

Influence of Religious Perceptions on Birth Control amongst Teenagers in Some Secondary Schools in Douala, Cameroon

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Abstract Unintended pregnancy among adolescents is a growing public health concern, particularly in sub-Saharan Africa where cultural and religious norms significantly influence sexual health behaviors. This study explores the level of awareness and the influence of religious perceptions on birth control among teenagers in selected secondary schools in Douala, Cameroon. Employing a cross-sectional design, data were collected through structured questionnaires targeting students aged 13–19 years. The findings reveal that although a portion of the respondents demonstrated basic awareness of birth control methods such as condoms and pills, significant gaps remain in their understanding of natural contraceptive methods, ovulation cycles, and access to reproductive health services. Religious beliefs, particularly within Christianity and Islam, were shown to play a central role in shaping attitudes toward contraceptive use, with many teenagers reporting that birth control was either discouraged or regarded as sinful. The study also identified multiple barriers to effective birth control usage, including socio-cultural taboos, poor parent-child communication on sexual matters, misinformation, fear of side effects, and economic limitations. The results underscore the urgent need for comprehensive sexual education programs tailored to adolescents, incorporating accurate reproductive health information while respecting religious and cultural contexts. Collaboration between schools, religious leaders, healthcare providers, and parents is essential to empower teenagers to make informed decisions about their sexual health. By bridging knowledge gaps and addressing religious concerns, stakeholders can help reduce unintended pregnancies and associated health and social burdens among Cameroonian adolescents.

Keywords Adolescent Reproductive Health, Birth Control, Religious Perceptions, Unintended Pregnancy.

Introduction

Adolescence is a critical period of transition characterized by physical, emotional, and psychosocial changes, including the development of sexual and reproductive maturity. Despite this biological and social evolution, many adolescents remain poorly informed about reproductive health and birth control, particularly in developing regions like sub-Saharan Africa, where sexuality education is limited by cultural and religious barriers [1]. Globally, unintended pregnancies among adolescents aged 15–19 years are estimated at over 21 million annually, with nearly 50% being unplanned [2]. In sub-Saharan Africa, the adolescent birth rate is the highest in the world, with an incidence of 101 births per 1000 girls aged 15–19 years [3].

Worldwide, awareness of birth control remains inconsistent among adolescents. While over 70% of women of reproductive age in Europe and North America use contraception, the rate drops to less than 25% in parts of Western and Central Africa [4]. According to WHO estimates, about 252 million adolescents live in developing countries, and over 38 million are sexually active but do not want to become pregnant within the next two years. Of these, only 15 million use a modern contraceptive method, while 23 million have an unmet need [5]. This gap highlights both a knowledge deficit and limited access to youth-friendly sexual health services.

In Cameroon, early and unintended pregnancy among teenagers is a growing concern, with studies revealing prevalence rates of 24% among students in Yaoundé and 26% in Kumbo [6]. These pregnancies often result in serious health, social, and economic consequences. Teenage mothers face higher risks of eclampsia, puerperal endometritis, and systemic infections, while their babies are more likely to suffer from low birth weight, preterm birth, and neonatal complications [7]. The lack of knowledge about contraception, coupled

with cultural and religious perceptions that often stigmatize its use, contributes significantly to this public health issue. Despite government efforts to integrate family planning into the minimum package of health services, modern contraceptive prevalence remains low. The 2011 Demographic and Health Survey reported a contraceptive use rate of 23.4% among sexually active women aged 15–49 years [8]. For adolescents, these figures are even lower due to stigma, fear, misinformation, and restrictive social norms [9].

Religious beliefs significantly shape individual and collective attitudes toward contraception. In many faith-based communities, especially among Christians and Muslims, contraception is often viewed as a violation of divine law or a promoter of sexual promiscuity [10]. The Roman Catholic Church, for example, recognizes only natural methods of family planning such as the rhythm method and condemns all artificial contraceptive methods [11]. Similarly, certain Islamic interpretations prohibit the use of contraceptives unless medically indicated, though some flexibility exists regarding temporary birth spacing [12].

Protestant and Pentecostal denominations present a more varied stance. While some churches permit contraceptive use within marriage, others discourage it as contrary to biblical teachings [13]. In Judaism, contraceptive use is often subject to the husband's approval and is generally discouraged unless for health or economic reasons [14]. These doctrinal positions influence the behavior of adherents, particularly adolescents, who are already vulnerable due to peer pressure, misinformation, and lack of autonomy.

In Cameroon, where Christianity and Islam are the dominant religions, the influence of religious teachings on reproductive choices is profound. Teenagers raised in conservative religious families may reject contraceptive use due to fear of sin, excommunication, or family

rejection [15]. This dilemma often leads to secrecy, unsafe sexual practices, and eventually, unintended pregnancies or unsafe abortions [16].

