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Prevalence and awareness of female sexual and reproductive health and rights and intimate partner violence in the Fako Division, Cameroon

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Abstract

Background Interventions towards ending intimate partner violence (IPV) and female sexual and reproductive health and rights (SRHR) violation are more successful when the prevalence amongst females, and awareness level of these rights amongst males and females are known. This fosters a compounding holistic impact on women's health and wellbeing throughout the rest of their lives.

Objective This study assessed the prevalence of IPV and SRHR violation amongst females and the awareness of IPV and female SRHR amongst males and females in the Fako Division, Cameroon.

Methods A cross-sectional community-based quantitative study design was used to collect data from participants in Limbe and Buea health districts of the Fako Division. Participants were selected through a multistage sampling technique. A structured questionnaire was used to collect data on IPV from 860 female participants and on the awareness of SRHR from 1487 male and female participants. The data was analyzed in SPSS version 26. Factors associated with the number of IPV experienced by females and awareness of IPV and SRHR were identified using poison and logistic regression models respectively. Awareness of IPV and SRHR among males and females was compared using a Chi squared test. p < 0.05 was considered statistically significant.

Results Of the 860 females surveyed, 818 (95.1%) and 556 (64.7%) have experienced at least one form of IPV and SRHR violation respectively. Factors independently associated with the number of times IPV was experienced included being an internally displaced person (p=0.004, IRR=1.38), unskilled (p=0.001, IRR=1.48), divorced (p<0.001, IRR=3.09), widowed (p<0.001, IRR=0.08) and earning a lower income (p=0.003, IRR=0.72). In addition to having a lower level of education, the associated factors were similar to the prevalence of SRHR violation experienced. Both males (85.5%, 83%) and females (85%, 87%) had a high awareness level of IPV and female SRHR. Amongst the factors associated with IPV awareness, level of education was significant in both females and males (p=0.015, 0.038 respectively) and having a skilled job was significant (p=0.003) with female SRHR awareness.

Conclusion This study showed that though both males and females have a high awareness level of IPV and SRHR, the prevalence of IPV and SRHR violation amongst females is still very high. Male-directed education aimed at promoting behaviour change that fosters respect of women's rights, changes harmful social norms and engages men as champions of female SRHR and ending IPV will likely decrease the prevalence of IPV and female SRHR violation.

Keywords Prevalence, Awareness, SRHR violation, IPV, Fako Division

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Introduction

Women's Sexual and Reproductive Health and Rights (SRHR) are vital prerogatives to their Sexual and Reproductive Health (SRH). The Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (SRHR) defined SRHR as "a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity" [1]. The SRHR unawareness by both males and females, limits women and girls' ability to claim these rights, and result to low sexual and reproductive health (SRH) outcomes. Intimate Partner Violence (IPV) is behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours [2]. The IPV frequency and severity can vary, and will range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years. The IPV can result to death and with over 42% of female IPV survivors having sustained injury, 1.5 times more likely to have an STI, twice likely to have an abortion, 16% more likely to suffer a miscarriage, 41% more likely to have a pre-term birth, higher rates of infant and child mortality and morbidity (through, for example diarrhoeal disease or malnutrition and lower immunization rates) [2, 3]. Every 1 in 3 women are subjects of physical or sexual violence by an intimate partner or a non-partner, and this proportion has stayed constant for the past decade [4]. According to Dr Tedros Adhanom Ghebreyesus, WHO Director-General, "Violence against women is endemic in every country and culture, causing harm to millions of women and their families" which is exacerbated by emergencies such as conflicts, as in the case of the South West Region of Cameroon [4].

Women's inability to have control over their SRH, which worsens in conflict settings, is a major public health problem and an engraved violation of women's rights, that affects the lives and physical and mental health of millions of women and girls globally [2, 5]. According to the WHO, SRHR involves efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality SRH services, including contraceptive services, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and SRH needs of adolescents [6]. Violence against women and girls remains overwhelmingly persistent and starts at a very young age [4]. The current prevalence of 1 in 3 women being subjects of physical or sexual violence by an intimate partner or sexual violence from a non-partner, has stayed constant over the past decade [4]. Before reaching their mid-twenties, 1 in 4 young women (aged 15–24 years) who have been in a relationship will experience violence by an intimate partner [4]. Intimate partner violence is the most prevalent form of violence against women globally, affecting about 641 million women [4]. Given the high levels of stigma and under-reporting of sexual abuse, including the context of Cameroon where reporting is very low, the true magnitude of women experiencing intimate partner violence is likely to be significantly higher [4, 7].

Harmful masculine behaviours, male controlling behaviours towards their partners and ideologies of male entitlement, have been identified as risk factors [2]. "It is deeply disturbing that this pervasive violence by men against women not only persists unchanged, but is at its worst for young women aged 15–24 who may also be young mothers. Every government should be taking strong, proactive steps to address this, and involving women in doing so", said UN Women Executive Director Phumzile Mlambo-Ngcuka [4]. Violence affects women living in low and middle-income countries more, and it worsens in pregnancy [4, 8].

