List of Figures

Figure 1.1 Africa 9

Figure 1.2 Democratic Republic of Congo 9

Figure 3.1.Conceptual Framework of the study 66

Figure4.1 Percentage of women educational level 69

Figure 4.2 Percentage of women literacy 69

Figure 4.3 Percentage of husband's educational level 70

Figure 4.4 Percentage of young women employment status 70

Figure 4.5 Percentage of young women family wealth index 70

Figure 4.6 Percentage of women exposure to media 71

Figure 4.7 Percentage of marital status 73

Figure 4.8 Percentage of birth order 73

Figure 4.9 Percentage of ideal number of children 74

Figure 4.10 Percentage of family size 74

Figure 4.11 Knowledge of ovulatory cycle 75

Figure 4.12 Knowledge of contraceptive methods 75

Figure 4.13 Percentage of insurance coverage 77

Figure 4.14 Percentage of place of residence 77

Figure 4.15 Percentage of age at first sex 78

Figure 4.16 Percentage of age at first cohabitation 78

Figure 4.17 Age at first birth 79

Figure 4.18 Current use of contraceptive methods 79

Figure 5.1 Age at sexual intercourse by educational level 82

Figure 5.2 Age at first sexual activity by Family Wealth Index 82

Figure 5.3 Mean of age at first sexual activity by ethnicity 83

Figure 5.4 Mean of age at first sexual activity by provinces 85

Figure 5.5 Age at first cohabitation by educational level 86

Figure 5.6 Age at first cohabitation by educational level 86

Figure 5.7 Percentage of age at first cohabitation by Family Wealth Index 87

Figure 5.8 current use of contraceptive methods by knowledge of methods 103

Figure 5.9 Percentage of current use of contraceptive methods by ever tried to delay pregnancy 104

UNIVERSITY of the
WESTERN CAPE

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIA	Central Intelligence Agency
CRC	Convention on the Rights of the Child
CS	Centre de Santé
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
GDP	Gross Domestic Product
GRH	General Referral Hospital
HIV	Human Immunodeficiency Virus
HZ	Health Zone
IAC	Inter-African Committee
ICPD	International Conference on Population and Development
INS	Institut National de Statistique
IPPF	International Parenthood Planning Foundation
ICRW	International Centre for Research on Women
IYF	International Youth Foundation
MDGs	Millennium Development Goals
MHCS	Maternal Health Care Services
MI	Moustiquaire Impregnée
MISC2	Multiple Indicators Cluster Survey 2
MISC4	Multiple Indicators Cluster Survey 4
MMR	Maternal Mortality Ratio
MEPSP	Ministère de l'Enseignement Primaire, Secondaire et Professionnel
MS	Ministère de la Santé

UNIVERSITY of the WESTERN CAPE

MPF	Ministère de la Planification Familiale
PNAM	Programme National d'Approvisionement en Medicament
PNDS	Plan National de Développement Sanitaire
PNLS	Programme National de Lutte contre le Sida
PNMLS	Progamme National Multisectoriel de Lutte contre le Sida
PNSA	Progamme National de Santé des Adolescents
PNSR	Progamme National de Santé de Reproduction
PRB	Population Reference Bureau
PRSP	Poverty Reduction Strategy Paper
SBA	Skills Birth Attendance
TFR	Total Fertility Rate
UIS	UNESCO Institute for Statistics
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

UNIVERSITY of the
WESTERN CAPE

Chapter I

1. THE CONTEXT AND BACKGROUND OF THE STUDY

1.1 Introduction

The world is experiencing the largest generation of young people in history, roughly half of the world's population is under the age of 25 (WHO, 2005; UNFPA, 2006); those who are aged 10-24 constitute about a quarter of the world's population (UNFPA, 2014). The majority of young people (88 per cent) live in developing countries (PRB, 2013). About 22 per cent of those living in developing countries live in Africa (PRB, 2013). Young people are increasingly acknowledged as assets and key partners to step up economic development and reduce poverty and inequality (Bankole & Malarcher, 2010; Guerra & Bradshaw, 2008; Pittman, 2011; UNFPA, 2014). However, young people, especially adolescent girls and young women living in the developing World, suffer disproportionately from negative sexual and reproductive health outcomes, which challenge their ability to contribute to their communities' and countries' development (Minkler & Wallerstein, 2011; Sawyer *et al.*, 2012; UNFPA, 2007a; UNFPA, 2014).

UNIVERSITY of the
WESTERN CAPE

As part of the largest youth generation in the history of the world, today's adolescents need information, services, and support to prevent early marriage, unplanned pregnancies, unsafe abortions, HIV/AIDS and sexually transmitted infections STIs (Boonstra, 2007; Bearinger *et al.*, 2007; Singh *et al.*, 2009). In contrast, they are challenged by substantial social and economic barriers in accessing sexual and reproductive health information and services (Bearinger *et al.*, 2007; Bankole & Malarcher, 2010; Fatusi & Hindin, 2010), which is evidenced by persistently high levels of adolescent pregnancies, unmet needs for contraception, maternal mortality and HIV incidence. Around 16 million young women aged 15 to 19 give birth every year, nearly more than one out of ten among these pregnancies(11.1 per cent) are to children under the age of 15 and

nine out of ten (90 per cent) adolescent pregnancies in the developing world are to girls who are already married (WHO, 2012). Up to 75 per cent of the 16 million annual adolescent pregnancies are intended and planned (WHO, 2008b). Furthermore, young women aged 15 to 19 are twice as likely to die during pregnancy or childbirth compared to those over age 20 (WHO/UNFPA, 2006). Worldwide nearly 4.5 million adolescents undergo abortions each year; 40 per cent occur under unsafe conditions (WHO/UNFPA, 2006). In 2012, an estimated 780,000 youth aged 15-24 were newly infected with HIV, with 97 per cent of the new infections occurring in low and middle income countries (UNICEF/UNAIDS, 2012). Moreover, young women aged 15 to 24 are 50 per cent more likely to acquire HIV than their male peers (UNAIDS; 2012). This alarming situation, appears particularly dramatic in sub-Saharan Africa where are clustered the countries with the highest child marriage and adolescent fertility rates in the world (UNFPA, 2012; World Bank Data, 2012). Investigation has suggested that there is a great benefit in investing in young people by creating pathways for accelerated development (UNFPA-SA, 2013).

