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Research Article

Assessment of the Knowledge, Attitudes and Practices of the Populations of the Obala Health District Centre Region Cameroon, Regarding Sexual and Reproductive Health Care Services

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Abstract

Sexual and Reproductive Health (SRH) remains a major public health issue in Cameroon, particularly in rural areas such as the Obala health district, where maternal morbidity and Sexually Transmitted Infections (STIs) persist. Despite national efforts, significant gaps in Knowledge, Attitudes, and Practices (KAP) hinder access to essential services. This study aimed to assess the KAP of women of reproductive age (18-49 years) and health personnel regarding SRH in the Obala health district, as well as to identify key barriers and levers for improvement. A cross-sectional study using a mixed method was conducted between 2024 and 2025. The quantitative component included 360 randomly selected women interviewed with a standardized questionnaire. The qualitative part comprised 18 semi-structured interviews with women and 7 with health professionals. Recordings were transcribed and analyzed using Bardin's (2013) method. Quantitative data were processed in Excel. Data integration occurred during design, analysis, and interpretation.

The data collected indicate a link between knowledge of HIV prevention practices and marital status ($\chi^2(8) = 12.27$; $p = 0.1$), but no significant association with age. From an attitudinal perspective, 65.83% of women considered SRH services inaccessible, mainly due to high cost (31.39%) and poor reception (26.11%). A significant association was found between the state of discomfort expressed by women when SRH issues were discussed and the perceived accessibility of services ($\chi^2(4) = 30.76$; $p = 0.001$), as well as between income level and access to care ($\chi^2(10) = 36.26$; $p = 0.001$). Regarding practices, 48.33% report using condoms and 78.61% obtain information through social media. Interviews reveal a distrust of modern methods (*"It makes you sterile," P3*) and a preference for family counseling (*"I go to my mother's," P1*). Health personnel report outdated equipment and cultural resistance, underscoring the need for integrated action: community education; service improvement; traditional leader involvement and youth awareness via social media.

Keywords: Sexual and reproductive health, Knowledge-attitudes-practices, Access to care, Cameroon, Contraception**Abbreviations:** CSF: Cerebrospinal Fluid; CT: Computed Tomography; DSF: Depressed Skull Fracture, GCS: Glasgow Coma Scale; GKMC: Gajju Khan Medical College; MTI: Medical Teaching Institution; TBI: Traumatic Brain Injury.

Introduction

Sexual and Reproductive Health (SRH) is defined by the World Health Organization as "a state of physical, emotional, mental, and social well-being in relation to sexuality and reproduction" [11]. It concerns people of all ages and regardless of gender. SRH includes maternal and child health, infertility, family planning, adolescent reproductive health, and STIs/HIV/AIDS. It is essential for individual, family, and collective well-being, as well as for the socioeconomic development of communities and countries [12].

The ability of women and their partners to enjoy good sexual health depends on access to quality information, appropriate care, and a supportive environment. However, adolescents and young adults, particularly in rural and disadvantaged settings such as the Obala health district, face major challenges: physiological vulnerability; early onset of sexual relations; economic insecurity; cultural taboos; insufficient sexuality education, and low availability or acceptability of SRH services [9,11,12].

To understand health behavior dynamics in SRH, this study uses three frameworks. The theory of social representations analyzes shared knowledge, beliefs, and cultural norms shaping perceptions and care behaviors [4]. The Health Belief Model explores how individuals assess their vulnerability, the severity of risks, the perceived benefits of preventive actions and the barriers to these behaviors [3]. Finally, the theory of planned behavior examines how individual attitudes, perceived social pressures (subjective norms) and perceived control over behavior condition the intention to use or not SRH services [5,6]. These perspectives provide a framework to assess knowledge, attitudes, and practices in the Obala district and identify levers to improve accessibility, acceptability, and quality of SRH care, hence the question, what are the population's KAP regarding these services?

Objectives of the Study

General Objective

To assess the knowledge, attitudes and practices of the population of Obala district Centre region Cameroon regarding sexual and reproductive health care.

Specific Objectives

a) To determine the knowledge of the inhabitants of Obala district regarding sexual and reproductive health care.

b) To explore attitude of population of Obala health district in relation to sexual and reproductive health care.

c) To describe sexual and reproductive health care practices of women in the Obala health district.

d) To identify factors associated with knowledge, attitudes and practices of residents of Obala health district regarding sexual and reproductive health care.

