn't want to get a girl pregnant if he doesn't love her. But when you are with a girl that you love, a steady partner, you can have unprotected sex (body to body), because you're not afraid of any infections.

–*In-school male adolescent, Binza*

Some boys in Binza mentioned using a little plastic bag, called an “0.5” (in reference to the size of the bag) instead of condoms. They use these bags to prevent pregnancy, HIV and STIs. The majority of boys and some of the girls also mentioned using pharmaceutical products to avoid pregnancy, such as Dividra (a deworming drug) and Tanzol (a steroid).

The majority of girls cited traditional methods of preventing pregnancy and inducing abortion, such as urinating or washing their vaginas immediately after sex, inserting a piece of manioc into their vaginas to open the cervix, and douching with soap, papaya leaves or guava leaves.

Key informants viewed the lack of use of modern contraception by adolescents as a serious problem and attributed it to lack of knowledge, lack of availability, and misconceptions about condoms in particular:

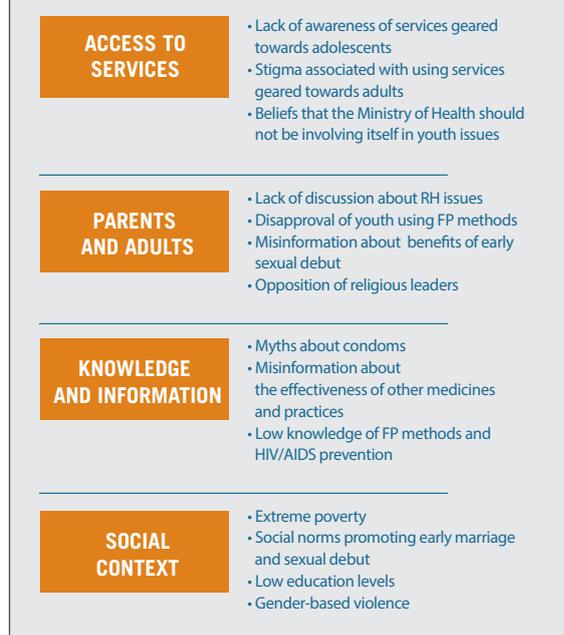
A lot of youth don't use condoms, otherwise we wouldn't have seen an increase in unwanted pregnancies. They say that condoms can break or stay in the vagina, that they are “foreign bodies” that can cause a lot of problems. They also decrease sexual pleasure.

–*NGO coordinator, N'Sele*

Like the adolescents, key informants named several non-contraceptive products that girls use to prevent pregnancy, including deworming drugs, quinine, tetracycline, and cold water.

Figure 1 summarizes the barriers to use of ARH services that were identified in this research. These include barriers related to: 1) Quality and availability

FIGURE 1:
BARRIERS TO USE OF ARH SERVICES



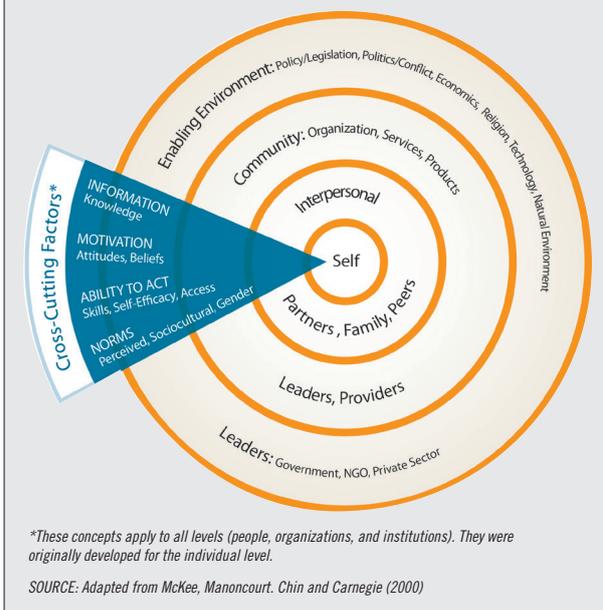
of ARH services; 2) Influence of parents and adults; 3) Knowledge and information about family planning methods and HIV/AIDS prevention; and 4) Social context in DRC.

Motivating and Communicating with Youth

Virtually all adolescents in both health zones preferred receiving information through schools, youth clubs/associations, churches and TV. Key informants also mentioned films, internet, and interpersonal communication with adults, peers, and friends. They cautioned, however, that older adults have a negative influence on adolescents, because they spread misinformation and encourage the early initiation of sexual relations.

When asked how adolescents could be motivated to use contraceptives, key informants suggested “in kind” motivation and psychological motivation. Given the high levels of poverty in which many adolescents live, they suggested that adolescents could be given incentives to use contraceptives under the guise of transportation money or bags of food. Other informants recommended creating more welcoming environments within health facilities and providing adolescents with services in a more discrete manner.

FIGURE 2:
THE SOCIO-ECOLOGICAL MODEL FOR CHANGE



IMPLICATIONS FOR SBCC

The findings reveal several important implications for SBCC, which can be organized according to the Socio-Ecological Model presented in Figure 2. According to this model, a person’s ability to change their behavior is influenced by factors at many different levels, including information, motivation, ability to act and an enabling environment.