In addition to religious beliefs, other barriers compound teenagers' limited access to birth control. Socio-cultural norms, gender inequality, low parental communication about sexuality, and economic constraints play major roles. Most adolescents are not aware of the menstrual cycle, ovulation, or the timing of fertility, and many have misconceptions about the effectiveness and side effects of contraceptives [17]. Furthermore, access to family planning services is often limited by laws requiring parental consent, provider bias, and lack of confidentiality in health settings [18].

Economic barriers also persist. Adolescents from poor backgrounds may lack the financial means to purchase contraceptives or seek sexual health counseling. Moreover, inadequate sexuality education in schools fails to prepare teenagers for responsible sexual behavior. Studies have shown that comprehensive sexuality education reduces risky sexual behavior and delays sexual debut [19].

The increasing prevalence of unintended pregnancies among teenagers in Douala and the associated health and social implications call for urgent and context-specific interventions. In this context, religion and cultural beliefs remain double-edged swords: while they can serve as sources of moral guidance, they may also hinder access to vital reproductive health information and services. To develop effective strategies for preventing unintended teenage pregnancies, it is essential to understand the level of awareness about birth control and how religious perceptions shape reproductive decision-making among adolescents.

This study is justified by the persistent gap in reproductive health education and the high rate of teenage pregnancies in Cameroon. Previous research has focused mainly on adult populations or general contraceptive use

without adequately exploring the intersection of awareness, religion, and adolescent reproductive choices. By focusing on teenagers in secondary schools in Douala, this research seeks to provide critical insights that could inform policy, health education, and community-based interventions. The objective of this study was therefore to assess the level of awareness and religious perceptions on birth control among teenagers in selected secondary schools in Douala.

Material and Methods

Study Design

This study employed a descriptive cross-sectional design using a quantitative approach. The design was chosen to assess the level of awareness and to explore the influence of religious perceptions on birth control practices among teenagers. The cross-sectional nature of the study allowed for the collection of data at a single point in time from a representative sample of secondary school students in Douala.

Study Setting

The study was conducted in the Douala IV municipality, located in the Littoral Region of Cameroon. This area includes a mixture of urban and peri-urban settings with a high concentration of secondary schools, both public and private. The population is religiously diverse, comprising Christians (Catholics, Protestants, and Pentecostals), Muslims, and other religious groups. The choice of this setting was motivated by the relatively high prevalence of teenage pregnancies reported in the area and the observed influence of religion on sexual health behavior.

Study Population

The study population consisted of teenagers (boys and girls) aged 13–19 years enrolled in selected secondary schools in Douala IV municipality. Participants were required to be attending school regularly and to provide

informed consent (and assent for those below 18 years, with parental or school approval).

Inclusion Criteria

1. Adolescents aged 13–19 years.
2. Enrolled in the selected secondary schools.
3. Willing to participate and provide informed consent (or assent with parental approval).

Exclusion Criteria

1. Teenagers outside the age range of 13–19 years.
2. Not present during the time of data collection.
3. Refusal to participate.

Sample Size Determination

The sample size was calculated using Cochran's formula for cross-sectional studies. The estimated prevalence of awareness of birth control was assumed at 50% for maximum variability. To account for potential non-responses or improperly completed questionnaires, a 10% buffer was added. A total of 422 students were thus targeted for inclusion in the study.

Sampling Technique

A multistage stratified random sampling technique was used. Schools were first stratified into public and private categories. Within each category, schools were randomly selected. From each selected school, students were stratified by class level (Form 3 to Upper Sixth), and participants were selected randomly using class registers as sampling frames.

Data Collection Tools and Procedure

Data were collected using a structured self-administered questionnaire designed in English

and French. The questionnaire consisted of four sections:

1. Sociodemographic characteristics (age, sex, religion, school type, class level).
2. Awareness of birth control methods (knowledge, sources of information, understanding of fertility cycle, types of contraceptives).
3. Religious perceptions (attitudes influenced by religion, family/religious teachings on contraception).
4. Barriers to access (economic, cultural, institutional, and personal barriers).

The questionnaire was pre-tested on 30 students in a nearby school not selected for the main study to check for clarity, relevance, and reliability. Necessary modifications were made based on feedback.

Trained data collectors administered the questionnaire in the classrooms under supervision to ensure completeness and confidentiality. Anonymity was ensured by omitting names or identifiable personal data.

