Sexual Behaviors and Outcomes among Female and Male Youth from Major Urban Areas in Kenya, Nigeria, and Senegal

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Short Abstract:

Urban youth have greater education and employment opportunities than their rural counterparts; this does not always translate into lower health risks. Of particular interest to this paper are the sexual and reproductive health behaviors of youth living in major urban areas in Kenya, Nigeria, and Senegal. Data used were collected in 2010/2011 as part of baseline data collection for the Urban Reproductive Health Initiative. The findings indicate greater sexual risk-taking in the Kenyan urban sites as compared to the other two countries. This includes greater premarital sex and unprotected sex among both female and male youth. The outcome of teen pregnancy is examined in the three urban samples and indicates greater teen pregnancy experience among the least educated and poorer women; moreover in Kenya, a greater percentage of the sampled youth had a teen pregnancy than in Nigeria and Senegal. Programmatic implications of the findings are presented by country setting.

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Extended Abstract:

Introduction

Improvements in health and well-being over the 1990s in much of sub-Saharan Africa coupled with declining fertility in many countries has led to an increase in the number of youth worldwide and particularly in sub-Saharan Africa (Ashford, Clifton, Kaneda, 2006). At the same time that there are increasing numbers of young people globally, there is also increased urbanization in these same contexts. This urbanization translates into a high proportion of the urban population being made up of youth ages 10-24. At an aggregate level, urban residents are often better off in terms of health and living conditions relative to their rural counterparts; however, with more refined analyses, the urban poor often do not fare well (Montgomery, 2009; Ezeh et al., 2010).

Of particular interest in this paper are the sexual and reproductive health behaviors of urban youth. In most sub-Saharan African countries, increased urbanization has been found to be associated with a change in the dynamics of sexual initiation and marriage with one of the major changes being an increase in premarital sexual activity among young people ages 15-24. Notably, while age at sexual initiation does not appear to be declining globally, a greater proportion of sexual activity is happening outside of marriage, particularly in urban areas where young people are staying in school and delaying marriage longer (Mensch, Grant, Blanc, 2006). Sexually active young people are at risk of HIV/AIDS and unintended pregnancy. Compared to their rural counterparts, urban youth have more access to condoms and are more at liberty to use them without fearing what the community will think about them. However, while contraceptives, including condoms are more available, young urban youth (e.g., 15-19) are less likely to use protection than 20-24 year olds (Ashford, Clifton, Kaneda, 2006), while unmarried youth may experience policy and social barriers to accessing contraceptive use. A greater understanding of youth sexual risk behaviors in major urban areas is needed to know what strategies are needed to meet the changing needs of urban youth today.

Much of what we know on the sexual and reproductive health behaviors of urban youth in sub-Saharan Africa comes from recent Demographic and Health Surveys. In these surveys, urban areas are defined differently across countries, however, they tend to include capital cities, large cities, smaller cities, and towns (e.g., with a population of 2000+ residents). The wide variability in the definition of urban areas in these surveys means that interpretation of findings to major urban areas is less clear (although notably, major urban areas will hold greater weight in these surveys than smaller towns). This paper contributes to our understanding of youth sexual behaviors in major urban areas by examining recently collected data from young (ages 15-24) women and men from major urban areas in three sub-Saharan African countries (Kenya, Nigeria, and Senegal). The study answers the following research questions:

1) What are the key demographic characteristics of youth in major urban areas that should be considered for design of sexual and reproductive health programs targeting this group?
2) Are urban youth at risk of HIV and unintended pregnancy and are there differences in sexual risk-taking behaviors across the three sub-Saharan African sites?
3) Which urban youth are at the greatest risk of a teenage pregnancy?

