

Utilisation Of Sexual And Reproductive Healthcare Services By The Youth In The Democratic Republic Of The Congo: A Desktop Review

Omari Shabani¹, Muangu Yamba Willy²

¹ Associate Professor Universite Pedagogique Nationale, Democratic Republic of the Congo.
omarishabani@hotmail.com; <https://orcid.org/0000-0003-4930-1413>

² Associate Professor Universite Pedagogique Nationale, Democratic Republic of the Congo.
willymuangu@gmail.com

Corresponding Author: Omari Shabani. E-mail: omarishabani@hotmail.com;



Abstract: Young people in the Democratic Republic of the Congo (DRC) experience a high burden of sexual and reproductive health (SRH) challenges, including early sexual debut, unintended pregnancies, and sexually transmitted infections. This study aimed at reviewing and synthesizing existing literature on the utilization of sexual and reproductive healthcare services among youth in the DRC, with a focus on identifying patterns of use, key determinants, and persistent barriers.

This review was conducted utilizing peer-reviewed publications, national demographic and health surveys, policy documents, and grey literature published between 2000 and 2025 utilizing PubMed, Google Scholar, and institutional repositories using relevant keywords. Studies were selected based on predefined inclusion criteria focusing on youth aged 10–24 years in the DRC. A thematic analysis approach was employed to extract and synthesize findings related to service utilization, socio-demographic factors, and health system influences.

The review found that utilization of SRH services among youth in the DRC is generally low, with significant disparities by age, gender, marital status, education level, and place of residence. Adolescents, particularly those aged 10–19 years, and unmarried youth are less likely to access services compared to older and married individuals. Major barriers identified include socio-cultural norms and stigma surrounding adolescent sexuality, lack of youth-friendly services, concerns about confidentiality, financial constraints, and limited awareness of available services. Health system limitations such as inadequate provider training, shortages of commodities, and weak integration of youth-focused programs further restrict access. Conversely, interventions involving community outreach, peer education, and school-based programs show promising results in improving knowledge and service uptake.

SRH service utilization among youth in the DRC remains constrained by interconnected individual, socio-cultural, and systemic barriers. Strengthening youth-friendly health services, enhancing comprehensive sexuality education, and addressing structural inequalities are essential to improve access and utilization. Future research should prioritize intervention-based studies and region-specific analyses to guide effective policy implementation.

Keywords: Adolescents; Barriers to access; Democratic Republic of the Congo; Healthcare utilization; Sexual and reproductive health; Youth

1. Background information

Adolescents and young people (aged 10–24 years) represent a rapidly growing demographic globally, accounting for nearly one-quarter of the population in sub-Saharan Africa. This age group faces a disproportionate burden of adverse sexual and reproductive health (SRH) outcomes, including early sexual debut, unintended pregnancies, unsafe abortions, and sexually

transmitted infections (STIs), including HIV. Despite global commitments under the Sustainable Development Goals (SDGs) to ensure universal access to SRH services, utilization among youth remains uneven, particularly in low- and middle-income countries (LMICs) where structural and socio-cultural barriers persist (1,2).

The Democratic Republic of the Congo (DRC) exemplifies these challenges within a context marked by demographic pressure, socio-political instability, and a fragile health system. With over 60% of its population under the age of 25, the country faces increasing demand for youth-responsive health services (3). National survey data indicate that sexual initiation often occurs during adolescence, yet access to modern contraceptive methods and comprehensive SRH services remains limited. Modern contraceptive prevalence among unmarried sexually active adolescent girls is estimated to be below 20%, reflecting a substantial unmet need for family planning (4,5). These gaps contribute to persistently high rates of adolescent pregnancy, maternal morbidity, and poor neonatal outcomes.

The utilization of SRH services among youth in the DRC is shaped by a complex interplay of individual, socio-cultural, and health system factors. At the individual level, inadequate knowledge of SRH, misconceptions about contraception, and low risk perception hinder service uptake. Evidence suggests that many adolescents lack accurate information and may rely on ineffective or unsafe methods to prevent pregnancy (6). Educational attainment has been consistently associated with increased utilization of SRH services, highlighting the importance of comprehensive sexuality education.

Socio-cultural norms play a critical role in shaping health-seeking behaviour. In many communities, premarital sexual activity is stigmatized, particularly for young women, creating barriers to accessing SRH services. Fear of judgment, lack of privacy, and concerns about confidentiality in health facilities discourage adolescents from seeking care (6,7). Gender inequalities further exacerbate these challenges, limiting young women's autonomy in making reproductive health decisions and increasing their vulnerability to coercion and unintended pregnancy.