Results

Sociodemographic Characteristics of Respondents

A total of 412 questionnaires were correctly filled and returned, giving a response rate of 97.6%. Table 1 shows the sociodemographic characteristics of respondents. The mean age of participants was 16.2 ± 1.7 years. The majority were female (55.8%) and attended public schools (61.2%). Most respondents identified as Christian (82.5%), followed by Muslims (14.1%) and others (3.4%).

Table 1. Sociodemographic Characteristics of Respondents (N = 412)

Variable	Frequency (n)	Percentage (%)
Age Group		
13–15 years	142	34.5
16–17 years	178	43.2
18–19 years	92	22.3

Sex		
Male	182	44.2
Female	230	55.8
School Type		
Public	252	61.2
Private	160	38.8
Religious Affiliation		
Christian	340	82.5
Muslim	58	14.1
Others	14	3.4

Awareness on Birth Control Methods

Most respondents (77.4%) reported having heard about birth control methods. However, only 45.1% could correctly identify at least three modern contraceptive methods. The main sources of information were school health talks (41.8%), peers (25.5%), and media (19.7%). Awareness of the menstrual cycle and ovulation was limited: only 32.3% of respondents could correctly identify the fertile period.

Religious Perceptions on Birth Control

Table 2 shows the religious perceptions of participants on contraception. Approximately 61.7% of respondents reported that their religion discouraged the use of modern contraceptives. Among Christian students, 58.5% viewed contraception as a sin, whereas 70.7% of Muslim students expressed similar beliefs. The most accepted methods were natural methods like abstinence or the calendar method. A small minority (9.5%) reported being taught positively about birth control in religious settings.

Table 2. Religious Perceptions on Contraception

Statement	Agree (%)	Disagree (%)	Not Sure (%)
Contraception is forbidden by my religion	61.7	21.8	16.5
Using contraceptives promotes immorality	52.4	29.3	18.3
My religion supports only natural methods	57.2	22.1	20.7
I would be willing to use contraceptives if permitted	66.5	18.2	15.3

Barriers to Birth Control

Table 3 shows the barriers to contraceptive use as reported by participants. The most frequently reported barriers were lack of information (44.4%), fear of parental judgment (40.3%), religious restriction (36.7%), and fear of side effects (31.8%). Girls reported more religious and cultural resistance compared to boys ($p < 0.05$). Only 23.6% of respondents

had ever discussed contraception with a parent or guardian. Chi-square analysis showed a statistically significant association between religious affiliation and attitudes toward contraceptive use ($\chi^2 = 11.82$, $p = 0.019$). Muslim and Pentecostal Christian students were significantly less likely to express willingness to use modern contraceptives, even if accessible.

Table 3. Reported Barriers to Contraceptive Use

Barrier	Frequency (n)	Percentage (%)
Lack of information	183	44.4
Religious or moral opposition	151	36.7
Fear of side effects	131	31.8
Fear of being judged by parents	166	40.3
Social stigma among peers	108	26.2

**Multiple Responses were Allowed*

Discussion

This study assessed awareness and religious perceptions of birth control among teenagers in secondary schools in Douala IV municipality. The findings revealed that while a considerable proportion of respondents had heard of birth control methods, their actual understanding and ability to use them correctly was limited. In addition, religious beliefs were found to significantly influence attitudes and practices related to contraception, contributing to persistent barriers and knowledge gaps.

Awareness of Birth Control Methods

The study found that a vast majority of respondents had heard of at least one method of birth control, with condoms being the most recognized. However, only 45.1% could correctly identify three or more methods, and knowledge of the menstrual cycle and ovulation was poor (32.3%). These findings are consistent with earlier research showing that although contraceptive awareness is widespread among adolescents in sub-Saharan Africa, comprehensive knowledge is often lacking [1, 2].

Similarly, a study by Darroch et al. estimated that out of 38 million sexually active adolescents in developing countries, only 15 million use modern contraception while 23 million have unmet needs due to misinformation and limited education [7]. In Cameroon, a low contraceptive prevalence rate of 23.4% among reproductive-aged women [8] underscores the limited reach of family planning education. Adolescents, in particular,

may not access sexual health information due to taboos, limited school programs, and minimal parent-child communication [3, 18].

In our study, schools were the primary source of information (41.8%), followed by peers and media. This supports UNESCO's call for comprehensive sexuality education within formal curricula to foster accurate knowledge and informed choices [19]. However, peer-based knowledge is often fragmented and may perpetuate myths, further complicating adolescent decision-making [9].

Religious Perceptions and Contraceptive Use

Religious affiliation emerged as a strong predictor of contraceptive attitudes. A majority of respondents (61.7%) reported that their religion discouraged contraceptive use, and 57.2% indicated that only natural methods like abstinence or the calendar method were acceptable. Christian and Muslim students expressed similar levels of opposition, consistent with previous studies that documented doctrinal resistance to modern contraception [10-12].