Data and Methods

This study uses baseline data for the Urban Reproductive Health Initiative. In each of the study countries (Kenya, Nigeria, and Senegal), the Measurement, Learning & Evaluation (MLE) project partnered with the local implementing agencies – called Tupange in Kenya; Nigerian Urban Reproductive Health Initiative (NURHI) in Nigeria; and Initiative Sénégalaise de Santé Urbaine (ISSU) in Senegal – to collect data from a representative sample of women and men in each study city. In Kenya, data from women and men were collected in Nairobi, Kisumu, and Mombasa; additional data were collected from women only in Kakamega and Machakos, these two cities are not included in this analysis.[1] In Nigeria, data were collected from women and men in Abuja, Ibadan, Ilorin, and Kaduna. Data from women were collected also in Benin City and Zaria; these data are included in the analyses as these are major cities that are similar to the other major urban areas in Nigeria. In Senegal, data were collected from women and men in Dakar, Pikine, Guédiawaye, and Mbao.[2]

In each country, a similar two-stage sampling design was used; however, in Kenya and Senegal, prior to selecting the first stage sampling units (primary sampling units - PSU) the sampling frame was divided into poor/non-poor sites. In Kenya, the 2009 census was used as the sampling frame. The census sampling frame had information on whether each PSU was informal (no land tenure/slum) or formal (has land tenure/non-slum). In Senegal, a unique approach was used to identify the poor and non-poor areas in the sampling frame prior to selection (for more details contact the first author). In Nigeria, there was no way to distinguish PSU as poor or non-poor prior to selection and thus the recent census sampling frame was used. Based on the sampling frames for each city, only urban PSUs were eligible for selection in the first stage. In each city (within each country), a representative sample of PSUs was selected with an appropriate number to represent that city (numbers per city varied from 54-144 across the countries/cities). In all selected PSUs, a listing and mapping exercise was conducted to identify all eligible households for second stage selection. In the second stage, a random sample of households was selected (30 per PSU in Kenya, 41 per PSU in Nigeria, and 21 per PSU in Senegal). In all selected households all women (ages 15-49) who spent the previous night in the household were eligible for interview. In half of the selected households, all men (ages 15-59) who spent the previous night were eligible for interview. The interviewed sample serves as the baseline sample for the evaluation of the Urban Reproductive Health Initiative (Guilkey, Speizer, and Lance, 2009). All city-level data were weighted to account for varying sampling strategies and response rates in each country/city. The overall weights within country (but across cities) are used for this analysis.

For this study, the sample is restricted to only those female and male respondents ages 15-24. This includes 2398 female respondents from Kenya (n=3520 weighted); 5740 female respondents from Nigeria (n=5723 weighted); and 2154 female respondents from Senegal (n=2204 weighted). For men, the sample sizes are 782 male respondents from Kenya (n=754 weighted); 1735 male respondents from Nigeria (n=1750 weighted); and 867 male respondents for Senegal (n=799). The differences in the sample sizes across countries mostly reflect different sample size goals across the countries and the differences in the number of cities included in each country/sex group. Analyses presented include slightly smaller sample sizes when missing responses are dropped.

[1] The female data from these two cities were not included because the cities are smaller and more like towns and thus make the information less similar to the other countries.

[2] Data from women were also collected in Mbour and Kaolack; these data are not yet available and these are smaller towns, thus these cities will not be included in this analysis.

The main variables presented in this analysis are the background demographic characteristics and key sexual and reproductive health measures. Age is recoded into three groups, ages 15-17, 18-19, and 20-24. Educational attainment is recoded in each country on a similar scale to be no education, primary education, secondary education, and higher; there are a small number of missing values that are also reflected in the background table. Household assets were used to develop wealth quintiles coded within city and country as done by the Demographic and Health Survey (Gwatkin et al., 2000). As a simple demographic variable, wealth is not shown because the distribution by country and sex is as expected, at about 20% in each wealth category. However, wealth is used to examine differential teen pregnancy rates by wealth group by country. Marital status is included as a key factor that influences whether or not young people are sexually experienced and to identify how much of sexual activity is happening premaritally. Marital status is classified as: never married; currently married or living in union; widowed, divorced or separated. There are a small number of youth with missing marital status; this is reflected in the background table.

The key sexual behavior variable included in this analysis is sexual experience/activity. This variable is classified as: never had sex; had sex within the last 4 weeks; had sex more than four weeks ago. For the more detailed analysis of sexual activity by marital status, we also break out the last group into two groups: had sex 4 weeks ago but within the last year; and had sex more than a year ago. This additional classification permits an assessment of changes in youth behaviors and recognizes that sexually experienced youth are not necessarily currently sexually active. Also included is current contraceptive use. Of particular interest is whether or not the non-married, recently sexually active youth are using contraception and what methods they are using.