Sub-Saharan Africa is among the regions having the highest prevalence rates of intimate partner violence among women aged 15–49, ranging from 33 to 51% [4]. In 2018, Guttmacher Institute of the Lancet commission of SRHR shared that, all individuals have a right to make decisions governing their bodies and to access services that support that right, and achieving sexual and reproductive health relies on realizing sexual and reproductive rights [9]. Though SRHR is particularly known to remove barriers to women and girls exercising control of SRH in their lives, harmful social norms, gender stereotypes, power imbalances, perceived need to control female sexuality and other inequalities makes this challenging, and potentially impossible, especially among adolescents and girls [10, 11]. In addition, harmful masculine gender norms such as the perceived role of men and fathers in the family as final or authoritative decision-makers, patriarchal control over women's bodies, and of parents deep discomfort in talking to their sons and daughters about sexuality, and not identifying, challenging and changing gender norms early with boys, negatively influences the possibility of more significant positive outcomes of SRHR programs [12, 13].

With root causes of unequal power dynamics between women and men, which is aggravated by armed conflict, it is critical for males, as primary decision-makers regarding sexual and reproductive issues in the family and with a crucial role in advancing SRHR among women and girls, to be aware of IPV and female SRHR [14]. This should also include the health benefits to the woman, family and communities, in order to make and support better informed health choices for their female partners and family [15]. The current study was conducted with the aim of assessing the prevalence of IPV and SRHR violation amongst females and the awareness of IPV and female SRHR amongst males and females in the Fako Division, Cameroon. Findings from this study will provide evidence that informs policy decision-makers of relevant institutions towards making more informed context-specific decisions related to prevalence of IPV and female SRHR violation amongst females, and level of IPV and female SRHR awareness amongst males and females.

Methods

Study setting and design

This study was carried out from June 2022 to September 2022 amongst 1487 participants from 24 communities and eight health areas of Buea and Limbe health districts of Fako Division, in the South West region of Cameroon. The health areas and communities include Muea (Moli, Lyongo and Mile 14 communities), Molyko (Bokwai, Ndongo and Dirty South communities), Bova (Bonakanda, Bova 1 and Bova 2 communities) and Tole (Biukwu, Mevio and Tole Weeding communities) health areas in Buea health district. Those of Limbe health district include Bojongo (Lower Bojongo, Wotutu and Ewongo communities), Seaport (Duckyard 1, Duckyard 2 and Down beach communities), Batoke (Etome, Mbassi and Catchment area communities) and Moliwe (Camp 7, New Camp and Main Camp communities) health areas. Buea and Limbe are highly complex communities caught between a blend of urban, semi-urban, rural and traditional settings and found in the highly conflict-hit South West region of Cameroon with increasing violence against women and girls and a 60% aged population of 15 years and above [16-18]. Buea and Limbe have a population of 90,090 and 84,223 respectively, with those aged between 15 years and above being 54,054 and 50,534 [16, 19]. Though these two towns have as indigenes the Bakwerians, they are homes to people from other ethnic groups of Cameroon and other countries in Africa and the world. Most importantly, since the ongoing conflict in the region, these two towns harbour the highest number of internally displaced women and men within Fako Division of the South West region of Cameroon [20, 21].

A cross-sectional community-based quantitative study design was used to collect data on IPV and SRHR violations amongst females, and level of awareness of IPV and female SRHR amongst males and females in selected households in the Limbe and Buea health districts of the Fako Division.

Study population and sample size

The study included males aged 18 years and above and females aged 15 years and above living in the Limbe and Buea health districts, and who consented to partake in the study. Those not present at the time of the study, debilitated and/or of poor mental state were excluded from the study. The study population comprised of a representative sample of 595 participants from Buea and 557 participants from Limbe, calculated at 95% confidence interval, with the formula for sample size calculation of a cross-sectional study, $n_0 = Z^2 p (1-p)/d^2$, p at 50% (based on the UN Women 2016 Global Database on Violence Against Women in Cameroon), and an effect size of 3 to boost the study strength. The sample representation of each town was obtained through a probability proportionate to size approach. The participants from Limbe and Buea were drawn from 4 health areas and 12 communities each.

Sampling technique

A multistage sampling technique comprising of four stages, was employed in this study. In the first stage, purposive sampling was used to select two health districts of the Fako Division. In the second and third stages, simple random sampling was used to select four health areas from each health district and three communities from each of the four health areas respectively. Thus, a total of eight health areas and 24 communities were included in the study. In the fourth stage, households were conveniently selected. Households with individuals who met the inclusion criteria and consented were selected. In each household, eligible individuals were interviewed.

Study instruments

A pretested standard questionnaire (pretested in two communities and 10% of the study population with similar characteristics to those of the study setting) was utilized as the standard instrument. The questionnaire was adapted from the UNFPA/Engender health tool on engaging men in SRHR programming and the CDC intimate partner violence and sexual violence victimization assessment instruments for use in healthcare settings [22, 23]. The questionnaire consisted of two sections used to obtain information on the prevalence of IPV and SRHR violation amongst females, and the awareness of IPV and SRHR violation amongst males and females. It covered topics on partner support in domestic activities, sexual satisfaction, decision-making on family planning, decision on access to family, physical and mental abuse, forceful sex, reporting and accessing legal support; primary awareness of IPV/ SRHR, sources of information, importance of SRHR

and SRHR services to females, legal age of marriage, female's right to access SRHR services and SRHR decision-making, awareness about legal and supportive services, rights to sexual satisfaction, family planning, family planning decisions and decisions on choice of partner.