Methodology

Type of Study

Mixed cross-sectional study with quantitative and qualitative components. (Determine KAP on SRH and explore social, cognitive, and cultural influences). The study was guided by social representations theory, the Health Belief Model, and the Theory of Planned Behavior to understand psychosocial determinants of SRH behaviors.

Study Site

The study was conducted in the Obala health district (Lekié, Centre Region Cameroon), chosen due to the high prevalence of patients referred to Yaoundé for sexual and reproductive health care. Established in 1953, it is located about 40 km from Yaoundé on the Yaoundé-Bafia axis.

Study Period

Four months, from september 2024 to january 2025.

Population Studied

Women aged 18-49 in Obala who consented completed a questionnaire, and some were invited for in-depth interviews to collect qualitative data.

Selection Criteria

Inclusion Criteria

a) Female gender

b) Aged 18 to 49

c) Obala health district

d) Free and informed consent

Exclusion Criteria

a) Age < 18 years

b) Refusal to consent

Research Methods and Techniques

Research Method: The mixed nature of the study responds to the need to cross-reference objective quantitative data (from the CAP questionnaire) and rich qualitative data (from the participants' speeches), the aim is understanding shared social beliefs (theory of social representations), individual perceptions of risks and benefits (HBM), as well as behavioral intentions and perceived social norms (TPB).

Quantitative Component

a) Sample Size and Justification

The minimum sample size obtained was 358 participants, rounded to 360, using the Cochrane formula:

$$n = \frac{Z^2 P(1-P)}{E^2}$$

n = required sample size; P = estimated prevalence of an indicator = 63.1%;

Z = z score corresponding to the degree of confidence = 1.96; E = margin of error = 0.05;

Confidence interval = 95%.

b) Study Variables

Dependent variables: KAP (Knowledge, Attitudes, Practices regarding SRH), experiences of unwanted pregnancies, perception of SRH services.

Independent variables: sociodemographic factors; economic and cultural factors; contextual accessibility.

c) Collection Tools

The questionnaire has demographic characteristic's section, knowledge of SSR services, lastly attitudes and Practices.

d) Sampling Procedure

Sampling was conducted randomly across the district's 12 health areas. Participants were recruited from gathering places such as markets, schools, and health facilities. After informed consent, participants completed questionnaires on demographics, knowledge, and attitudes toward sexual and reproductive health care. Identified key informants participated in in-depth interviews using a semi-structured guide.

e) Data Analysis

Data were analyzed using Excel 2013 and SPSS v25. Univariate and bivariate analyses were conducted to identify significant determinants of attitudes and behaviors.

Qualitative Component

a) Sample Size and justification

The sample size of 18 was obtained a posteriori after data saturation, following interviews with participants. These resource persons were recruited from the sample of 360 respondents.

b) Data Collection Tool

A semi-structured guide, based on HBM, TPB, and local social representations, explored Obala's SRH attitudes and practices. Interviews with respondents were conducted in French, with interpreter support as needed, in a private setting using a Dictaphone and laptop.

c) Data Analysis

A thematic analysis according to Laurence Bardin (2013) was carried out for the qualitative data. This allowed them to be classified and commented on into themes, categories illustrated by verbatim.

Ethical Considerations

Confidentiality and Respect for Privacy: Precautions were taken to protect the confidentiality of data collected from participants (anonymity; archiving and limitation of access to data; respect for professional secrecy).

Ethical Clearance: Ethical clearance (N02024/08/1708/CE/CNERSH/SP) from the National Committee for Ethics and Research in Human Health of the Center.

Conflicts of Interest: No declared conflicts of interest.

Results

Quantitative Component

Sociodemographic Data:

Age: 360 women of childbearing age were surveyed, with a mean age of 25.08 (+/- 6.614) years old; mode (19) and median (24) years old with extreme values of 18 and 47 years old.

Marital Status: The majority of participants are single (55%) or married (37.78%). (02 were without answers) (Table 1).

Table 1: Sociodemographic characteristics of respondents (n=360).