Finally, the one outcome of interest in this analysis is teenage pregnancy experience. All youth ages 15-19 that have ever been pregnant were coded one; all other 15-19 year olds are coded as zero. Teenage pregnancy is based on having a pregnancy before the age of 20. In addition, among young adults ages 20-24, we examined their age at first pregnancy to determine who had a first pregnancy before age 20. The teen pregnancy measure among current 15-19 year olds underestimates teen pregnancy while the teen pregnancy rate among 20-24 year olds represents the extent of the problem since these women have already passed the age of 20.

All analyses are descriptive. Univariate and bivariate analyses are presented to demonstrate differing trends across the countries and between males and females within a country. Chi-square tests are used to determine whether the percentage of women who experienced a teen pregnancy differs by the demographic characteristics within each country.

Results

Urbanization has played out differently in the three countries included in this analysis. According to the 2011 World Population Data Sheet (PRB, 2011), the proportion of the population urban is the highest in Nigeria at 51% followed by Senegal at 43%, and lastly Kenya at 18%. Kenya's urban proportion may be somewhat underestimated; when the peri-urban areas are included based on recent census data, the proportion urban goes up to 32% (KNBS, 2010).

Table 1 presents descriptive characteristics of the urban youth samples of women and men in each country. The Kenyan female and male samples are older than the Nigeria and Senegal samples. In Kenya, instead of about half of the sample being in the oldest age group (20-24),

close to 70% of women and men are in this age group. Conversely, the Nigeria male sample is the youngest with 34% in the 15-17 age group. The female and male samples in Senegal are similar in terms of age to each other and the female youth sample in Nigeria. As expected, the urban samples in all three countries are highly educated. Only a small percentage of respondents have no education; with Senegal having the highest values for women and men (27% and 13%, respectively). In each country, more than 60% have secondary education or higher; with the exception of Senegalese women - only 46% have secondary education or higher.

In all three countries, a lower percentage of male youth are married or in union as compared to female youth. In Nigeria and Senegal only 2% of male youth are in union. In Kenya the percentage is higher at 19%; however this may reflect the older male sample in Kenya. Among female youth in Nigeria and Senegal, about three-quarters have never married; the percentage is lower in Kenya at 56%, again likely reflecting an older sample in Kenya. Notably, the age distinctions in these samples of urban youth across the three countries suggest that the sexual and reproductive health needs of Kenyan youth in major urban areas are different than those in major urban areas of Nigeria and Senegal, possibly an indication of the Kenyan urban youth population being older on average than the other two countries.

Presented at the bottom of Table 1 and then in more detail in Table 2 are the proportions of female and male youth in each country that are sexually experienced and have had recent sex. Male youth in Nigeria are the least likely to report ever having sex (72% never had sex). In Senegal, 67% of females and 64% of males report never having had sex. Fifty-six percent of female youth in Nigeria report never having sex. In Kenya, the proportion of youth that never had sex is lower at 28% among female youth and 21% among males; this might reflect the sample being older than the other two countries. Among youth who have ever had sex, most have had recent sex; this likely reflects the sexual behaviors of married youth. Table 2 provides greater information on sexual behaviors of married and unmarried youth. Of particular interest are the sexual behaviors of unmarried youth. Among unmarried female youth in Senegal, only 10% have ever had sex. About one quarter of unmarried female and male youth in Nigeria have ever had sex, with about half of this sexual activity occurring in the last 4 weeks and the other half in the last year but more than four weeks ago. Among unmarried males in Senegal, the pattern is similar to that of Nigeria, although a slightly greater proportion had ever had sex. Finally, among unmarried youth in Kenya, about half of female youth and three quarters of male youth have ever had sex. About half of this sex was recent (in the last four weeks) and half was longer ago; although females reported less recent sex. Among widowed, separated and divorced female youth, sexual activity happened in the last year, but less so in the last four weeks; this may reflect recent marriage transitions in this group in all three countries.