With reference to the structure of the population, the DRC is a youthful country. This young population represents 49.9 million young people below the age of 25 years and 33.7 million aged under 15 years, embodying 68.1 per cent and 46.0 per cent of the total DRC's population, respectively (PRB, 2015). With 73.3 million Congolese, young people aged between 15 and 24 years constitute one fifth (22.2%), while those aged 60 years and older represent three per cent (PRB, 2015). Youths in DRC constitute a focal part of the population, which place them at the heart of the future of the Country. As observed by Bankole and Malarcher, "Investing in young people is of great importance not only because of the size of the adolescent population but also because of the roles this group will play in shaping the future of their societies"(Bankole & Malarcher, 2010). The development of the DRC depends largely on its youth's health. However, in the DRC, like in other Sub-Saharan African countries, young people face a large number of reproductive health problems. Despite several health care programs implemented by the concerned health officials, young people still have many

problems, particularly a lack of sexual health information, poor health care, inability to avoid early and unprotected sexual relationships, early marriage and childbearing, unsafe abortion and Sexually Transmitted Infections (STIs) including HIV and AIDS.

DRC, though the 2006 sexual violence law that criminalises child marriages in the country, makes the legal age of marriage 15 for women and 18 for men (DRC, Code de la famille, 1987). However, the practice of early marriage persists. Available statistics showed that nearly 74 per cent of young women aged 15-19 married before reaching their eighteenth birthday (DRC-MICS4, 2010). Among women aged 20-24, nine per cent are married by age 15 and 39 per cent by age 18 (PRB, 2013). Additionally, the contraceptive prevalence rate, modern method among married females was only four per cent and five per cent for adolescents aged 15-19 and youths aged 20-24 respectively during the period 2005-2011 (PRB, 2013). According to WHO (2013), the contraceptive prevalence was less than 20 per cent (18 per cent) during the period 2005–2012 whereas unmet needs for family planning was 24 per cent during the same period .

UNIVERSITY of the WESTERN CAPE

A survey conducted in 2014 by Demographic Health Survey (DHS, 2014) revealed that 1.2 per cent (1.6% for men and 0.6% for women) of the DRC's population aged 15-49 years tested HIV positive while one per cent (1.3 % for female and 0,6 % for men) young people aged between 20 to 24 years were HIV positive. The same source showed that 0.5 per cent (0.7 % for female and 0.2% for male) of young people aged between 15 and 19 years tested HIV positive. In light of the above prevalence among young people in DRC, HIV/AIDS remains a growing public concern and women are one of the most vulnerable groups. The lack of comprehensive correct knowledge of HIV/AIDS and use of condoms has shown that there is a danger of the spread of the disease within the DRC's population (PRB, 2013).

Indeed, despite the illegality of abortion in DRC and all the dangers associated with it, especially when performed in inadequate conditions, the rate of illegal abortions remains high among adolescents (PNSR, 2008). Induced abortions and

their consequences therefore pose a real public health problem in the Democratic Republic of Congo.

The Democratic Republic of Congo has one of the highest total fertility rates (TFR) in the world with 6.6 births per woman in 2014 (DHS, 2014). The adolescent fertility rate remains unacceptably high (138 births per 1,000 women in 2014) (DHS, 2014) which affects not only young women and their children's health but also their long-term education and employment prospects. With regards to pregnancy related school dropouts, it has become a matter of concern in DRC. Mostly, school girls who become pregnant either resort to illegal unsafe abortions or they face official school expulsion (CEDAW, 2013). Moreover, once girls have a baby, the chances of continuing education are negligible, despite the provisions made for them under the legislation regarding reintegration into the formal education system after the birth of their child. This places them at a further disadvantage (CEDAW, 2013).

The above situation shows that poor sexual and reproductive health among adolescents is still a relevant topic in the DRC. This study will therefore focus on youth fertility behaviour issues in the DRC as well as their utilisation of the health care system.

UNIVERSITY of the
WESTERN CAPE

1.2 The Democratic Republic of Congo: Facts, context and statistics

1.2.1 Geographical situation

The Democratic Republic of Congo (DRC) is located in the African Great Lakes region of Central Africa, and lies on the Equator. It covers an area of 2,345,095 of square kilometers and shares a 9,165 km border with nine neighbouring countries namely: the Central African Republic and South Sudan to the north; Uganda, Rwanda, Burundi and the United Republic of Tanzania in the east; Zambia and Angola to the south; the Republic of the Congo, the Angolan enclave of Cabinda, and the Atlantic Ocean to the west. By its size, the Democratic Republic of Congo (DRC) is the second largest country in Africa after Algeria. With a population density of about 30 inhabitants per km^2 (PRB, 2013), the population is concentrated on the set off into the Savannah, near the Congo River and the lakes,

the northern and central part of the country. The equatorial forest that covers much of the country is almost uninhabited (PNSR, 2008).

1.2.2 Demographics

An official census has not been carried out in a long time in DRC, making it therefore difficult to give with precision the number and structure of the country's population. In the scientific census of 1984, the DRC had a population which stood at 29 million against 13.5 million in 1958. In 2015 the mid-population was estimated at 73.3 million by the Population Reference Bureau (PRB, 2015), 79.4 million by the Central Intelligence Agency (CIA, 2015) and 85.0 million by the "Institut National de la Statistique" (INS, 2015). With regards to recording the" civil state", DRC's rate is among the lowest on the continent, 25 per cent of children below five years registered with the civil state in 2013 with disparity between urban (30%) and rural (22%) areas (DHS, 2014).

In light of the population growth rate in the DRC, it was estimated in 2013 to be 3.4 per cent by the INS, but at 2.9 per cent by PRB and 2.7 per cent by the United Nations (INS, 2015; PRB, 2013; UN, 2012). It should be noted that despite these differences, all the currently available estimates indicate that the population of the DRC is expected to reach 100 million before or around 2030. The DRC capital, Kinshasa, is characterized by a strong increase in its population estimated at 1.5 million in 1975; it increased to more than 11 million in 2015 and continues to grow rapidly. The majority of the population (65% to 67%) lives in rural areas (UN, 2012; PRB, 2013). Numerical superiority of women is seen more in urban than in rural areas. (Ministry of Planning - MICS2, 2001). Women represent 51 per cent of the total population against 49 per cent of men(INS, 2015). On average, a Congolese home has six members and women of childbearing age represent 21 per cent of the total population, while there are 45 births per 10 000 persons and 16 deaths per 10 000 persons (PRB,2013) .