Variable	Category	Frequency	Percentage (%)
Age (years)	Mean ± SD	25.08 ± 6.614	–
	Mode	19	–
	Median	24	–
	Range	18–47	–
Marital status	Bachelor	198	55
	Bride	136	37.78
	Divorcee	14	3.89
	Widow	10	2.78
Religion	Christian	301	83.61
	Muslim	32	8.89
	Non-believer	15	4.17
	Traditionalist	9	2.5
Occupation	Student	165	45.84
	Shopkeeper	90	25
	Health personnel	9	2.5
Income	Irregular	211	58.61
	40,000–100,000 FCFA	110	30.55
Education level	Secondary	233	64.72
	Primary	70	19.44
	Superior	54	15
	None	3	0.83
Number of children HIV status	Mean ± SD	1.46 ± 1.76	–
	Positive	43	11.94

Most of the participants are of Christian religion 301/360 (83.61%) with a traditionalist minority (2.5%). (03 were without answers). Students represent 45.84% (165/360) of the respondents, followed by shopkeepers (90/360; 25%). Only 2.5% are health personnel (02 were without responses). Most of the respondents have an irregular income (58.61%; 211/360) and vary between 40,000 FCFA and 100,000 FCFA (30.55%). (06 had no response). The majority of respondents have a secondary education level (64.72%). Most of the respondents had an average number of 1.46 (+/- 1.76) children, with a median of 1 child (2 were without responses). 11.94% (315/358) of participants were HIV positive (02 had no response).

Knowledge of the Inhabitants of Obala District Regarding Sexual and Reproductive Health Care: (Table 2) 238/360 respondents (66.11%) have already heard of sexual or reproductive health. Condoms were the most familiar SRH term among them (86.11%), prevention of mother-to-child transmission of HIV (PMTCT) (63.89%), abstinence (53.33%), and sexually transmitted infections (51.67%). 331/360 respondents (91.94%) have knowledge of prevention practices related to HIV transmission. Regarding contraceptive methods, the most known by them are condoms (304/360; 84.44%), pills (128/360; 35.56%) and

traditional methods (115/360; 31.94%). The main consequences of unprotected sexual intercourse noted on sexual and reproductive health by the respondents are sexually transmitted diseases (309/360; 85.83%).

Table 2: Knowledge of sexual and reproductive health (SRH).

Knowledge Item	Frequency	Percentage (%)
Heard of SRH	238	66.11
Familiar SRH terms: condoms	304	84.44
PMTCT	230	63.89
Abstinence	192	53.33
STIs	186	51.67
Knowledge of HIV prevention	331	91.94

Table 3: SRH experiences and practices.

Item	Frequency	Percentage (%)
Experienced unwanted pregnancy	99	27.5
Experienced twice	63	17.5
Experienced thrice	14	3.89
More than four	13	3.61
Outcome: gave birth	142	39.44
Outcome: abortion	47	13.06
Comfort discussing SRH topics	201	55.83
Uncomfortable discussing SRH	158	43.89
Considered SRH services inaccessible	237	65.83
Main obstacles: insufficient information	171	47.5
High cost	113	31.39
Poor quality of reception	94	26.11

Obala Health District Towards Sexual and Reproductive Health Care: (Table 3) 27.5% of participants reported having already experienced an unwanted pregnancy; 17.5% had experienced it twice, 3.89% for three times. Furthermore, 3.61% more than four unwanted pregnancies. Regarding the outcome of unwanted pregnancies, 39.44% gave birth, while 13.06% had an abortion. Regarding comfort in discussing SRH-related topics, 55.83% reported feeling comfortable discussing SRH-related topics with their peers. 43.89% reported feeling uncomfortable about this, which would reflect the persistence of taboos and embarrassment surrounding these topics, fostered by a tight space in terms of confidentiality for communication. SRH services were considered inaccessible by 65.83% of respondents. The main obstacles to accessing these services were insufficient information (47.5%), high cost of SRH inputs and services (31.39%), and poor quality of reception (26.11%). Regarding the perception of the impact of SRH services, the majority (98.06%) believe that access to SRH improves health and well-being. Suggestions made by respondents to improve SRH include: improving communication; educating young people; making contraceptives available; providing free or affordable services; and providing quality care.