By examining contraceptive use among the never married sexually active youth, it is possible to know if they are at risk of HIV/STI and or a pregnancy (intended or unintended). Table 3 presents contraceptive use among unmarried female and male youth who had sex in the last four weeks in each country. Also presented is the percentage of women and men using each method of family planning. Table 3 illustrates that in Kenya, two-fifths of women who had recent sex (in the last four weeks) are not using a family planning method; these women are at risk of a pregnancy and possibly HIV. Notably, these women who are older (as shown earlier) may want to get pregnant as in many settings, a pregnancy/baby may come before the union is formalized. In Nigeria and Senegal, the percentage of recently sexually active unmarried women not using family planning is lower at around 27%. These women are also at risk of a pregnancy and HIV. Among recently sexually active men in all three countries, the percentage reporting non-use of contraception is similar to the percentage of women, however, in Kenya, a

greater percentage of men report using as compared to women. The most common method used in all three settings among recently sexually active unmarried women and men is condoms. Notably, in Nigeria and Senegal reported use of condoms by men is similar to that of women. In Kenya, the percentage of men reporting condom use is nearly two times higher than the percentage of women reporting condom use. Condoms as the most common method among urban youth is not surprising, especially since these youth may not have regular sex. The next most common methods are injections (Kenya), traditional methods, and emergency contraception (Nigeria). The method mix indicates that there is room for improvements for youth in all of these settings. While condom use is important, it may be necessary to promote dual protection with another more effective and consistent family planning methods than traditional methods and emergency contraception.

Table 4 presents information on the outcome of teenage pregnancy (a pregnancy before age 20) among youth in major urban areas of the three countries. Notably, while the sample is older in Kenya, the first distribution that is presented by current age group is not affected by this age distinction. That is, the percentages presented are the percentage of women at each age who have ever been pregnant. In Kenya, for all one-year age groups, a greater percentage of youth have ever had a teen pregnancy than in the other two countries. The pattern in all three countries is as expected such that a greater percentage of the older youth have had a teenage pregnancy as compared to the younger age groups. By age 17, the distinction between Kenya and the other two countries is large.

The examination of the percentage of 15-19 year olds who had a teen pregnancy by their education level and wealth quintile is also interesting. The pattern is the same across all three countries such that youth with lower education or who are in a lower wealth quintile group report significantly greater experience with a teen pregnancy as compared to their more educated or richer counterparts. This suggests inequities in urban areas in all three countries in terms of teen pregnancy experience. As expected, ever married youth are more likely to have had a teen pregnancy than never married youth; the difference between formerly married and currently married youth is small.

Also presented in Table 4 is the percentage of current 20-24 year olds who had a teen pregnancy. These women are already past the age of a teen pregnancy and thus there is not the same problem with censoring that is found when looking at 15-19 year olds. As expected, Kenya has higher teen pregnancy experience (30%) as compared to Nigeria and Senegal where the percentage of youth who had a teen pregnancy is similar at about two-fifths of 20-24 year olds.

Discussion

The findings presented here have implications for program planning in major urban areas in the three countries included but also in other countries in sub-Saharan Africa. First, in cities like those in Kenya where youth are older than in the two other countries, programs need to identify and address the needs of older youth that may be different than their younger, school-age counterparts. Second, as expected, youth in major urban areas are highly educated; this means that programs can test innovative approaches in and out of schools for increasing demand for smaller family sizes and family planning use in these settings. Depending on the country and setting, many male youth ages 15-24 will be never married (all three countries) and likewise for female youth (e.g., Senegal). Conversely, in a place like Kenya, many female youth have married and these youth may have different family planning needs than their non-married counterparts.

In the Kenya context, there are clearly young women and men who are at risk of HIV and pregnancy (intended and unintended). We showed that among the never married female youth, half have ever had sex; while among male youth, premarital sexual activity is even more common. These sexually active unmarried youth have family planning and condom use needs, as indicated by the fact that two-fifths of the women were not currently using any method of family planning. Programs are needed to target urban Kenyan youth with family planning methods (and condoms) in places where youth congregate and to ensure that these youth understand their risks of not using family planning, especially if they are still in school or establishing themselves financially. Teen pregnancy prevention in Kenya should be a priority, especially targeting the least educated and poorest women (and men) in these urban settings.