Data collection

Six data collectors (three per health district) were trained in-person. In-person reinforced training was conducted, and remotely through Zoom. Training topics included a presentation on the research topic, community engagement and methods, risks and mitigating measures during data collection, a reflection on the pretest, exploration of the hard copy questionnaire and Kobo tool, as well as sharing gaps and proposing alternative strategies. The training allowed for open-learning and identification and addressing of gaps in the data collection instrument both in-person and digitally. A reiterating component was the sensitivity of the research topic, building rapport and prioritizing confidentiality. A pre- and post-test examining these elements was also conducted, and the mean score pre- and post-training were 6.3 and 8.6 respectively. On the scheduled data collection days, for each household, a male and female were interviewed after presentation of the study information sheet and obtained informed consent or assent, with consideration of inclusion of different age groups as per the study population (15 years and above for females, 18 years and above for males). The data collection process was interviewer administered and the interviewing process took into consideration gender sensitivity by male data collectors interviewing male participants, and female data collectors interviewing female participants. Due to participants' sensitivity from perceived security/safety risks of revealing sociodemographic information such as age, occupation and monthly income in such conflict-affected settings, questions on IPV/SRHR prevalence and awareness were first asked to build more trust with participants. To reduce the potential for bias from inaccurate female responses due to stigma, fear and other consequences from their male partners and household members, privacy was strictly ensured during female participant interviews, allowing for safety, comfort and freedom that enhances more honest responses. Data collectors also verified the completeness of each survey with participants, and quality control was conducted by the primary research investigator prior to data entry in order to minimize missing data bias and other sources of bias. The collected hardcopy data were entered daily into the KoboCollect tool and a second quality control conducted by the primary research investigator.

Data management and statistical analysis

Codes instead of names were assigned to each participant. The statistical package for social sciences software (SPSS) version 26 was utilized in statistical analysis. Each questionnaire was sorted, coded, and validated before entering into Kobo Collect and subsequently imported into the IBM SPSS version 26 for analysis.

The outcome variables for this study were prevalence and awareness. The IPV/SRHR violation prevalence amongst females was analysed as proportion of females who have experienced at least one of the eight indicators assessed for IPV and at least one of the five indicators assessed for SRHR violation for the past six months. That of IPV/female SRHR awareness amongst females was analyzed as females with above three positive responses from the six indicators assessed for IPV awareness and proportion of females with above seven positive responses from the 15 indicators assessed for awareness of female SRHR as good awareness, and below as poor awareness. Male awareness of IPV/female SRHR was analysed as proportion of males with above three positive responses from the six indicators assessed for IPV awareness and proportion of males with above seven positive responses from the 15 indicators assessed for awareness of female SRHR as good awareness, and below as poor awareness.

A poison regression model was fitted to identify factors independently associated with the number of IPV experienced by females. Logistic regression models were fitted to identify factors independently associated with the prevalence of SRHR violation as well as awareness of SRHR and IPV. A Chi square test was used to compare the level of awareness of IPV and SRHR between males and females. p < 0.05 was considered statistically significant.

Ethical and administrative considerations

The Faculty of Health Sciences (FHS) Institutional Review Board of University of Buea provided the ethical clearance for the study (Ref: 2022/1845-05/UB/SG/ IRB/FHS). Administrative clearance was obtained from the Regional Delegation of Public Health, South West Region of Cameroon (Ref N°: R11/MINSANTE/SWR/ RDPH/PS/851/762). Approval was also obtained from community heads. Informed consent was obtained from participants of the study aged above 21 years, and assent obtained from all participants aged below 21 years.

Results

Participants' distribution in the study site

Of the 1487 participants enrolled in the study, 770 (51.8%) were from Buea and 717 (48.2%) from Limbe

Variable	Categories	Frequency	Percent
Health district	Buea	770	51.8
	Limbe	717	48.2
	Total	1487	100
Buea Health Distr	ict		
Muea	Moli	63	8.2
	Lyongo	62	8
	Mile 14	73	9.5
Molyko	Bokwai	63	8.2
	Ndongo	64	8.3
	Dirty South	65	8.4
Bova	Bonakanda	64	8.3
	Bova 1	63	8.2
	Bova 2	61	7.9
Tole	Biukwu	63	8.2
	Mevio	63	8.2
	Tole Weeding	66	8.6
	Total	770	100
Limbe Health Dis	trict		
Bojongo	Lower Bojongo	65	9
	Wotutu	63	8.8
	Ewongo	62	8.6
Seaport	Duckyard 1	62	8.6
	Duckyard 2	66	9.2
	Down beach	63	8.8
Batoke	Etome	66	9.2
	Mbassi	63	8.8
	Catchment area	62	8.6
Moliwe	Camp 7	59	8.2
	New camp	21	2.9
	Main camp	65	9.1
	Total	717	100

health districts. Table 1 presents the distribution of the study participants per health district, health areas and communities included in the study.

Socio-demographic characteristics of the study participants

Table 2 show the socio-demographic characteristics of the study participants. Most participants in the study were females (57.8%), aged 21–30 years (36.3%), married (50.8%), Christians (93.8%), of secondary education (50.4%), unskilled (51.4%) and earned a monthly income of < 50,000 xaf (46.8%) (Table 2).