The fertility level remains high even though it has undergone changes. Indeed, the Total Fertility Rate (TFR) improved slightly but remains above the average of Sub-Saharan Africa. It went from 7.1 children per woman (MICS 2, 2001) to 6.6

UNIVERSITY of the
WESTERN CAPE

in 2014 according to PRB (2015). This is related to poor access to family planning and contraception, as well as sociocultural factors. Since 1998 (two decades ago), the DRC has faced a dramatic humanitarian situation due to a long period of socio-political crises and armed conflicts which have resulted in the deaths of more than five million people from war, and associated famine and disease (IRC, 2007 as cited by Cox, 2012).

1.2.3 Socio cultural context

The Democratic Republic of Congo is a multi-ethnic country shaped by over 260 ethnic groups, of which the majority is Bantu (80%). Other Congolese populations are Sudanese, Nilotic and pygmies. Several studies had shown that the culture of the Democratic Republic of Congo reflects the diversity of its hundreds of ethnic groups and their differing ways of life throughout the country. Moreover, evidence suggests that ethnic background has implications for some aspects of adolescent and young people's reproductive health. Approximately 242 languages are spoken in the country, but only four have the status of national languages: Kikongo (Kituba), Lingala, Tshiluba and Swahili. French is the official language of the Democratic Republic of Congo. It is meant to be an ethnically neutral language, to ease communication among the many different ethnic groups of the Congo. According to the CIA (2013), Christianity is the majority religion in the Democratic Republic of Congo, and is followed by about 80 per cent of the population, Indigenous beliefs account for about 1.8 to 10 per cent, and Islam for 1.5 to 10 per cent (CIA, 2013). Based on available data, the country is ranked 141st position according to the gender-specific indicator of human development according to the World Report on Human Development 2007.

1.2.4 Education

The DRC's education system operates on a four-level principle: pre-primary, primary, secondary and tertiary. The first level is the pre-primary cycle, called the 'Maternel.' It is optional and is closely followed by primary education known as 'cycle primaire'. Primary education in the DRC is not free and compulsory, even though the Congolese constitution says it should be (Article 43 of the 2005

Congolese Constitution). The reality is that households still bear a significant portion of the costs of primary education due to school expenses and 26.8 per cent of children aged 6 to11 years were not enrolled in school in 2012 (MEPSP, 2013). Moreover, the education system has suffered from decades of conflict although recent years have shown an improvement. Statistics show that in 2011, 105 per cent (113% of boys and 98% of girls) were enrolled in primary school while 43 per cent (54% of boys and 32% of girls) in age were enrolled in secondary school and 8 per cent (11% of male and 5% of female) in age were enrolled in tertiary education for the same period (UNESCO-UIS, 2013). With regards to literacy, the adult literacy rate was estimated to be 61.2 per cent (76.9% male and 46.1% female) while the youth literacy rate was estimated to be 65.8 per cent (78.9% male and 53.3% female) in 2007 (UNESCO-UIS, 2013).

Despite the above given situation, the educational system of the DRC is marked by its resilience. In spite of its decades' long history of brutal violence and political transition, the educational system has emerged relatively intact. The Percentage of children who have never attended school (28.5) (MEPSP, 2013) is lower in Congo, than the average for the Sub-Saharan African region. This is true regardless of the fact that Congolese households fund approximately 80 to 90 per cent of educational spending (UNHCR, 2012).

UNIVERSITY of the
WESTERN CAPE

1.2.5 Socio-Economic profile

The Democratic Republic of Congo is widely considered to be the richest country in the world regarding natural resources; its untapped deposits of raw minerals are estimated to be worth in excess of US$ 24 trillion (Morgan, 2009). Unsurprisingly, the DRC's economy is primarily based on the mining sector.

Despite such vast mineral wealth, the economy of the Democratic Republic of Congo has declined drastically since the mid-1980s. The country's woes mean that, despite its potential, its citizens are among the poorest people on earth, the Congolese being consistently assigned the lowest, or near lowest, nominal GDP per capita in the world. According to World Health Statistics 2013, 59.2 per cent of the population in the Democratic Republic of Congo lived on less than $1 (PPP int. $) a day in the period 2005–2008 (World Health Statistics, 2013). In addition,

the DRC had the world's lowest Human Development Index (0.338) in 2013 (UNDP, 2014). Central Intelligence Agency (2014) suggested that, the GDP / H is estimated at around 416 USD for the whole country in 2014, but it is highly variable from one province to another.

In term of youth employment, evidence suggests that young people's skills do not meet employers' demands, and young people find few opportunities to earn a decent wage (IYF, 2013). PRB (2013) estimated that the Labour Force Participation of youth aged 15 to 24 at 49 per cent and 42 per cent for females and males respectively in 2010 (PRB, 2013), whereas MICS4 (2010) hold 42 per cent of children aged between 5 to14 have been involved in child labour in the same period. According to the Ministry of Planning, youth unemployment in the formal economy is at 32.2 per cent, nearly double the national average of 17.8 per cent (DRC Ministry of Planning, 2011b). Nevertheless, the factual magnitude of underemployment and unemployment among the youth is unknown, the 2012 African Economic Outlook stated that more than 70 per cent of youth between ages 15 and 24 do not have jobs, and those in urban and peri-urban areas were the hardest hit (African Development Bank, 2012).

UNIVERSITY of the
WESTERN CAPE

1.2.6 Administration

Administratively, the DRC is a unitary state highly decentralized. It is divided into ten provinces and one city-province, namely, Kinshasa the capital city. The provinces are Bandundu, Bas-Congo, Equateur, Kasai-Occidental, Kasai-Oriental, Katanga, Maniema, Nord-Kivu, Orientale and Sud-Kivu. The provinces are subdivided into districts which are divided into territories. Overall, DRC is made up of 25 administrative districts, 21 cities, 145 towns and 77 administrative territories. The Constitution of the Third Republic (February 2006), provides the shift from 11 to 26 provinces and ended the existence of the step "district".