Women's Sexual and Reproductive Health Care Practices are Multiple: (Table 4) Respondents stated that the most commonly used prevention practices were condoms (174/360; 48.33%) and fidelity within the couple (28.06%). (11 had no response). Regarding the main sources of information, the respondents obtain their information most often through social networks (78.61%), and also from health personnel (47.5%). Only 53.33% (192/360) of them have ever received formal education on sexual and reproductive health at school or in another context (05 were without responses). However, 93.61% (337/360) would be interested in additional training sessions on sexual and reproductive health. Then the most requested topics were contraception, STI/HIV prevention, and early pregnancy.

Table 4: SRH prevention practices and sources of information.

Practice / Source	Frequency	Percentage (%)
Condom use	174	48.33
Fidelity with in couple	101	28.06
Main sources : social networks	283	78.61
Main sources : health personnel	171	47.5
Received formal SRH education	192	53.33
Interested in additional training	337	93.61

Factors Associated with Knowledge, Attitudes and Practices of Residents of Obala Health District Regarding Sexual and Reproductive Health Care: (Table 5)

Knowledge of Sexual and Reproductive Health: Data analysis revealed an association between knowledge of HIV transmission prevention practices and the participants' marital status ($\chi^2(8) = 12.27$; $p = 0.1$), suggesting that marital status could influence access or exposure to certain preventive information; no significant association was observed between the level of knowledge and the age of the women surveyed, indicating a relatively homogeneous dissemination of information between generations.

Table 5: Factors associated with SRH knowledge, attitudes, and practices.

Dependent Variable	Associated Factor	Statistical Association
Knowledge of HIV prevention	Marital status	$\chi^2(8)=12.27$; $p=0.1$
Comfort discussing SRH	Age	$\chi^2(4)=13.37$; $p=0.01$
Comfort discussing SRH	Perceived accessibility of services	$\chi^2(4)=30.76$; $p=0.001$
Perceived accessibility	Monthly income	$\chi^2(10)=36.26$; $p=0.001$
Received formal SRH education	Level of education	$\chi^2(6)=36.16$; $p=0.001$
Number of unwanted pregnancies	Age	$\chi^2 16)=81.4\ 7$; $p=0.001$
Number of unwanted pregnancies	Monthly income	$\chi^2(20)=54.12$; $p=0.001$

Attitudes Towards Sexual and Reproductive Health (SRH) Services: A significant proportion of women (65.83%) considered SRH services inaccessible, the main reasons shared was high cost of care (31.39%); poor quality of reception (26.11%). A highly significant association was observed between the discomfort felt during discussions on SRH-related topics and perception of the infrastructural accessibility of services ($\chi^2(4) = 30.76$; $p = 0.001$), reflecting a link between communication discomfort and physical or organizational barriers. Furthermore, a significant association was identified between discomfort in communication and age ($\chi^2(4) = 13.37$; $p = 0.01$), as well as between the perceived accessibility of services and the monthly income level of the women ($\chi^2(10) = 36.26$; $p = 0.001$), confirming the impact of economic inequalities on the perception of access to care.

SSR Practices: 48.33% of women reported using condoms, and 78.61% indicated that they obtained their information mainly through social networks, highlighting the growing role of digital technology in the dissemination of health information. Qualitative interviews highlighted a distrust of modern contraceptive methods *("It makes you sterile", P3),* as well as a priority recourse to family circle for advice *("I go to my mother", P1),* which demonstrates the weight of social representations in health decision-making.

Health Workforce Perspectives: As for the healthcare staff, they are mostly composed of nurses with more than 10 years of experience (71%). Professionals deplore the lack of suitable equipment *("The delivery table is outdated", P1)* and the cultural resistance of certain communities *("Tradition prohibits certain practices", P1),* which limits the effectiveness of SSR interventions.

Associated Sociodemographic Factors: A significant association was found between having received formal education in sexual health and the level of education ($\chi^2(6) = 36.16$; $p = 0.001$). Furthermore, the number of unwanted pregnancies was significantly associated with age ($\chi^2(16) = 81.47$; $p = 0.001$), as well as with the level of monthly income ($\chi^2(20) = 54.12$; $p = 0.001$). Although single women had unwanted pregnancies, married women were more affected, raising questions about marital dynamics, reproductive power, and contraceptive access.