Prevalence of IPV and SRHR among females

Amongst the 860 interviewed females, 818 (95.1%) have experienced at least one of the eight indicators assessed for IPV and 64.7% (556) have experienced at least one of the five indicators assessed for SRHR violation for the past six months.

Factors independently associated with the number of IPV experienced

The study revealed that the number of IPV experienced were independently associated with occupation, IDP status, location, marital status and monthly income (Table 3).

The number of IPV significantly increased amongst females who were unskilled [IRR=1.48, CI (1.18, 1.87), p=0.001] compared to those who were skilled. Experience of IPV significantly increased in females who were divorced [IRR=3.09, CI (1.78, 5.36), p<0.001] compared to those who were single. The number of IPV was significantly reduced among widows [(IRR=0.08, CI (0.05, (0.15), p < (0.001)] compared to those who were single. The number of IPV experienced was significantly reduced among those who earned an income 50,000-100000 xaf [IRR=0.72, CI (0.58, 0.90), p=0.003], 100,001-200000 xaf [(IRR=0.48, CI (0.33, 0.70), p<0.001)] and 200,001-250000 [(IRR=0.40, CI (0.18, 0.87), p=0.021)] compared to those earning below 50,000 xaf. The number of IPV experienced was also significantly reduced in participants who live in an urban area [IRR=0.66, CI (0.52, 0.84), p = 0.001 compared to those who live in a rural areas.

The number IPV experienced was significantly increased amongst participants who were IDPs [IRR=1.38, CI (1.11, 1.71), p=0.004] compared to the hosts.

Factors associated with the prevalence of SRHR violation amongst females

The risk of SRHR violation decreased significantly in the age group 31-40 years compared to those below 20 years (p=0.045). The risk increased significantly in participants with no level of education [aOR=3.11, CI (1.53, 6.32), p=0.002], primary [aOR=1.43, 5.23), p=0.002] and secondary education [aOR=4.28, CI (1.72, 10.67), p=0.002] compared to those who had higher education level. Unskilled workers had a significantly higher risk [aOR=2.60, CI (1.60, 4.20), p < 0.001] compared to skilled workers. For monthly income, the odds of good knowledge were significantly higher in those who earned more than 250,000 frs CFA [aOR = 3.13, CI (1.01, 9.74), P=0.049], but lower in those who earned between 50,000 and 100,000 frs CFA [aOR=0.66, CI (0.46, 0.94), P=0.022] and those who earned between 100,000 and 200,000 frs CFA [aOR=0.47, CI (0.23, 0.95), P=0.036] compared to those earning below 50,000 frs CFA (Table 4).

Table 2 Socio-demographic characteristics of the study participants

Variable	Categories	Ν	Female n (%)	Male n (%)
Health district	Buea	770	444 (29.9)	326 (21.9)
	Limbe	717	416 (28.0)	301 (20.2)
	Total	1487	860 (57.8)	627 (42.2)
Age group (years)	< 21	70	43 (2.9)	27 (1.8)
	21-30	541	347 (23.3)	194 (13.0)
	31–40	316	162 (10.9)	154 (10.4)
	41–50	273	173 (11.6)	100 (6.7)
	>50	287	135 (9.1)	152 (10.2)
	Total	1487	860 (57.8)	627 (42.2)
Status of respondent	Host	1096	592 (39.8)	504 (33.9)
	IDP	273	197 (13.2)	76 (5.1)
	Returnee	118	71 (4.8)	47 (3.2)
	Total	1487	860 (57.8)	627 (42.2)
Marital status	Co-habit	201	139 (9.3)	62 (4.2)
	Divorced	37	23 (1.5)	14 (0.9)
	Married	755	429 (28.9)	326 (21.9)
	Single	452	235 (15.8)	217 (14.6)
	Widowed	42	34 (2.3)	8 (0.5)
	Total	1487	860 (57.8)	627 (42.2)
Number of years living together	1–2	350	189 (12.7)	161 (10.8)
	3–5	349	200 (13.4)	149 (10.0)
	6–9	239	136 (9.1)	103 (6.9)
	10-15	142	81 (5.4)	61 (4.1)
	15–20	139	96 (6.5)	43 (2.9)
	>20	268	158 (10.6)	110 (7.4)
	Total	1487	860 (57.8)	627 (42.2)
Religion	Christian	1395	833 (56.0)	562 (37.8)
	Muslim	27	10 (0.7)	17 (1.1)
	Others	65	17 (1.1)	48 (3.2)
	Total	1487	860 (57.8)	627 (42.2)
Education level	Never	60	36 (2.4)	24 (1.6)
	Primary	387	230 (15.5)	157 (10.6)
	Secondary	790	464 (31.2)	326 (21.9)
	Higher	250	130 (8.7)	120 (8.1)
	Total	1487	860 (57.8)	627 (42.2)
Partner educational level	Never	59	24 (1.6)	35 (2.4)
	Primary	355	188 (12.6)	167 (11.2)
	Secondary	750	423 (28.4)	327 (22.0)
	Higher	323	225 (15.1)	98 (6.6)
	Total	1487	860 (57.8)	627 (42.2)
Occupation	Nothing	111	87 (5.9)	24 (1.6)
	Skilled job	440	217 (14.6)	223 (15.0)
	Student	171	101 (6.8)	70 (4.7)
	Unskilled	765	455 (30.6)	310 (20.8)
	Total	1487	860 (57.8)	627 (42.2)