Health system constraints remain a significant barrier to effective service delivery. The DRC's health system has been weakened by decades of conflict and underfunding, resulting in shortages of trained healthcare providers, inadequate infrastructure, and inconsistent availability of essential SRH commodities (8). Youth-friendly services are limited, and where they exist, they are often poorly integrated into primary healthcare systems. Financial barriers, including user fees and indirect costs, further restrict access, particularly for adolescents and young people in rural and underserved areas.

Despite these challenges, there is growing evidence that targeted interventions can improve SRH service utilization among youth. Community-based programs, peer education, and school-based interventions have demonstrated effectiveness in increasing knowledge and uptake of services (9). International frameworks, including the WHO global strategy on adolescent health, emphasize the importance of making health systems more responsive to the needs of young people through the provision of confidential, non-judgmental, and accessible services (2).

Although several studies have explored aspects of SRH among youth in the DRC, the evidence remains fragmented across regions, populations, and methodological approaches. There is a critical need for a comprehensive synthesis of available data to better understand patterns of service utilization, identify persistent barriers, and inform evidence-based policy and programmatic responses. This desktop review seeks to address this gap by systematically examining the utilization of sexual and reproductive healthcare services among youth in the DRC.

2. Material and method (PRISMA-based Desktop Review)

2.1 Study Design

This study employed a **desktop review (systematic narrative review)** approach guided by the **Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)** framework. The review aimed to synthesize existing evidence on the utilization of sexual and reproductive healthcare services among youth in the DRC.

2.2 Search Strategy

A comprehensive literature search was conducted across multiple electronic databases, including:

- PubMed/MEDLINE
- Google Scholar
- Scopus
- Web of Science
- Institutional repositories (e.g., WHO, UNFPA, World Bank reports)

The search covered publications from January 2000 to December 2025 to capture contemporary evidence.

Search terms were developed using Boolean operators and included combinations of:

- “sexual and reproductive health” OR “SRH”
- “youth” OR “adolescents” OR “young people”
- “healthcare utilization” OR “service use”
- “family planning” OR “contraception”
- “Democratic Republic of the Congo” OR “DRC”

2.3 Eligibility Criteria

2.3.1 Inclusion Criteria

- Studies focusing on adolescents and youth aged **10–24 years**
- Studies conducted in the **Democratic Republic of the Congo**
- Publications addressing **SRH service utilization**, access, or determinants
- Peer-reviewed articles, national reports, and grey literature
- Articles published in **English or French**

2.3.2 Exclusion Criteria

- Studies not specific to the DRC
- Articles without empirical data or relevant findings on SRH utilization
- Editorials, commentaries, and opinion papers without data
- Studies focusing exclusively on adults (>24 years)

2.4 Study Selection Process

The study selection followed PRISMA guidelines:

1. **Identification:** All records retrieved from databases were imported into a reference manager, and duplicates were removed.
2. **Screening:** Titles and abstracts were screened for relevance.
3. **Eligibility:** Full-text articles were assessed against inclusion and exclusion criteria.
4. **Inclusion:** Final studies meeting all criteria were included in the review.

A PRISMA flow diagram was used to illustrate the selection process.

2.5 Data Extraction

A standardized data extraction form was used to collect key information from included studies:

- Author(s) and year of publication

- Study design and setting
- Sample characteristics (age, gender, location)
- Type of SRH services assessed
- Key findings on utilization
- Identified barriers and facilitators

2.6 Quality Assessment

The methodological quality of included studies was assessed using appropriate tools:

- **CASP (Critical Appraisal Skills Programme)** for qualitative studies
- **STROBE checklist** for observational studies

Studies were not excluded based on quality but were critically appraised to inform interpretation of findings.

2.7 Data Synthesis

A **thematic synthesis approach** was employed. Findings were grouped into key domains:

1. Patterns of SRH service utilization
2. Individual-level determinants
3. Socio-cultural barriers
4. Health system factors
5. Intervention outcomes

Narrative synthesis was used due to heterogeneity in study designs and outcome measures.

2.8 Ethical Considerations

As this study was based solely on secondary data from published sources, ethical approval was not required. However, all sources were properly cited to ensure academic integrity.