Qualitative Component

Women of Childbearing Age

Profile of Participants: The majority of participants in the qualitative part of the study live in the city center. Their education level and age are diverse, revealing two main profiles; young women aged 20 to 28, generally students and without children; on the other, older women, between 33 and 48, most of them have three to six children.

Main Themes: Qualitative interview results are discussed across: SRH knowledge; access; contraceptive perceptions; information sources; obstacles and recommendations.

A. Representations of Sexual and Reproductive Health

Knowledge about SRH remains unclear; some do not know precisely what SRH covers. She is sometimes seen as protection against disease. *"I understand it as protecting yourself. You have to be clean, avoid diseases, and therefore protect yourself." (P1)* or protected sex and hygiene. *"It has to do with unprotected sex and related diseases." (P6, P10).*

B. Knowledge and Access to Services

Knowledge on existing services and contraceptive methods among women remains limited. The visibility of local structures remains low. *"I don't know any methods" (P1, P2, P3, P4).* Perceptions of SRH access vary; some note family support or facilities, others face stigma, lack of information, or taboos. Main sources are mothers, friends, social networks, and sometimes health personnel. *I'm coming out of the crossing; it wasn't easy to have personal follow-up." (P2)*. The main barriers to accessing SRH services are lack of awareness, fears related to the side effects of contraceptives, social and cultural taboos (particularly towards curious young girls) and limited trust in health facilities: *"I wish there was more confidentiality." (P10).*

C. Perceptions of Contraceptive Methods

Women's perceptions of contraceptive methods are ambivalent. Although they recognize its benefits (pregnancy prevention), common fears remain (fears related to side effects, sterility, menstrual disorders). These perceptions are linked to their sometimes superficial or confusing knowledge of contraceptive methods. *"A friend became seriously ill because of it." (P1) "It can make you sterile." (P3).*

D. Expressed Needs and Expectations

The needs and expectations expressed by women mainly concern awareness raising (awareness campaigns and educational discussion sessions); education of young girls and mothers and improvement of equipment and reduction of exam's costs.

"We should educate young girls better." (P3).

"Reduce the cost of exams." (P6).

"Increase the number of educational discussion sessions." (P4)

Health Personnel

Profile of Health Personnel: The majority of the health staff were nurses, working in the maternity/family planning department, experience varied from 2 to 25 years.

Main Themes Covered: Four axes: knowledge relating to Sexual and Reproductive Health (SRH), challenges and obstacles encountered, practices and needs identified, as well as recommendations made.

A. Representations of Sexual and Reproductive Health

SRH is represented as a comprehensive approach that integrates conception, contraception, childbirth, STI prevention, family planning, postpartum care, psychosocial support.

"Everything relating to conception up to menopause in women." (P1)

"Means for young people and adults to be sexually healthy." (P3)

The latter recognize the institutional framework, giving importance to national policies, even if certain laws are unknown.

"Well yes, national policies, I know for example that family planning must be accessible to everyone regardless of age, we must not refuse to see because the patient is too young (...) regardless of ethnicity, we must offer care to everyone. And as a policy, STI screening is systematic in consultations" (P1).

"I don't know the laws. And regarding the Ministry of Health's policy, I believe that we shouldn't rape young girls or perform abortions." (P5).

B. Knowledge and Access to SSR Services

The priority services cited relate to maternal and preventive care. Knowledge of SRH services covers definitions, cited services, and legal gaps. Some staff view SRH holistically ("from conception to menopause"), while others give vague definitions. Priority services focus on maternal and preventive care.

"CPN, family planning, STI screening, mother-to-child transmission" (P1).

However, the latter have a lack of knowledge of the laws and a poor grasp of national policies. *"It doesn't come to mind» (P2, P3, P4).*

For health personnel, the major obstacles to accessing SRH services are insufficient human and material resources (cramped premises, outdated equipment, lack of educational materials); sociocultural barriers: traditions, religion, taboos, reluctance to consult and insufficient continuing training.

The equipment is obsolete (P3: "Confined premises"). "The delivery table is old" (P1).

"The problem is tradition." (P1) There are conflicts between local norms and medical practices. *"Tradition says that at Eton, we don't do such and such a thing" (P1).*

"Young girls are afraid to come to the hospital (...) one girl used bleach to have an abortion" (P4).