Variable	Categories	Ν	Female n (%)	Male n (%)
Monthly income (× 1000)	< 50	695	477 (32.1)	218 (14.7)
	50-100	548	301 (20.2)	247 (16.6)
	101–200	175	65 (4.4)	110 (7.4)
	201–250	44	13 (0.9)	31 (2.1)
	> 250	25	4 (0.3)	21 (1.4)
	Total	1487	860 (57.8)	627 (42.2)

Table 3 Factors independently associated with the number of IPV experienced by females in the Fako Division

Variable	Categories	IRR	95% CI	p-value	
			Lower	Upper	
Occupation	Nothing	0.93	0.65	1.35	0.709
	Unskilled	1.48	1.18	1.87	0.001
	Student	0.86	0.60	1.23	0.408
	Skilled job	1			
Health District	Limbe	0.50	0.41	0.61	< 0.001
	Buea	1			
Location	Urban	0.66	0.52	0.84	0.001
	Rural	1			
IDP status	Returnee	0.90	0.64	1.27	0.554
	IDP	1.38	1.11	1.71	0.004
	Host	1			
Marital status	Widowed	0.08	0.05	0.15	< 0.001
	Married	0.85	0.66	1.09	0.192
	Divorced	3.09	1.78	5.36	< 0.001
	Co-habit	1.16	0.87	1.55	0.322
	Single	1			
Income level	50,000-100,000	0.72	0.58	0.90	0.003
	100,001-200,000	0.48	0.33	0.70	< 0.001
	200,001-250,000	0.40	0.18	0.87	0.021
	> 250,000	2.38	0.65	8.75	0.191
	< 50,000	1			

IRR: Incidence rate ratio

Bold values indicates the variable categories that are statistically significant (p < 0.05)

Awareness and factors associated with good awareness of IPV and SRHR amongst females

Of the 860 females assessed, 731 (85%) and 748 (87%) females were aware of IPV and SRHR respectively. Factors independently associated with IPV awareness were the health district and education level. The odd of females in the higher education having good awareness of IPV was 4.3 times higher [aOR=4.30, CI (1.33, 13.98), p=0.015] compared to those with no education level (Table 5). Participants with good awareness have above

three positive responses from the six indicators assessed for IPV awareness and above seven positive responses from the 15 indicators assessed for awareness of female SRHR.

Similarly, to the awareness of IPV, the odd of females with a skilled job having good awareness of SRHR was 1.94 times higher [aOR=1.94, CI (1.26, 2.98), p=0.003] compared to those with no occupation (Table 6).

Awareness and factors associated with IPV and SRHR among males in the Limbe and Buea Health districts

Of the 627 males assessed, 536 (85.5%) and 520 (83%) had good awareness of IPV and SRHR violence respectively.

Factors independently associated with good awareness of IPV in males were the level of education and age group. The odd of males in the higher education having good awareness of IPV were 5.88 times higher [aOR=5.88, CI (1.10, 31.27), p=0.038] compared to those with no education level. The odds of males in the age group > 50 year [aOR=3.67, CI (1.31, 10.27), p=0.013] and 31–40 years [aOR=3.96, CI (1.44, 10.91), p=0.008] having good awareness of IPV were significantly higher compared to those in the age group below 21 years (Table 7).

The awareness of female SRHR by males increased significantly with age. The odds of males having good awareness of female SRHR were more than 4 times significantly higher among males with age above 21 years than those below 21 years. The awareness of SRHR decrease with the number of years of marriage or cohabiting [aOR=0.97, CI (0.95, 1.00), p=0.037] (Table 8).

Gender comparative analysis of awareness of IPV and female SRHR awareness

A comparative analysis of the awareness of IPV and female SRHR awareness amongst males and females showed no statistically significant difference between males and females in the Fako Division (Table 9). Participants having above three positive responses from the six indicators assessed for IPV awareness and above

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Variable	Categories	COR	95% CI		Sig	AOR	95% CI		p-value
District	Limbe	2.01	1.51	2.67	< 0.001	0.5	0.36	0.7	< 0.001
	Buea	1				1			
Age group	>50	0.60	0.30	1.19	0.145	0.5	0.23	1.11	0.087
	41-50	0.66	0.34	1.30	0.229	0.47	0.22	1.03	0.061
	31–40	0.51	0.26	1.01	0.053	0.45	0.21	0.98	0.045
	21-30	0.51	0.27	0.97	0.040	0.56	0.28	1.14	0.110
	<21	1				1			
Education	Never schooled	0.27	0.10	0.69	0.006	3.11	1.53	6.32	0.002
	Primary	0.48	0.30	0.74	0.001	2.73	1.43	5.23	0.002
	Secondary	0.72	0.48	1.06	0.095	4.28	1.72	10.67	0.002
	Higher	1				1			
Occupation	Nothing	0.29	0.17	0.51	< 0.001	1.14	0.55	2.36	0.729
	Unskilled	0.44	0.32	0.62	< 0.001	2.6	1.6	4.2	< 0.001
	Student	0.45	0.28	0.74	0.002	1.07	0.51	2.23	0.863
	Skilled job	1				1			
Income	> 250,000	1.72	1.27	2.33	< 0.001	3.13	1.01	9.74	0.049
	50,000-100,000	5.76	1.74	19.02	0.004	0.66	0.46	0.94	0.022
	100,001-200,000	3.84	2.25	6.56	< 0.001	0.47	0.23	0.95	0.036
	200,001-250,000	0.85	0.09	8.28	0.891	0.37	0.08	1.59	0.18
	< 50,000	1				1			