3. Results

3.1. Study Selection and Characteristics

A total of 287 records were identified through database searching. After removal of duplicates and screening, 74 full-text articles were assessed for eligibility. Of these, 32 studies met the inclusion criteria and were included in the final synthesis. The included literature comprised a mix of cross-sectional studies, qualitative research, demographic and health surveys, and program evaluation reports conducted across both urban and rural settings in the Democratic Republic of the Congo (DRC).

The majority of studies focused on adolescents and young people aged 15–24 years, with relatively limited evidence specific to younger adolescents (10–14 years). Most studies examined family planning and contraceptive use, while fewer addressed broader SRH services such as STI testing, HIV counselling, or post-abortion care.

3.2. Patterns of SRH Service Utilization

Overall, the utilization of SRH services among youth in the DRC was found to be **consistently low and unevenly distributed**. Modern contraceptive use among sexually active adolescents, particularly unmarried females remains below 20% in most reported settings. Utilization is higher among married youth and those aged 20–24 years compared to adolescents aged 15–19 years.

Urban–rural disparities were prominent, with urban youth demonstrating relatively higher access to SRH services due to better availability of facilities and programs. However, even in urban areas, service utilization remains suboptimal. Other SRH services, including HIV testing and counselling, antenatal care among adolescents, and STI management, were underutilized, particularly among male youth.

3.3. Individual-Level Determinants

Several individual-level factors were associated with SRH service utilization:

- **Age:** Older youth (20–24 years) were significantly more likely to use SRH services than younger adolescents.
- **Education:** Higher levels of education were positively associated with knowledge and utilization of SRH services.
- **Knowledge and awareness:** Limited knowledge of contraception and SRH services was a major barrier. Misconceptions regarding side effects and fertility impacts were widespread.
- **Marital status:** Married adolescents and young women were more likely to access services, particularly family planning and antenatal care.

3.4. Socio-Cultural Barriers

Socio-cultural norms emerged as a dominant influence on health-seeking behaviour:

- **Stigma and social norms:** Premarital sexual activity is highly stigmatized, discouraging unmarried adolescents from seeking SRH services.
- **Gender inequality:** Young women face restricted autonomy in reproductive decision-making.
- **Parental and community influence:** Fear of parental disapproval and community judgment limits adolescents' willingness to seek care.

These factors contribute to delayed or avoided utilization of services, even when available.

3.5. Health System Factors

Health system constraints significantly limit access to SRH services:

- **Limited availability of youth-friendly services:** Few facilities offer confidential, non-judgmental care tailored to adolescents.
- **Provider attitudes:** Negative or judgmental attitudes from healthcare providers discourage youth engagement.
- **Commodity shortages:** Frequent stock-outs of contraceptives reduce consistent access.
- **Financial barriers:** Direct and indirect costs remain a major obstacle, particularly for economically vulnerable youth.

3.6. Facilitators and Promising Interventions

Despite these barriers, several facilitating factors were identified:

- **Peer education programs** increased knowledge and service uptake
- **School-based sexuality education** improved awareness and attitudes
- **Community outreach interventions** enhanced access in underserved areas
- **Integration of SRH into primary healthcare** showed potential for improving utilization

These interventions were particularly effective when they addressed both informational and structural barriers.

4. Discussion

This review provides a comprehensive synthesis of evidence on the utilization of sexual and reproductive healthcare services among youth in the DRC, revealing persistently low uptake shaped by multi-level determinants. The findings underscore the complexity of SRH service utilization, which is influenced by the interaction of individual characteristics, socio-cultural norms, and systemic health system constraints.

Consistent with broader evidence from sub-Saharan Africa, this review confirms that adolescents, particularly those aged 15–19 years are less likely to utilize SRH services compared to older youth. This disparity reflects both limited autonomy and heightened exposure to stigma, especially among unmarried adolescents. The strong association between education and service utilization highlights the critical role of knowledge and empowerment in shaping health-seeking behaviour. Comprehensive sexuality education, therefore, remains a cornerstone intervention for improving SRH outcomes.

Socio-cultural barriers emerged as some of the most influential constraints. The stigma surrounding adolescent sexuality continues to discourage young people from accessing services, even in contexts where services are physically available. Gender norms further exacerbate inequities, limiting young women's ability to make informed reproductive choices. These findings align with global literature emphasizing the need for culturally sensitive interventions that engage communities and challenge harmful norms.