In Nigeria and Senegal, programs need to ensure that young people have access to modern family planning methods to avoid unintended pregnancies and HIV. That said, there is less risk-taking among urban youth in these settings, but it is not negligible. In settings like these where premarital sexual activity is less common, young people may be reluctant to identify family planning and condom sources and seek out these services when needed. These youth may fear negative responses from health care providers or shop keepers or that their religious leaders (e.g., Imams and pastors) may learn about their family planning use. Programs need to ensure that sexually active youth who seek to protect themselves from HIV and an unintended pregnancy have open access to condoms and other family planning methods and do not run into barriers such as policies that do not permit provision of methods to youth or unmarried individuals or pharmacists who refuse to provide a method to a young person. In settings such as Nigeria and Senegal, programs should consider training providers and religious leaders that young people (male and female; married or unmarried) need protection from HIV and an unintended pregnancy so that they can achieve their fullest potential and contribute fully to their local societies.

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Table 1. Descriptive characteristics of urban female and male youth (15-24) surveyed in three African countries* as part of baseline data collection for the Urban Reproductive Health Initiative/MLE (2010/2011).

Characteristic	Kenya				Nigeria				Senegal			
	Female youth		Male youth		Female youth		Male youth		Female youth		Male youth	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age												
15-17	440	12.5	86	11.4	1705	29.8	589	33.7	617	28.0	202	25.3
18-19	579	16.5	146	19.3	1153	20.1	383	21.9	454	20.6	160	20.1
20-24	2501	71.1	522	69.3	2865	50.1	779	44.5	1134	51.4	436	54.6
Education												
None	102	2.9	14	1.9	295	5.2	31	1.8	585	26.6	104	13.0
Primary	1361	38.7	235	31.1	488	8.5	53	3.0	606	27.5	203	25.4
Secondary	1567	44.5	316	41.9	3954	69.1	1338	76.4	888	40.3	418	52.3
Higher	486	13.8	184	24.4	910	15.9	285	16.3	125	5.7	75	9.4
Missing	3	0.1	6	0.8	76	1.3	44	2.5	0	0.0	0	0.0
Marital status												
Never married	1959	55.7	612	81.2	4263	74.5	1704	97.4	1607	72.9	781	97.8
Married/union	1452	41.3	123	16.4	1387	24.2	39.6	2.3	556	25.2	18	2.2
Wid/div/sep	104	3.0	19	2.5	55	1.0	0	0.0	40	1.8	0	0.0
Missing	4	0.1	3	0.3	18	0.3	6.4	0.4	1	0.0	0	0.0
Sexual activity												
Never had sex	974	27.7	159	21.1	3177	55.5	1268	72.4	1474	66.9	510	64.2
Ever/recent	1724	49.0	308	40.9	1710	29.9	273	15.6	441	20.0	107	13.5
Ever/>1 month	816	23.2	281	37.3	801	14.0	203	11.6	285	12.9	175	22.0
Missing	6	0.2	6	0.8	35	0.6	6	0.3	3	0.2	3	0.3
Total	**3520**	**100.0**	**754**	**100.0**	**5723**	**100.0**	**1750**	**100.0**	**2204**	**100.0**	**795**	**100.0**

*Note – All values weighted; Kenya female and male data based on three cities: Nairobi, Mombasa, and Kisumu; Nigeria female data based on six cities: Abuja, Ibadan, Ilorin, Kaduna, Benin City, and Zaria; Nigeria male data based on only first four where data were collected; Senegal female and male data based on four cities: Dakar, Pikine, Guédiawaye, and Mbao (all in the region of Dakar).

Table 2. Recent sexual activity by marital status among all urban youth (15-24) by sex and country, Urban Reproductive Health Initiative/MLE data (2010/2011).