Bold values indicates the variable categories that are statistically significant (p<0.05)

Table 5 Factors associate	ed with good	awareness of	FIPV in	females
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Variable	Categories	COR	95% CI		Sig	AOR	95%CI		Sig.
Health district	Buea	2.13	1.43	3.19	0.000	0.5	0.32	0.76	0.001
	Limbe	1				1			
Education	Higher	2.79	1.23	6.31	0.014	4.3	1.33	13.98	0.015
	Primary	1.24	0.55	2.84	0.605	1.05	0.45	2.43	0.918
	Secondary	6.59	2.24	19.41	0.001	1.8	0.77	4.22	0.174
	Never schooled	1				1			
Occupation	Skilled job	0.63	0.33	1.21	0.166	1.68	0.66	4.25	0.277
	Student	1.31	0.55	3.14	0.546	0.74	0.29	1.9	0.528
	Unskilled	3.31	1.37	7.98	0.008	0.54	0.28	1.06	0.072
	Nothing	1				1			

Bold values indicates the variable categories that are statistically significant (p<0.05)

Table 6 Fact	ors associated	l with gooc	l awareness o	of SRHR in	females
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Variable	Categories	COR	95% CI		Sig	AOR	95% CI		Sig.
Location	Urban	1.53	1.11	2.10	0.009	1.46	1.04	2.03	0.027
	Rural	1				1			
Occupation	Unskilled	0.90	0.64	1.26	0.533	0.87	0.62	1.22	0.414
	Student	1.77	1.07	2.92	0.026	1.62	0.97	2.68	0.064
	Skilled job	2.00	1.30	3.07	0.002	1.94	1.26	2.98	0.003
	Nothing	1				1			

Bold values indicates the variable categories that are statistically significant (p<0.05)

Variable	Categories	COR	95% CI		p-value	AOR	95% CI		p-value
Health district	Buea	0.47	0.31	0.70	< 0.001	0.42	0.25	0.72	0.002
	Limbe	1				1			
Location	Rural	1.09	0.60	1.95	0.782	1.66	0.87	3.16	0.124
	Urban	1				1			
Age group	>50	0.27	0.11	0.68	0.005	3.67	1.31	10.27	0.013
	21-30	0.31	0.13	0.74	0.009	2.22	0.89	5.52	0.087
	31-40	0.18	0.07	0.47	< 0.001	3.96	1.44	10.91	0.008
	41-50	0.30	0.12	0.78	0.013	2.71	0.94	7.85	0.066
	<21	1				1			
Education	Higher	0.15	0.04	0.55	0.004	5.88	1.1	31.27	0.038
	Primary	0.51	0.17	1.55	0.234	1.15	0.3	4.36	0.836
	Secondary	0.57	0.20	1.64	0.297	0.93	0.24	3.57	0.915
	Never schooled	1				1			
Education partner	Higher	0.28	0.11	0.71	0.008	1.5	0.41	5.44	0.54
	Primary	0.38	0.17	0.88	0.024	2.08	0.78	5.54	0.142
	Secondary	0.34	0.16	0.74	0.007	2.77	0.97	7.93	0.057
	Never schooled	1				1			
Monthly income	> 250,000	1.24	0.43	3.56	0.695	3.14	0.97	10.22	0.057
	200,001-250,000	0.27	0.06	1.19	0.083	0.53	0.11	2.53	0.429
	100,001-200,000	0.35	0.17	0.75	0.007	0.63	0.28	1.44	0.276
	50,000-100,000	0.57	0.34	0.94	0.027	0.86	0.49	1.51	0.592
	< 50,000	1							

 Table 7
 Factors associated with good awareness of IPV in males

Bold values indicates the variable categories that are statistically significant (p<0.05)

Table 8 Factors associated with good awareness of female SRHR in males

Variable	Categories	COR	95% CI		Sig	AOR	95% CI		Sig.
Age group	> 50	1.09	0.43	2.78	0.860	4.32	1.15	16.19	0.030
	41-0	1.98	0.72	5.51	0.189	5.05	1.43	17.78	0.012
	31–40	2.10	0.80	5.55	0.135	4.33	1.34	14.01	0.014
	21-30	2.60	0.99	6.83	0.052	4.40	1.44	13.43	0.009
	< 21	1				1			
Occupation	Unskilled	1.08	0.41	2.83	0.872	0.85	0.31	2.31	0.754
	Student	3.56	1.02	12.37	0.046	3.64	0.87	15.20	0.076
	Skilled job	3.58	1.27	10.09	0.016	2.78	0.95	8.14	0.062
	Nothing	1				1			
Number of years together	Years together	0.97	0.96	0.99	< 0.001	0.97	0.95	1.00	0.037

Bold values indicates the variable categories that are statistically significant (p<0.05)

 Table 9
 Awareness of IPV and SRHR among males and females in the Fako Division

Gender	N	Awareness IPV		p-value	Awareness SRHF	p-value	
		Good (%)	Poor (%)		Good (%)	Poor (%)	
Female	860	735 (85.47)	125 (14.51)	0.991	744 (86.51)	116 (13.49)	0.097
Male	627	536 (85.49)	91 (14.53)		523 (83.41)	104 (16.59)	
Total	1487	1271 (85.47)	216 (14.53)		1267 (85.21)	220 (14.79)	

seven positive responses from the 15 indicators assessed for awareness of female SRHR have good awareness, and below have poor awareness.