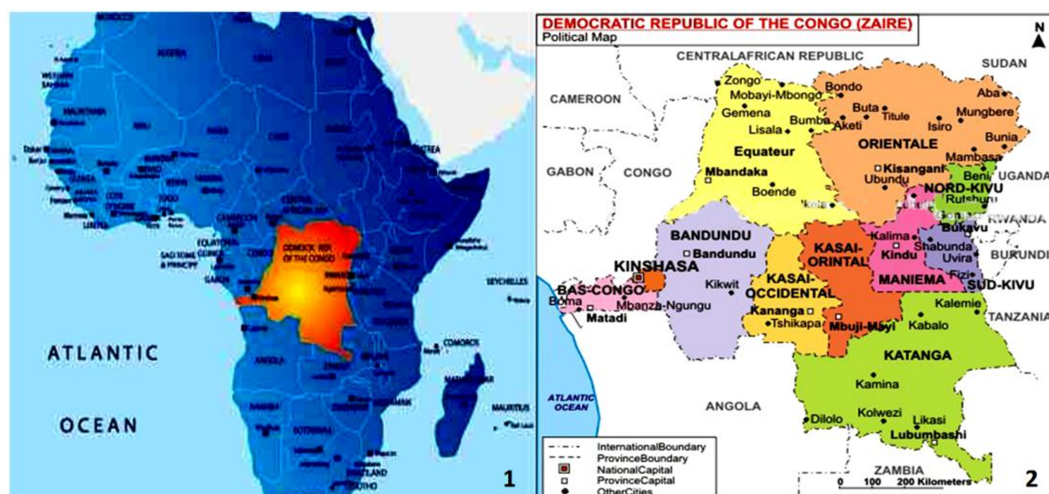


Figure 1.1 Africa. *Source: http://www.mining.com/drcs-corrupt-mining-industry-highlighted-on-website.*

Figure 1.2 Democratic Republic of Congo. *Source: http://focusafrica.gov.in/Country_at_glance_DRC.html.*

1.3 Health Situation of the DRC

This section contains health conditions and indicators, reproductive health in general, and youth sexual and reproductive health.

1.3.1 Health conditions and indicators

UNIVERSITY of the
WESTERN CAPE

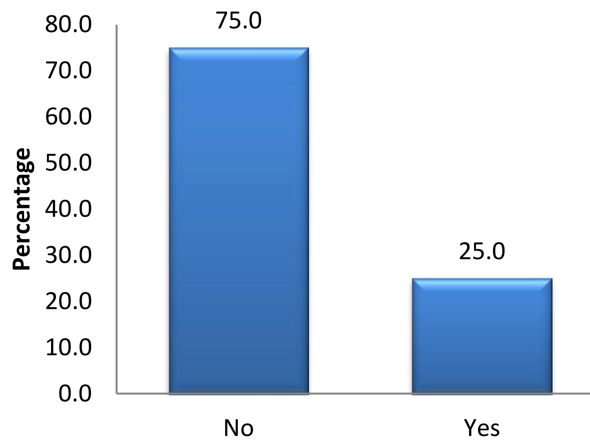
In the DRC, like in most developing countries, the health sector faces several challenges including inadequate health services or its concentration in urban areas, inadequate distribution of health workers at the expense of rural areas, the lack of reproductive health training for health workers, the obsolescence and deterioration of infrastructure and equipment, a supply deficiency of products including contraceptives, etc. Efforts to date in DRC, to improve the quality of care and health services, have had only very limited results on the health of the population in general, and particularly on reproductive health.

DRC's Health System is inspired by the Alma Ata Declaration of 1978 based on the strategy of Primary Health Care, and the Bamako Initiative of 1987 having devoted the involvement of communities in the management system health and cost-sharing. In this system, the operating unit is the Health Zone (HZ) (PNAM, 2009). The country is divided into 515 health zones (HZ) among which 424 are operational with each having an available General Referral Hospital (GRH) or

Type of Media exposed

With regard to the type of media exposed viz. radio, television and newspapers, Figure 4.6 indicates that three quarters of the respondents were not exposed 75.0% (2594) to media against only one quarter who were exposed 25.0% (865).

Figure 4.6 Percentage of women exposure to media



Source: DRC-DHS-2013-2014; computed by author

4.2.2 Socio-cultural characteristics

Socio cultural characteristics implied religion and ethnicity.

Ethnicity

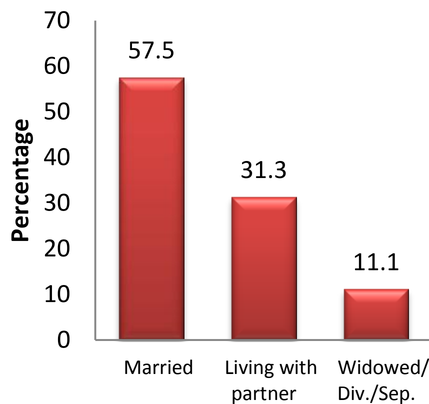
The distribution of ethnicity is presented in the Table A.3 in appendices. The preponderant ethnic groups are Kasai, Katanga, Tanganika & Lunda (28.1%) and Basele-K, Man. & Kivu (20.0%) while the Bakongo Nord & Sud women represent only 5.2%.

Religion

Regarding the religion aspect, the Table A.3 in appendices displays that more than one in three young women (36.9%) expressed their confession as "Other Christians".

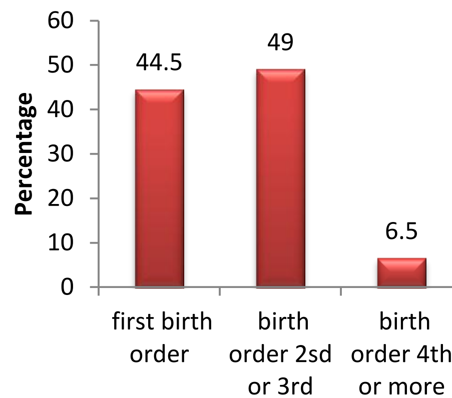
or third and 6.5% was in fourth order and above. It appears that nearly half of young women were in second or third birth order.

Figure 4.7 Percentage of marital status



Source: DRC-DHS-2013-2014; computed by author

Figure 4.8 Percentage of birth order



Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

Age of husband/partner

Pertaining to husband's age, findings from Table A.4 brings to light that the average age of respondents' husbands was 27.8 years. However, the majority 62.6% (1918) of women's husbands were aged 25-34, followed by 26.3% (339) aged 15-24, while not more than 11.1% (339) were aged 35 and above.

Number of children ever born

Table A.4 in appendices displays the repartition of number of children ever born. The overall average number of children ever born was 1.5 per young women; the majority (65.6%) of respondents have one to two children, 17.7% three to seven births and 16.7% have not experienced child birth.

Number of living children

The distribution of the number of living children is presented in the Table A.4 in appendices. In general, the average number of living children was 1.4 per young woman; the majority (77.3%) of respondents had 1 to 3 living children, very few (3.1%) had four to six and 19.1% had no living children.

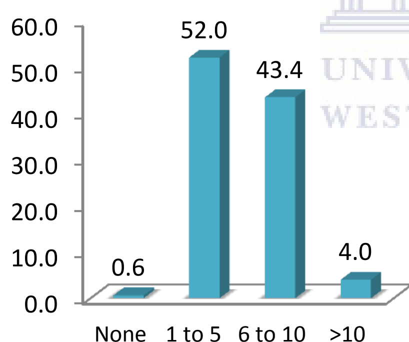
Ideal number of children

Figure 4.9 highlights that on average the ideal number of children was 6.0. However, the majority of respondents (52.0%) wanted one to five children against 43.4% who wanted between six to ten children. Moreover, 4.0% wanted more than ten children while 0.6% did not want children.