Information

This study revealed that adolescents of both sexes lack knowledge about modern contraceptive methods, with male condoms being the only method that could be identified. Adolescents were hesitant to use condoms, however, due to myths about their safety and the perception that they reduce sexual pleasure. At the same time, adolescent girls are exposed to a lot of misinformation about other pharmaceutical products and traditional practices that they erroneously believe prevent pregnancy.

There is a clear need for adolescents to receive accurate information about modern contraceptive methods as well as HIV/AIDS prevention. This information needs to be tailored according to their gender, education level and marital status (e.g., married adolescents need information about the benefits of planning a family and pregnancy spacing, but such messages would not resonate with unmarried adolescents).

Motivation

Some adolescents have negative attitudes towards family planning, viewing it as an adult matter or, in the case of some males, as shameful. Some adolescent girls do seem aware of their vulnerability to unwanted pregnancy and HIV/STIs and are interested in accessing ARH services, but they are not currently doing so. There is evidence of a strong motivation to avoid unwanted pregnancies, as demonstrated by adolescents’ stated knowledge of ways to do so (although some of these ways were ineffective or even risky). Adolescent boys do not wish to impregnate girls that they do not love, although they seem less worried about getting girlfriends pregnant. Reasons for avoiding pregnancy are not entirely clear, although the following were mentioned—a desire to complete one’s education or worries about how to financially support children. It is clear that sexual pleasure plays a large role in the non-use of condoms, especially for adolescent boys. Communication campaigns that promote modern contraception as an issue relevant for young people and a way of increasing pleasure by reducing worries about unplanned pregnancies could be effective with adolescents of both sexes.

Ability to Act

The ability of Congolese adolescents to use modern contraceptive methods is hindered by extreme poverty and a limited access to family planning services. Even though PNSA has established ARH services in 14 health zones within the catchment area of this study, neither the adolescents nor the key informants interviewed in this study were aware of these services. Adolescents do not seem comfortable accessing reproductive health services geared towards adults.

Because of poverty, many adolescent girls must prioritize their immediate survival above other needs, e.g., having sex in exchange for material support or school fees. This type of transactional sex is often encouraged by parents. Sex is often unprotected, suggesting that girls do not have the skills to negotiate condom use. Adolescents are clearly able to take some kind of action to protect themselves—as demonstrated by their ability to procure plastic bags and other types of pharmaceutical products—but their ability to use modern contraception is clearly limited. Adolescent girls may be also be victims of rape by older men, precluding them from protecting themselves against pregnancy.

The expansion of ARH services along with advocacy to obtain the support from religious leaders, teachers,

and parents will be critical for the creation of an enabling environment in which adolescents can freely obtain ARH information and services.

Norms

Cultural norms promoted by adults hinder adolescents' ability to act, by creating pressure to have sex early in order to prove their virility (for males) or fertility (for females). In addition, social norms that discourage the discussion of reproductive health matters between parents and children make it difficult for adolescents to learn about and access ARH services. Many key informants seemed to harbor negative attitudes towards today's adolescents—specifically regarding their early age of sexual debut. This stands in contrast to the fact that some elders pressure youth to have sex early, as mentioned earlier. Such attitudes may make it difficult for youth to confide in adults about ARH issues and access services. In addition, many religious leaders in DRC oppose the use of modern contraception, influencing the attitudes of young people and their parents alike.

Communication campaigns that combat myths about early sexual debut and encourage parental communication could empower adolescents to use modern contraception. These campaigns could include peer education programs to help adolescents negotiate condom use, deal with gender-based violence and discuss ARH issues with their sexual partners.

CONCLUSIONS AND RECOMMENDATIONS

This study has demonstrated the urgent need to provide accurate sexual and reproductive health information and effective services for adolescents in order to increase the use of modern contraceptives and discourage the use of dangerous and ineffective pregnancy prevention methods. Given the early age of sexual debut in DRC, these services need to be

provided starting at a young age (10 years of age for girls and 15 years of age for boys) in locations that are accessible and welcoming to both in-school and out-of-school youth.

Existing ARH services should be improved to meet all of the originally established criteria for provider training, youth-friendly environments, and activity space. Additional services should also be established in more health zones and provinces, with the goal of covering the entire country. Both existing and future ARH services need to be widely publicized so that adolescents, parents, health care providers, teachers, and youth-focused NGOs are all aware of their existence.

The development of a national adolescent health communication strategy, in collaboration with international and national NGOs, would help to increase adolescents' knowledge of ARH and promote positive social norms and attitudes related to the use of modern contraceptive methods. The strategy should not only aim to provide information through a mix of channels (mass media, mid-media, digital media and interpersonal communication), but also engage adolescents and youth in meaningful ways. Targeted messages should address the key issues that were identified during this research, including misconceptions about early sexual debut, the benefits of modern contraceptive methods for pregnancy prevention, the dangers of using other pharmaceutical and traditional products, and strategies for discussing ARH issues with partners and even parents.

Although this study focused primarily on the use of contraceptive methods, the strategy should integrate family planning and HIV/STI prevention messages, given that adolescents are at high risk of HIV and STIs (both prior to marriage and after marriage if their spouse has other sex partners).



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