C. Perceptions of Contraceptive Methods

Health personnel recognize the importance of modern methods, but express perceived cultural reluctance. *"Muslims would like to be received by men, women by women." (P1). "We must explain to them that science is different from religion." (P1).*

There is a preference for injectable methods (side effects mentioned) *"Depot, IUD, counseling" (P7).*

D. Expressed Needs and Expectations

To improve SRH service quality, health personnel suggest ongoing training on pregnancy/childbirth tools, strengthening technical platforms, partnerships (district, ministry, NGOs), integrating sexuality education in schools, and proactive outreach to youth. *"We would like some recycling on the partogram" (P1); "Training and recruiting for education (...) many do not know how to count their cycle" (P5). "Integrating the modules into schools (...) Parents threaten children instead of educating them" (P4). Furthermore, a call for institutional strengthening is desired, through "support from the ministry and the municipalities" (P6).*

Discussion

KNOWLEDGE, Attitudes and Practices (KAP) of population of obala district related to sexual and reproductive health (SRH) highlights several major issues which find relevant insights through the theory of social representations (TRS), the Health Belief Model (HBM) and the theory of planned behavior (TPB).

Knowledge of Respondents in SSR

Most women have basic SRH knowledge, including HIV prevention, but it is often superficial, limited to condoms or fidelity. [1] found only 38.5% of women across 18 sub-Saharan countries had in-depth HIV knowledge, able to identify transmission modes and reject misconceptions.

Marital status influences exposure to information, consistent with TRS, while age shows no significant effect, reflecting social network diffusion. Awareness of obstetric and maternal services remains low, indicating gaps in broader SRH knowledge.

Attitudes Towards SSR Services

65.8% respondents perceive SRH services as inaccessible due to cost and poor reception, reflecting persistent structural barriers. This aligns with Lince-Deroche [7,8] in South Africa, where women face costs despite theoretically free services. Quality, confidentiality, and staff availability influence use, showing accessibility depends on social, emotional, and economic acceptability. Discomfort discussing SRH, linked to age, indicates taboos and communication barriers, while HBM explains how perceived barriers and vulnerability affect service use. Income also shapes access, consistent with HBM of Rosenstock [10] and TPB, highlighting socioeconomic and contextual impacts on health behaviors Sone Wai Li [7].

Women's Practices in SSR

Condom use by nearly half of women shows prevention commitment, though fears of sterility persist. TRS Moscovici (1984), links these beliefs to attitudes and behaviors, while TPB Ajzen [2] highlights the role of family and normative pressure in shaping health behaviors.

Health Workforce Perspectives

Healthcare staff denounce material inadequacies and cultural resistance; they thus point to major structural and sociocultural obstacles. This situation limits the feeling of control over the quality of care (a key component of TPB) and impacts the perception of the benefits of accessing SRH services (HBM) Rosenstock [10].

Sociodemographic Factors

The links between education, age, income, and unintended pregnancies highlight the role of social determinants in SRH KAP. Married women are more affected, supporting Adino (2016) that marriage may increase risk due to frequent intercourse, male-dominated reproductive decisions, and pronatalist norms. TPB

Rosenstock [10] explains this via perceived control and normative pressure, emphasizing social norms and power relations in reproductive behaviors.

Conclusion

Obala health district highlights the complexity of Knowledge, Attitudes and Practices (KAP) in Sexual and Reproductive Health (SRH), influenced by both persistent social representations, a subjective perception of risks and benefits, and a low perceived control over health behaviors. The results reveal that barriers to accessing SRH services are not solely due to a lack of information, but are rooted in cultural beliefs, restrictive social norms, economic constraints, and a low perceived quality of care provision. The cross-analysis of the data through the prisms of the theory of social representations, of the Health Belief Model and the theory of planned behavior show that SRH behaviors are the result of a complex process, which combines knowledge, subjective judgment, social pressures and action capabilities. Therefore, any effective intervention will have to adopt an integrated approach, which combines community education, reduction of economic barriers, improvement of the provision of care, and mobilization of social and cultural resources, in particular family networks and community leaders to sustainably transform SRH behaviors.

Suggestions

Community education in local languages would enhance knowledge and use of SRH services. Subsidies and a basic free or affordable package, combined with better reception, would reduce inequalities and risky alternatives.

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Conflict of Interest

None

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