Country/Sex	Sexual Activity					
	Never had sex	Ever had sex: Last sex >1 year ago	Ever had sex: Last sex between 4 weeks and 1 year ago	Ever had sex: Last sex in last 4 weeks	Don't know/missing	Total (%)
Kenya Women						
Never Married	49.7	6.1	26.3	17.9	0.0	100
Currently married/union	0.0	0.3	7.7	91.9	0.1	100
Widowed/divorced/separated	0.0	14.3	48.4	37.3	0.0	100
Kenya Men						
Never Married	26.0	7.4	33.8	32.2	0.6	100
Currently married/union	0.0	0.0	18.3	81.7	0.0	100
Widowed/divorced/separated	0.0	4.2	34.2	61.6	0.0	100
Nigeria Women						
Never Married	74.5	1.5	10.6	13.1	0.3	100
Currently married/union	0.1	0.4	16.5	81.9	1.1	100
Widowed/divorced/separated	0.0	21.3	59.5	16.4	0.0	100
Nigeria Men*						
Never Married	74.2	1.7	9.5	14.4	0.2	100
Currently married/union	1.2	0.0	29.5	67.0	2.4	100
Senegal Women						
Never Married	90.3	1.3	5.7	2.6	0.0	100
Currently married/union	3.5	3.0	21.7	71.2	0.6	100
Widowed/divorced/separated	6.2	32.2	53.8	7.8	0.0	100
Senegal Men*						
Never Married	65.5	9.3	12.5	12.2	0.3	100
Currently married/union	0.0	0.0	28.7	71.3	0.0	100

*No men in the widowed/divorced/separated categories in Nigeria and Senegal.

Table 3. Contraceptive method use among never married female and male youth having sex in the last four weeks by country and sex, Urban Reproductive Health Initiative/MLE data (2010/2011).

Method	Kenya Women	Kenya Men	Nigeria Women	Nigeria Men	Senegal Women	Senegal Men
Non-user	40.8	31.2	27.9	25.4	26.9	21.3
Sterilization	0.2	0.0	0.0	0.5	0.0	0.0
Pill	5.1	1.9	1.8	0.3	3.1	0.0
IUD	0.5	0.4	0.0	0.0	0.0	0.0
Injections	11.9	6.0	0.7	0.4	0.0	0.0
Male condom	27.5	50.3	50.9	67.3	62.0	76.5
Implant	0.8	1.8	0.0	0.0	0.0	0.7
Emergency contraception	6.1	1.9	6.0	0.4	0.0	0.0
Breastfeeding/LAM	0.0	0.0	1.0	0.0	0.0	0.0
Other modern*	0.6	0.0	1.8	0.0	0.0	0.0
Traditional	6.5	6.4	9.5	5.6	8.1	1.5
Missing	0.0	0.0	0.4	0.0	0.0	0.0
(Total percent using)	(59.2)	(68.8)	(77.1)	(74.6)	(73.1)	(78.7)
Number of never married youth having sex in last 4 weeks	n=350	n=308	n=560	n=273	n=42	n=107

*Other modern includes spermicides and female condom.

Table 4. Percentage of women who ever experienced a teen pregnant (before age 20) by age group, education, wealth group, marital status, and country, Urban Reproductive Health Initiative/MLE data (2010/2011).

Characteristic	Kenya	Nigeria	Senegal
Age			
15	5.9	3.2	4.0
16	7.7	2.5	5.4
17	18.4	6.5	5.2
18	31.9	10.7	15.9
19	44.1***	17.5***	19.1***
Education			
None	44.8	46.9	21.7
Primary	35.6	32.1	15.6
Secondary	16.0	4.5	2.3
Higher	10.7***	0.0***	0.0***
Wealth			
Lowest	48.8	15.3	17.8
Second	38.2	9.9	12.6
Middle	24.2	8.4	10.6
Fourth	13.5	6.3	4.8
Highest	13.2***	1.5***	4.7**
Marital status			
Never married	9.4	1.0	3.1
Married/union	83.0	78.5	55.1
Widowed/divorced/separated	70.9***	63.0***	50.4***
Total (15-19)	26.3	7.9	10.2
Percent of 20-24 year olds who were ever pregnant before age 20	31.0	21.6	20.7

NA- no observations

Chi-square p-value: **p<0.01; ***p<0.001.