Family size

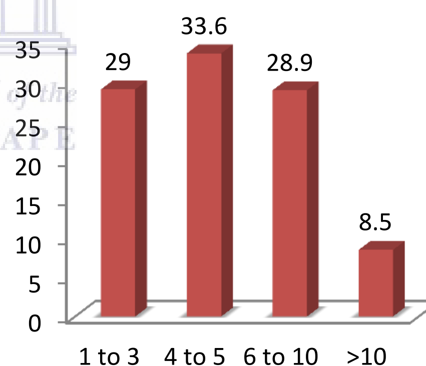
Concerning the number of household members, Figure 4.10 indicates the average size of household is 5.5 members. In addition, more than three in ten families (33.6%) have four to five members, less than three in ten have six to ten members (29%), while less than one in ten families (8.5%) have more than ten members.

Figure 4.9 Percentage of ideal number of children



Source: DRC-DHS-2013-2014; computed by author.

Figure 4.10 Percentage of family size



Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

Number of unions

Considering the number of unions, the majority of the respondents (94.1%) have not experienced more than one union while few (5.9%) have experienced more than one union.

Number other wives

Be concerned about the number of other wives, findings from the Table A.4 highlights the greater part of the participants (83.9%) were not in polygamous marriage against 16.1% who were in monogamous marriage.

4.2.4 Family planning characteristics

These variables deal with knowledge and awareness factors.

Knowledge characteristics

Knowledge characteristics taken into consideration in this section are variables such as knowledge of ovulatory cycle, knowledge of contraceptive methods, and ever used anything to delay pregnancy.

Knowledge of ovulatory cycle

Considering young women's knowledge of ovulatory cycle, the Figure 4.11 reveals that the majority of respondents (55.8%) reported not knowing their ovulatory cycle while 44.2% reported to know.

UNIVERSITY of the
WESTERN CAPE

Knowledge of contraceptive methods

Figure 4.12 highlights that the largest part of respondents (87.5%) reported knowing modern method, 3.6% know traditional and folkloric methods whereas 8.9 % testified not knowing any contraceptive methods.

Figure 4.11 Knowledge of ovulatory cycle

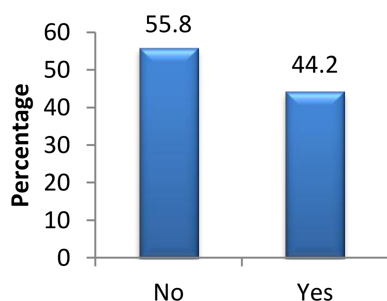
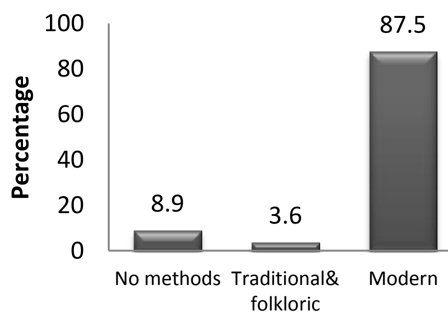
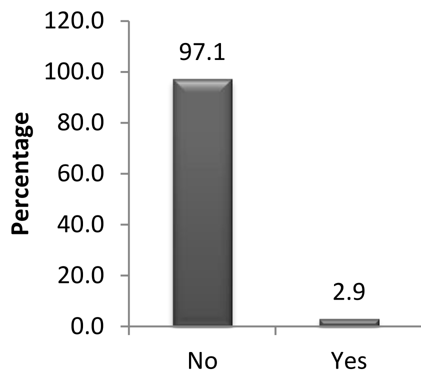


Figure 4.12 Knowledge of contraceptive methods



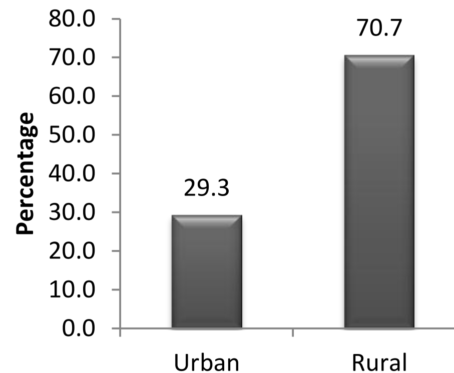
According to the place of residence, Figure 4.14 indicates the majority of respondents 70.7% (2461) resided in rural areas whereas 29.3% (1021) lived in urban areas.

Figure 4.13 Percentage of insurance coverage



Source: DRC-DHS-2013-2014; computed by author

Figure 4.14 Percentage of place of residence



Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

Province

As far as the provinces are concerned, Table A.6 in appendices points out that the highest proportion of respondents (15.4%) lived in Bandundu followed by Equateur (15.2%) while the smallest (3.2%) lived Bas Congo.

4.3 Behavioural characteristics

To the degree that behavioural characteristics are concerned, factors such as personal practices and reproductive health behavioural were taken into consideration.

4.3.1 Smoking status

With reference to smoking status which is the only personal practice taken into account in the context of this research, the results from the Table A.7 in appendices points out that nearly all of respondents reported not smoking (97.6%) whereas only 2.4% acknowledged smoking.

4.3.2 Reproductive health behaviour factors

These variables consist of age at first sexual intercourse, age at first cohabitation, age at first birth and Contraceptive use.

Age at first sexual intercourse

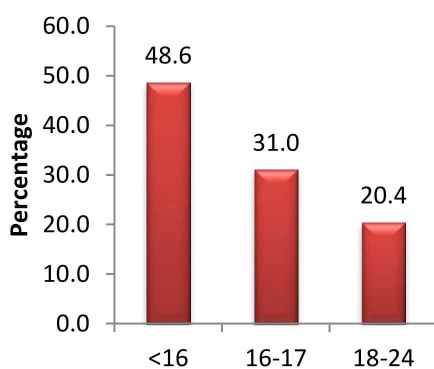
The repartition of age at first sexual intercourse is highlighted in the Table A.7. Averagely, young women age at the first sexual intercourse was 15.7. Furthermore, Figure 4.15 indicates that 48.6% of respondents had their first sexual intercourse before reaching the age of 16, 31.1% started at the age of 16-17 and 20.4% initiated it in emerging adulthood (18-24). Subsequently, 79.6% of respondents were sexually active before reaching the age of 18. This indicates the earlier age of sexual intercourse.