The Roman Catholic Church, for example, endorses only natural methods and prohibits artificial contraception, viewing it as a violation of the procreative purpose of sexual activity [11]. Similarly, conservative Protestant denominations and Islamic teachings often discourage contraceptive use, especially among unmarried individuals [12-13]. In our study, Muslim respondents had the highest proportion of religious objection (70.7%), a figure that

aligns with Omran's findings on Islamic views of reproduction and birth control [12].

These findings corroborate Dzedong and Ako's observations that religious doctrines in Cameroon, particularly among youth, can instill guilt, fear of divine punishment, and discourage the uptake of sexual health services [15]. Additionally, in environments where contraception is viewed as promoting immorality (52.4% agreement in this study), adolescents are less likely to seek or use birth control, even if they are sexually active.

Barriers to Contraceptive Access and Use

The study identified several barriers to birth control, including lack of information (44.4%), fear of parental judgment (40.3%), and religious restriction (36.7%). These findings reinforce earlier research indicating that sociocultural norms, lack of adolescent-friendly services, and restrictive policies limit access to contraception [16-18]. WHO has emphasized that adolescents face unique challenges in accessing reproductive health services due to provider bias, limited confidentiality, and restrictive legal frameworks [18].

Additionally, this study found that only 23.6% of adolescents had ever discussed contraception with a parent or guardian. This deficit in intergenerational dialogue has been documented as a risk factor for early and unintended pregnancies [3]. Kumi-Kyereme and Awusabo-Asare also noted that adolescents with low parental communication are less likely to delay sexual initiation or use contraception consistently [17].

Economic and accessibility issues also compound the problem. Although Cameroon has integrated family planning into the basic health package [8], many adolescents still lack the financial means or knowledge to utilize services effectively. Previous studies have shown that adolescents from low-income households are more likely to experience

unplanned pregnancies due to lack of contraceptive access and misinformation [7, 9].

Association Between Religion and Willingness to Use Contraceptives

The significant association ($p = 0.019$) between religious affiliation and willingness to use contraceptives highlights how doctrinal teachings impact individual health behaviors. This supports the findings of Chitando [13] and Freedman and Landy [14], who noted that doctrinal rigidity often translates into behavioral conservatism among religious youth. Even in the face of accurate information, religiously indoctrinated students may reject modern contraception due to perceived spiritual or moral conflict.

The tension between religious identity and reproductive autonomy is critical for policymakers and educators. It suggests that public health initiatives must adopt a culturally and religiously sensitive approach when promoting contraceptive use. Involving faith leaders in sexuality education initiatives may help bridge this gap, a strategy that UNFPA has successfully piloted through interfaith dialogues [10].

Implications for Public Health and Education

The findings of this study underscore the urgent need for expanded sexual health education programs tailored to adolescents, particularly those from religiously conservative backgrounds. Health education in schools must go beyond awareness and foster deeper understanding of reproductive biology, contraceptive options, and personal agency. According to WHO, empowering adolescents through education is one of the most effective strategies for reducing unintended pregnancy and maternal morbidity [1, 5].

Furthermore, engaging parents and religious leaders in adolescent reproductive health initiatives could help dismantle some of the cultural and religious barriers that hinder open

discussions on sexuality. UNESCO and other global bodies recommend multi-sectoral approaches that include schools, families, community-based organizations, and health services in designing youth-friendly programs [19, 20].

Conclusion

This study reveals significant gaps in contraceptive knowledge among teenagers in Douala and highlights how religious perceptions influence attitudes toward birth control. Despite relatively high awareness, misconceptions, religious constraints, and socio-cultural barriers prevent many adolescents from making informed reproductive choices. These findings support the need for comprehensive sexuality education and culturally sensitive interventions that respect religious diversity while safeguarding adolescent health.

Conflict of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

Ethical Approval

The study obtained ethical approval from the Institutional Ethics Committee of the Faculty of Health Sciences, University of Douala. Authorization to conduct the study was also obtained from the Regional Delegation of Secondary Education and from school authorities. Written informed consent was

obtained from participants aged 18 and above. For those below 18, assent was obtained along with parental or guardian permission through school consent protocols. Participants were informed of their right to withdraw at any point without any consequences. Data were securely stored and used solely for academic purposes.

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Author Contributions

Mohnchimbare Christina Mbongueh: Conceptualization, Data Collection, Methodology, Formal Analysis, and Project Administration. Mbabazi Asiati and Fankep Dihewou Alphonse Bertin: Original Draft Preparation. Kamga Fouamno Henri Lucien: Supervision, Review and Editing.

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Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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