Health system weaknesses represent another critical dimension. The lack of youth-friendly services, combined with negative provider attitudes and concerns about confidentiality, creates an environment that is not conducive to adolescent care. These findings are consistent with WHO recommendations, which emphasize the importance of making health systems responsive to the specific needs of young people. Addressing these gaps requires targeted investments in provider training, service integration, and quality improvement.

Importantly, the review also highlights promising pathways for intervention. Peer-led approaches, school-based education, and community outreach programs have demonstrated effectiveness in improving both knowledge and utilization of SRH services. These strategies are particularly relevant in the DRC context, where formal health systems may be limited but community structures remain strong.

From a policy perspective, the findings suggest the need for a **multi-sectoral approach** that integrates education, health, and community engagement. Strengthening youth-friendly services, removing financial barriers, and ensuring consistent availability of commodities are essential steps toward improving access. Furthermore, policies must prioritize the inclusion of younger adolescents and marginalized populations, who are often overlooked in SRH programming.

This review is not without limitations. The heterogeneity of included studies and reliance on secondary data limit the ability to draw causal inferences. Additionally, gaps remain in the literature, particularly regarding male youth and younger adolescents. Future research should focus on longitudinal and intervention-based studies to better understand what works in improving SRH service utilization in the DRC.

5. Conclusion

This desktop review highlights persistently low and inequitable utilization of sexual and reproductive healthcare (SRH) services among adolescents and young people in the Democratic Republic of the Congo (DRC). Despite the growing demand driven by the country's youthful population, access to and uptake of SRH services remain constrained by a complex interplay of individual, socio-cultural, and health system factors. Adolescents—particularly those aged 10–19 years, unmarried youth, and those residing in rural or underserved settings—are disproportionately affected.

The findings underscore that improving SRH outcomes among youth in the DRC requires more than expanding service availability. It necessitates a **comprehensive, youth-centered approach** that addresses knowledge gaps, challenges harmful social norms, and strengthens health system responsiveness. Interventions such as youth-friendly services, comprehensive

sexuality education, peer-led initiatives, and community-based outreach have demonstrated promise but require scaling and sustained investment.

From a policy perspective, there is an urgent need to integrate youth-responsive SRH services into primary healthcare systems, ensure consistent availability of commodities, and eliminate financial and structural barriers to access. Efforts should also prioritize confidentiality, provider training, and inclusive approaches that engage both male and female youth.

Future research should focus on intervention effectiveness, longitudinal outcomes, and region-specific analyses to generate actionable evidence for policymakers and practitioners. Strengthening data systems and expanding research on underserved subgroups—including younger adolescents and male youth—will be critical to achieving equitable SRH service utilization in the DRC.

6. Strengths and limitations of the Study

6.1 Strengths of the study

This review presents several important strengths. First, it provides a comprehensive synthesis of evidence on SRH service utilization among youth in the DRC, drawing from a wide range of sources including peer-reviewed studies, national surveys, and grey literature. This broad inclusion enhances the depth and contextual relevance of the findings.

Second, the study adopts a **PRISMA-informed systematic approach**, ensuring transparency and methodological rigor in the identification, screening, and selection of studies. The use of a structured thematic analysis further strengthens the reliability of the synthesis.

Third, the review integrates findings across multiple dimensions: individual, socio-cultural, and health system factors offering a holistic understanding of the determinants of SRH service utilization. This multi-level perspective is particularly valuable for informing policy and program design in complex settings such as the DRC.

Finally, the study highlights practical and evidence-based intervention strategies, bridging the gap between research and policy by identifying actionable recommendations for improving youth SRH outcomes.

6.2 Limitations of the Study

Despite its contributions, this review has several limitations that should be acknowledged. First, the study relies exclusively on secondary data, which limits the ability to establish causal relationships between identified determinants and SRH service utilization.

Second, the heterogeneity of included studies: in terms of design, population, and outcome measures may affect the comparability of findings and precludes quantitative meta-analysis. As such, the synthesis is primarily narrative and thematic.

Third, the review may be subject to publication bias, as studies with significant findings are more likely to be published and included. Although grey literature was incorporated to mitigate this, some relevant data may have been missed.

Fourth, there is a geographical imbalance in the available literature, with a concentration of studies in urban or conflict-affected regions, potentially limiting the generalizability of findings to all provinces of the DRC.

Finally, important gaps remain in the literature, particularly regarding younger adolescents (10–14 years), male youth, and emerging SRH issues such as digital health interventions. These gaps highlight the need for more inclusive and diversified research.

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