Age at first cohabitation

The Table A.7 in appendices depicts the distribution of the age at first cohabitation. Overall, adolescent and young adult women average age at first cohabitation was 16.7. Figure 4.16 shows that majority (64.3%) of respondents entered into cohabitation by 18, 35.7% got married in their emerging adulthood while 17.7% of participants were cohabitated in their early adolescence (by 15). It emerges that the substantial part of young women faced early cohabitation.

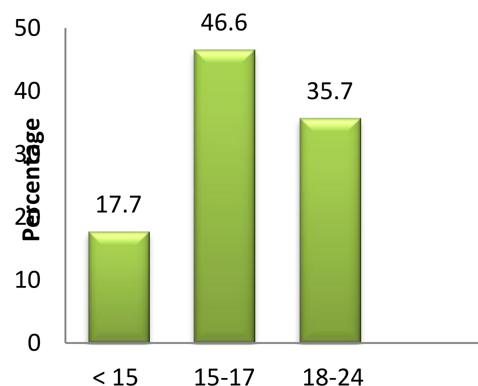
UNIVERSITY of the
WESTERN CAPE

Figure 4.15 Percentage of age at first sex



Source: DRC-DHS-2013-2014; computed by author

Figure 4.16 Percentage of age at first cohabitation



Source: DRC-DHS-2013-2014; computed by author

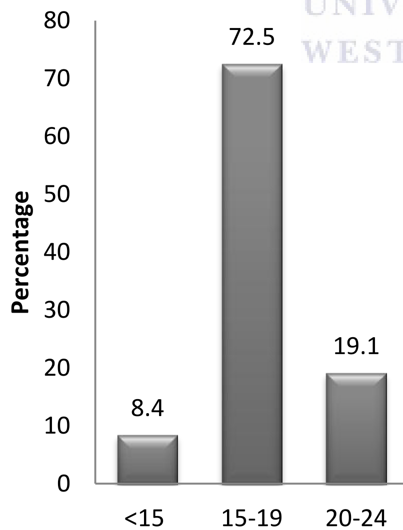
Age at first birth

Findings from Table A.7 in appendices reveal that the average age at first birth was 17.6. However, the Figure 4.17 indicates that the majority of participants (72.5%) experienced childbirth at the age 15-19, 8.4% experienced it in their early adolescence and 19.1% undergone childbearing in their emerging adult hood. Consequentially, the substantial part (80.9%) of respondents faced childbirth before 20. This indicates that young women predominantly faced early entry into motherhood.

Current contraceptive use

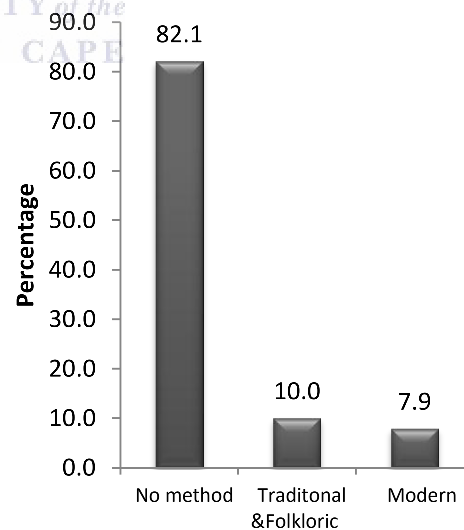
With regard to current contraceptive use, Figure 4.18 reveals in all, less than one tenth of participants reported using modern method (7.8%), only one tenth reported using traditional or folkloric method (10.0%) and more than eight tenths (82.1%) of participants reported not using contraception (82.1%). It emerges that the use of contraceptive methods remains low among young women.

Figure 4.17 Age at first birth



Source: DRC-DHS-2013-2014; computed by author

Figure 4.18 Current use of contraceptive methods



Source: DRC-DHS-2013-2014; computed by auth

UNIVERSITY of the
WESTERN CAPE

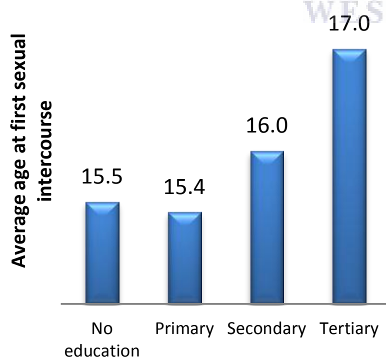
women with primary education scored higher (54.3%) in participants who experienced early sexual intercourse (before reaching the age of 16) while those with tertiary education scored lower (13.0%). This suggests that age at first sexual intercourse positively varied with educational level as expected.

Family Wealth Index

There was a significant and weak association between young women's family wealth index and age at first sexual activity (x^2= 28.8, df= 8, p=.000), with Cramer's V= 0.06. Figure 5.2 emphasises that young women in poorest wealth quintile were most likely (15.4 years on average) to start sexual activity at the early age compared to those recorded in other wealth quintiles such as richest quintile (16.2 years). Furthermore, Table A.8 in appendices reveals 53.4% of respondents registered in poorest quintile initiated sexual activity by 16 against 41.9% registered in richest quintile. Age at first sexual activity positively differed with the standard of living of household.