Discussion

The analysis of this study showed that despite several efforts to reduce the occurrence of intimate Partner violence (IPV) and female SRHR violation in the Fako Division of the South West region of Cameroon, the prevalence of IPV and SRHR violation are still high. However, the awareness level of both males and females are high, with no significant gender difference in the level of IPV and SRHR awareness.

This study revealed that over 95 percent of females (95.1%) have experienced intimate partner violence at least once, and about 65 percent (64.7%) have had their SRHR violated at least once by a current or former male partner in Fako Division, Cameroon. Therefore, 9 in 10 women and 6 in 10 women have experienced IPV and SRHR violation respectively in the past six months. This indicates the endemic nature of IPV and female SRHR violation in the Fako Division and similar to the high prevalence of 1 in 2 women in some developing countries [4]. The endemic nature of these finding are similar to Dr Tedros Adhanom Ghebreyesus' (WHO Director-General) perspective where he quoted that "Violence against women is endemic in every country and culture, causing harm to millions of women and their families" [4]. Though globally, 1 in 3 women are subjects of physical or sexual violence by an intimate or non-partner, as in this study, women living in low and middle-income countries are more affected [4]. Additionally, the prevalence of female IPV and SRHR violations are exacerbated and higher in emergencies such as the conflict-related humanitarian emergency in this study's settings, which has been ongoing for over six years [4]. These findings are also similar to a similar setting, Syria, where women who seek refuge, as in the case of internally displaced women, in other areas, reported high rates of domestic violence, sexual harassment and early and forced marriages [24]. This prevalence is slightly lower in other developing settings such as in Guyana, where a study among Guyanese women revealed that 55% of Guyanese women experience intimate partner violence [25]. In Cameroon, according to UN Women, the prevalence of lifetime physical and/or sexual intimate partner violence against women is 51% [26]. However, these slightly lower prevalence could be explained by the high levels of stigma and under-reporting of sexual abuse by victims, including the context of Cameroon where reporting is very low [7]. Consequently, the true magnitude of women experiencing intimate partner violence is likely to be significantly higher when these barriers are addressed [4]. As a result, this study, through a holistic integrated approach such as ensuring privacy, confidentiality, trust and rapport with female participants, addressed the stigma and fear of reporting gaps, in order to reveal the true extent to which female SRHR violation and IPV has been prevalent in conflict-affected settings of a developing country. Hence, these findings are similar to those of a humanitarian needs assessment in similar conflict settings of the South West region of Cameroon, shared by UNOCHA in 2019 which reported that, more than 85% of women and girls experienced rape, sexual assault, intimate partner violence, denial of resource/opportunities, psychological abuse, physical violence, and early marriage, with 58% of respondents further stating that most survivors do not tell or seek assistance when they experience violence because they think that people will not believe them [27]. Furthermore, according to Jess Craig for an Aljazeera report in 2021, the situation continuously gets worsened, and reflected by the results of our study, which shows an over 10% increase of IPV and SRHR violation in two years (85% in 2019) [27, 28].

It is therefore critical for females to claim their SRHR rights and their partners to fulfil their obligations in championing females' SRHR and ending IPV. However, several factors may prevent females from upholding their SRHR and not experience SRHR. This study revealed that females who are unskilled, divorced and earning lower incomes experience IPV and SRHR violation more frequently, and lower educational level is specifically associated with SRHR violation. These findings are similar to a study carried out in a similar developing setting, Guinea Conakry in 2015, which reported that 92% of women have experienced SRHR violation and some form of IPV in their lifetime [29]. Among these, the odds of experiencing IPV was higher in women with secondary and primary level of education than those with higher level of education [29]. Additionally, a qualitative study conducted in 2021 to ascertain adolescents and young women's SRHR in slums in Uganda, who are mostly unskilled, have lower education and earning lower, reported that fear and stigma prevented adolescent girls and young women from going to the police during SRHR violations and intimate partner violence, and instead, disputes regarding such issues were handled informally between families [30]. The study further highlighted the need for education and training of girls and women as well as the extension of SRHR education to boys and men given the importance of their role in ensuring women achieve their SRHR, and not to focus exclusively or more on women and girls as have been the case [30]. This will address harmful social norms, gender stereotypes, power imbalances, male's perceived need to control female sexuality and other inequalities [11]. Similarly, in Kenya, SRHR

unawareness limits women and girls' ability to claim these rights, and equally result to low sexual and reproductive health outcomes [31]. Contrarily, despite these associated factors, a 2016 publication by the research directorate, Immigration and Refugee Board of Canada, Ottawa and shared by UNHCR, revealed that, intimate partner violence and violation of women's SRHR is a widespread social problem in Cameroon [32]. UNO-CHA also shared a report by NRC which highlighted that though exacerbated by conflict, SRHR violations and IPV has long been occurring in Cameroon before the ongoing conflict, and with a nationwide prevalence of 56.4% [33]. These deeply-rooted long occurring violations could be explained by the absence of a legislation against IPV, and marital rape being unpunished and treated as a "private family affair" [31]. As a result, most women and girls in Cameroon do not report SRHR violations and IPV due to the alarming social incurring costs [31]. Additionally, in a similar conflict-affected setting in Cameroon called Bamenda, a survey conducted among 298 women in 2020, revealed that 75% of women had experienced IPV [34]. Therefore, despite the associated factors of lower education, being unskilled, divorced and earning lower incomes, with sustained less reporting by victims of IPV and SRHR violation due to fear, and enhanced by consequences of the conflict, and no legislative measures, victims tend to remain in abusive unions and the prevalence of IPV/SRHR violation continuously remain constant globally and exacerbated in developing or conflict-affected settings [4].