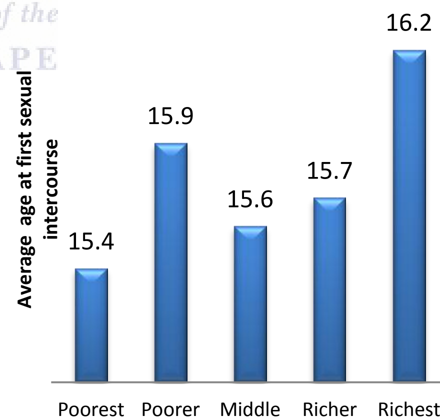
UNIVERSITY of the
WESTERN CAPE

Figure 5.1 Age atsexual intercourse by educational level



Source: DRC-DHS-2013-2014; computed by author

Figure 5.2 Age at first sexual activity by Family Wealth Index

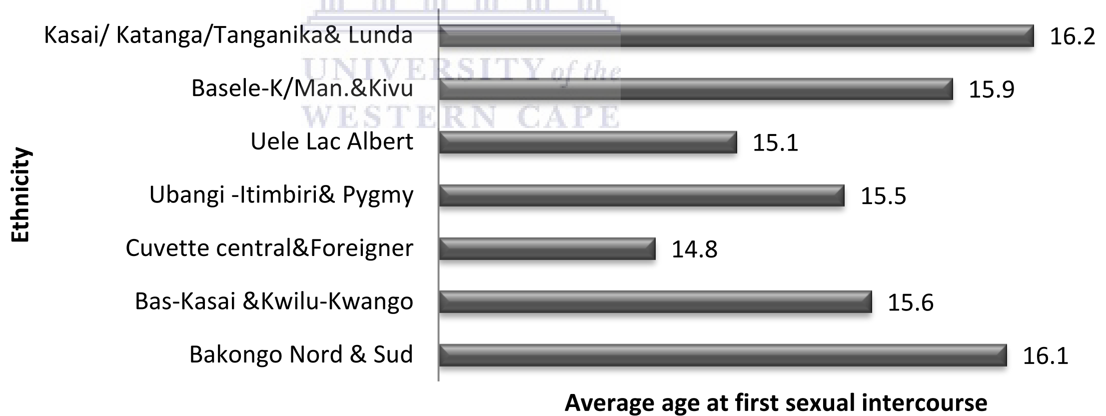


Source: DRC-DHS-2013-2014; computed by author

Religion and ethnicity

Religion was not significantly associated with young women's age at first sexual intercourse (χ^2 = 15.3, df= 10, p= .13), regardless that age at first sexual intercourse fluctuated between religions. Concerning ethnicity effects, there was a significant and small association with the age at first sexual intercourse (χ^2 = 110.0, df= 14, p=.000), together with Cramer's V= 0.13. Figure 5.3 brings to light that on average, Cuvette central & Foreigners young women experienced first sexual intercourse at early age (14.8) compared to other ethnic group's women for instance Kasai- Katanga / Tanganika & Lunda (16.2). Subsequently, the proportion of respondents who initiated early sexual activity was higher amongst cuvette central & Foreigners young women (63.5%) while the lower was found amongst Kasai-Katanga/Tanganika & Lunda women (40.3%). Age at first sexual intercourse sensibly varied with ethnicity.

Figure 5.3 Mean of age at first sexual activity by ethnicity

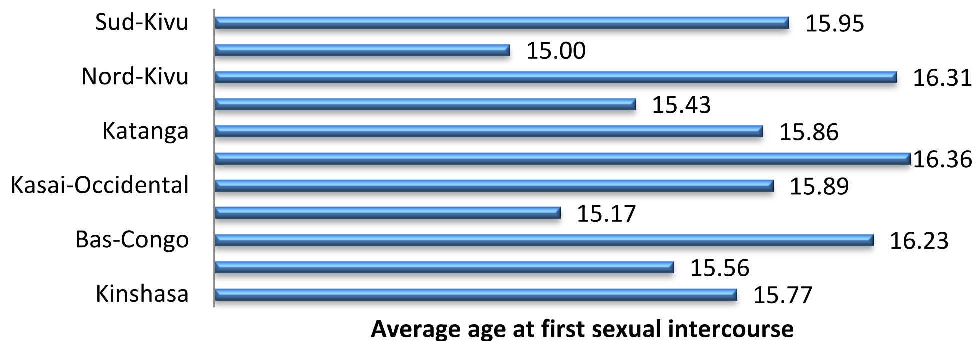


Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

participants who live in rural area experienced first sexual intercourse by 16 years of age, which declined to 43.4% amongst those who resided urban area. It emerges that young women age at first sexual activity fluctuated with place of residence.

Figure 5.4 Mean of age at first sexual activity by provinces



Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

5.3.2 Relationship between individual and behavioural characteristics and age at first cohabitation

Age at first cohabitation (marriage) is acknowledged socially mark the commencement of exposure to risk of pregnancy. Age at first marriage straight affects young people's fertility; its extent in some adolescent and young adults groups also helps to effective apprehend their exposure to fertility. The relationships between age at first cohabitation and the various variables of researches are depicted from the Tables 5.1, 5.2, 5.3, A.9 and A.10. Amongst 14 variables initially defined as potential predictors of age at conjugal union, 13 were found to be significantly related to the age at first cohabitation.

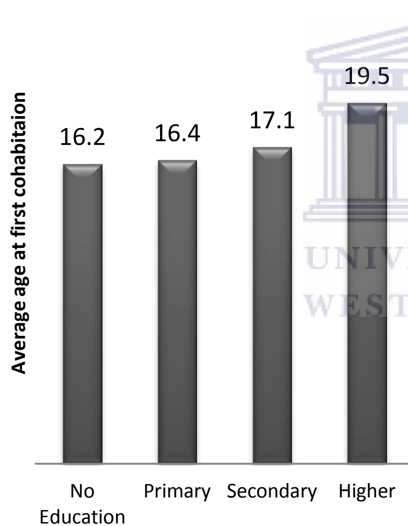
Age at first cohabitation by socio economic and cultural characteristics

Table A.9 in appendices presents the variations in age at first cohabitation within socio economic and cultural characteristics.

Highest Educational level

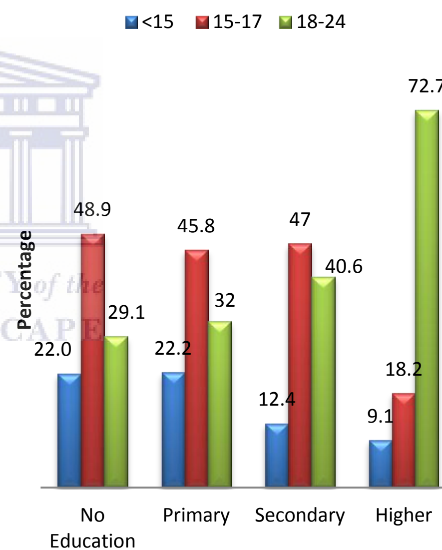
Women's level of education was significantly connected with the age at first cohabitation of the young women (x^2=136.1, df=9, p=.00), with a bit small association at 0.2 considering Cramer's V. However, Figure 5.5 displays the Average age at first union increased from young people with no education (16.2) to those with higher education (19.5). In the light of that, the Figure 5.6 reveals the highest proportion of participants who experienced early cohabitation (by 18 years) was found amongst young women with no education (70.9%), which was lowest among women with higher education (27.3%). Age at first cohabitation increased with educational level.

Figure 5.5 **Age at first cohabitation by educational level**



Source: DRC-DHS-2013-2014; computed by author

Figure 5.6 **Age at first cohabitation by educational level**



Source: DRC-DHS-2013-2014; computed by author

Literacy

Concerning women's literacy, there was a significant and weak relationship with age at first union (x^2=83.5, df= 3, p=.000), along with Cramer's V=0.110. On average, young women's age at first cohabitation increased from illiterate (16.3) to literate (16.9) implying that the higher literacy, the tardy cohabitation.

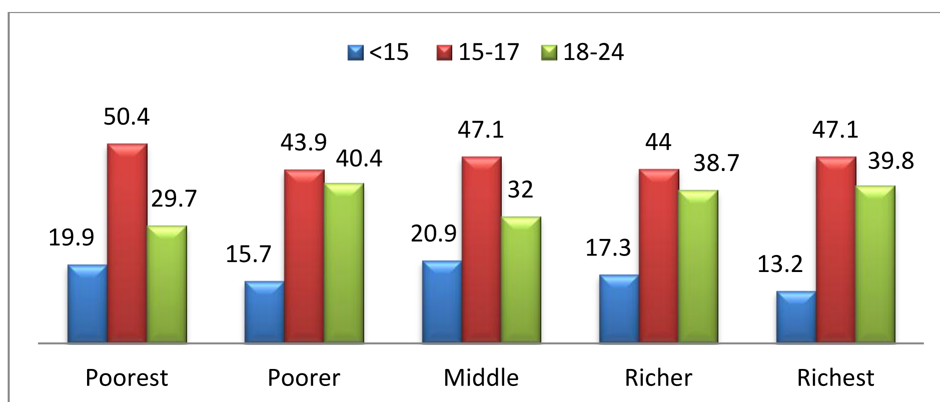
Furthermore, illiterate women scored the higher percentage (70.4%) in participants who have begun first union by 18 compared to literate women (60.4%). Moreover, 22.5% of illiterate women got married in the early adolescence against 14.7% of literate.

Women's employment status and family wealth index

Women's employment status was significantly associated with the age at first cohabitation (x^2=10.5, df=3, p=.015), though the strength of this relationship was found to be very small at 0.05 with Cramer's V. Results from Table A.9 in appendices indicates that 65.9% of employed women experienced first union by 18 years, which decreased among unemployed women (61.2%). Moreover, the age at first union was significantly associated with the living standard in the household (x^2=56.8, df=12, p=.000), in spite that this association was weak at 0.13 by Cramer's V. Figure 5.7 reveals women in the poorest wealth quintile were more likely to enter into cohabitation at the early age (16.3 years on average) when compared to women in other wealth quintiles such as richest (17.1 years). Likewise, the percentage of young people who experienced early marriage was bigger in the poorest quintile (70.3%), which decreased in other wealth quintiles for instance richest (59.6%). It appears that women's age at first union increased with the living standard in the household.

UNIVERSITY of the
WESTERN CAPE

Figure 5.7 Percentage of age at first cohabitation by Family Wealth Index



Source: DRC-DHS-2013-2014; computed by author

(x^2=77.9, df= 6, p=.000).With Cramer's V=.106. The prevalence of current contraceptive methods use decreased continually from women who desired none children (25.0%) to those who desired more than ten (10.9%). With regards to the number of household members, there was a significant and weak relationship with young women's current use of contraceptive methods and (x^2=40.0, df=6, p=.000), by Cramer's V= 0.076. The prevalence of current contraceptive use was higher (20.4%) among women with four to five household members against no more than12.4% amongst women with one to three household members.

Contraceptive use by family planning characteristics

Table A.15 in appendices displays significant associations between whole family planning variables involved in current contraceptive methods use.

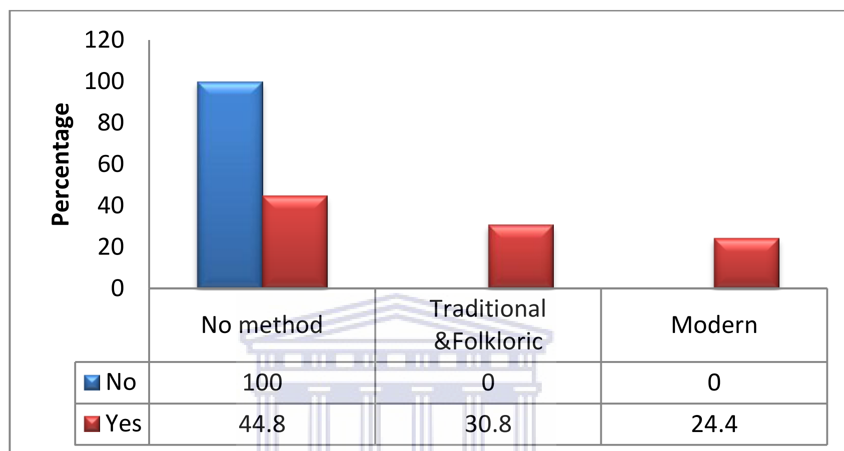
Knowledge of ovulatory cycle and Knowledge of any method

Knowledge of ovulatory cycle was found to be significantly and weakly associated to women's use of contraception methods (x^2=32.2, df=2, p=.000), at 0.096 using Cramer's V. Young women who have knowledge of their ovulatory cycle were more likely (22.1%) to use contraceptive methods compared to those who have no knowledge of it (14.7%). Current use of contraceptive methods varied positively with women's knowledge of ovulatory cycle. Regarding the knowledge of any contraceptive method, a significant and small relationship with women's use of contraceptive methods was uncovered (x^2=88.6, df=2, p=.000), with Cramer's V= 0.11. Figure 4.6 demonstrates that respondents with knowledge of modern contraceptive methods were more likely (20.1%) to use contraceptive methods than those with knowledge of traditional and folkloric methods (10.4%).

UNIVERSITY of the
WESTERN CAPE

illuminates that amongst young women who ever tried to delay or avoid getting pregnant, 24.4% have currently used modern contraceptive methods, 30.8% used traditional and folkloric methods while, 44.8% never used contraceptive methods. This suggests that young women's current use of contraceptive methods effectively varied whether she ever tried to delay or avoid getting pregnant or not.

Figure 5.9 Percentage of current use of contraceptive methods by ever tried to delay pregnancy



Source: DRC-DHS-2013-2014; computed by author

UNIVERSITY of the
WESTERN CAPE

Contraceptive use by enabling characteristics

Results from Table A.16 indicate significant relationship between all enabling variables implicated in current contraceptive behaviour with the current contraceptive use.

Health insurance

There was a significant and weak relationship between current use of contraceptive methods and health insurance (x^2=33.5, df=2, p=.000), at .098 with Cramer's V. Participants with health insurance were more likely (39.6%) to use contraceptive methods when compared to those who had not it (17.3%). Women's contraceptive methods use was positively related to health insurance status.