During an interview of MenEngage co-chair, Dean Peacock mentioned that, for men to support in championing the challenge against patriarchal norms and advocate for women's SRHR, an enabling environment needs to be created for women such that, a focus on men to understand these rights and women's autonomy in saying Yes or No, are incorporated as sole aspects in interventions about women's empowerment over their SRHR [35]. This study therefore assessed the level of awareness of IPV and female SRHR by both males and females. The results showed that both males (85.5%, 83%) and females (85%, 87%) have a good awareness level of IPV and female SRHR, with no statistically significant difference between awareness level and gender. While higher education, being skilled and increase in age were associated with good awareness of IPV and female SRHR amongst males and females, awareness amongst males decreased with longer years of living with their female partner/in a sexual relationship. These results are contrary to analysis of a qualitative study on men's perceptions of sexual and reproductive health (SRH) education within the context of pregnancy and HIV in Zambia, in 2021, which reported that men have limited knowledge on SRH despite their crucial role in advancing SRHR among women [15]. This difference could be explained by the limitation of the Zambia study which narrowed study participants to just male partners of pregnant women living with HIV, and difference in the methodology whereby the Zambia study conveniently selected and interviewed only 18 participants. Additionally, ongoing SRHR/IPV mass media educational campaigns by humanitarian actors responding to the conflict-related humanitarian crisis might have transcended to participants within the study setting. Though the awareness level of SRHR in this study is good, the prevailing SRHR violation and IPV seems to be an unchecked and compounding phenomenon which is considered normal by most women and prevailed by fear of the consequences of reporting on victims [36]. Contrary to the level of awareness in this study, in rural Bangladesh, a study to assess women's awareness and perception of their SRHR related to human rights in maternal health revealed that less than 10% had good knowledge, 50% believed their husbands were duty bearers, however, similar to this study, awareness was associated with increased education and income [37]. This difference could be explained by the more rural study setting and educational level of females in rural Bangladesh, as compared to this study's semi-urban settings. Men and fathers have over time been considered as the authoritative and final decision makers of the home. However, despite the good IPV and SRHR awareness level amongst males in this study, a qualitative study of men's SRHR perception in a similar developing setting, Lusaka, Zambia, reported that, though men are decision-makers of SRH in their homes such as in pregnancy, they were not confident in their ability to promote SRHR due to limited information and knowledge in this area [15]. Furthermore, a study carried out in Papua New Guinea revealed that though many men had heard about some SRHR aspects like family planning, many were unaware of their importance and of the types of services provided to address SRHR issues [38]. Similar to this study, there was also a very strong association between men's literacy and their knowledge of SRH issues, their discussion of these issues with their wives and their wives' utilization of SRH services [38]. In addition, giving priority to social obligations, although men made most decisions for sexual and reproductive issues, pregnancy, child birth and bringingup of children were regarded as women's responsibilities, yet, women do not have the power to make decisions on these socially enacted duties which concerns their lives, health and wellbeing [38].

The outcomes of this study provides an opportunity for global, national and district health policy makers to reflect the extent of progress, gaps and possible measures to integrate towards achieving SDG 3; Ensure healthy lives and promote well-being for all at all ages, and SDG 5; Achieve gender equality and empower all women and girls; and specifically target 5.6; Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action, including the outcome documents of their review conferences [39, 40].

The fact that a qualitative study was not triangulated to this study prevented an in-depth probing and explanations of responses provided by the respondents.

Conclusively, this study therefore suggests that, though both males and females have a good awareness of IPV and female SRHR, the prevalence is still very high in the conflict-setting of the Fako Division. Though this could be related to social constructs of males as "owners" and decision-makers of women's SRHR, it is highly possible that, males do not have an in-depth understanding of IPV and female SRHR, and the harms and benefits respectively, to the woman, family and society, to truly champion female SRHR and end all forms of violence against women. A male-directed education intervention should be conducted to enhance males' understanding of these issues, address harmful social norms and patriarchal beliefs, secure male buy-in and championing towards ending IPV and female SRHR violation. In addition, as evidence suggests males as primary decision-makers on their partners' SRH, it is critical for policies and interventions towards achieving SDG 3 and 5 to be more broadly targeted towards males.

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Author contributions

The study was conceived, designed, implemented, developed and finalized by NNA. TN partook in the study design, implementation, proof-reading and finalization. SNA and TOE partook in the design, implementation and proof-reading. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to the reason that it was primarily collected as school research of the first author, by the first author, but are available from the first author on reasonable request.

Declarations

Competing interests

The authors declare no competing interests.

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